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# IA SMALL GROUP EMPLOYER APPLICATION

(for 1–50 eligible employees)

Group Name as shown on Tax and Wage Statement:

Employer Federal Tax ID Number (TIN):

Group Contact:

Industry Type:

Email Address:

Physical Address:

Billing Address:

City:

State:

Zip Code:

Phone Number:

Fax Number:

## SECTION 1: ADDITIONAL GROUP INFORMATION

1. Total number of eligible employees:

2. Requested Health Alliance effective date:

3. Name of current carrier:

4. Is Health Alliance the sole source of health insurance?  Yes  No If No, identify other carriers:

5. Date business started:

6. Is your organization a:  State Government  Local Government  Publicly Traded Corporation  Non-Profit  
 Controlled Group  Privately Held Corporation  Sole Proprietorship  Partnership  Church Group  Other

7. Is the group subject to ERISA?  Yes  No

8. SIC Code:

## SECTION 2: MEDICARE SERVICES

**Please contact your Broker and/or Sales Account Executive for plan options, rates and details.**

1. Please check the plan(s) that interest you:  Medicare Advantage  Medicare Stand-Alone PDP  
Which plan(s)?:

2. Effective date of Medicare plan:  
*(please note applications for Medicare Services cannot be retroactive)*

3. Approximately how many Medicare-Eligible (primary) employees does your group have?:

4. Approximately how many Medicare-Eligible retirees does your group have?:

5. Medicare billing type: *(choose one)*  Group Level  Individual

6. Medicare plan contact information.

Medicare Group Contact:

Email Address:

Physical Address:

City:

State:

Zip Code:

Billing Address:

Phone Number:

Fax Number:

7. Sponsor type:  Employer  Union  Trustees of a Fund

8. Who will the plan(s) be offered to?  Future Retirees  Past Retirees  Both

9. Will the plan be offered to spouses?  Yes  No

10. Will the group allow non-Medicare eligible spouses to stay on the active plan if the spouse moves to the group Medicare plan?  
 Yes  No

Same for dependents?  Yes  No

11. Can retirees leave the plan and come back?  Yes  No

## SECTION 3: THIRD PARTY ADMINISTRATIVE SERVICES

1. Do you have a Health Savings Account (HSA)?  Yes  No

2. Do you have an HRA?  Yes  No

3. Are you currently using BPC to administer third party services such as COBRA, HRA, FLEX or HSA?:  Yes  No  
If Yes, please list services:

**SECTION 4: BROKER INFORMATION (IF APPLICABLE)**

I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application and the eligibility and enrollment information is accepted. I understand I have no right to bind this coverage, to alter terms of the Coverage Contract or Application in any manner or to adjust any claim for benefits under the Coverage Contract.

Print Broker Full Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree that the typed name above shall be treated as a valid signature for all purposes of this form.

**SECTION 5: GROUP INFORMATION**

I have read this application and attest to the accuracy of the above information.

Group Contact: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree that the typed name above shall be treated as a valid signature for all purposes of this form.