Health Alliance NORTHWEST℠

316 Fifth St.
Wenatchee, WA 98801

SMALL GROUP EMPLOYER APPLICATION

(for 1–50 total 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 employees including full-time, part-time, seasonal, owners, etc.?

1. Requested Health Alliance Northwest effective date:
2. Name of current carrier:
3. Is Health Alliance Northwest 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
6. Is your organization subject to ERISA? ☐ Yes ☐ No

SECTION 2: MEDICARE SERVICES

Please contact your Broker and/or Client Consultant for plan options, rates and details.

1. Are you interested in a Medicare Advantage plan? ☐ Yes ☐ No
   Which plan option?:
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

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.

I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud. If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

Group Contact: _____

Signature: _____ Date: _____

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