



3310 Fields South Drive
Champaign, IL 61822

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

Total number of eligible employees.

1. Requested Health Alliance effective date:

2. Name of current carrier:

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

4. Date business started:

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

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 Supplement 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

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.