Wellstar Health Plan

793 Sawyer Road, Marietta, GA 30062

Employer Group Application

SECTION A. GENERAL INFORMATION

1. Legal Name of Employer			
2. Company Name (DBA)		Tax ID	
3. Street Address	City	State	Zip
4. Mailing Address	City	State	Zip
5. Phone Number	Fax Number		
Email Address	Company Website		
6. Business Type ☐Sole Proprietorship ☐Partnership ☐Corporation ☐LLC ☐Other: some other business			
7. Nature of Business SIC Industry State		In Business Since	
8. Company Owner(s)	Email Address		
Title	Phone Number		
9.Company Contact(s)	Email Address		
Title	Phone Number		
10. Is Company subject to ERISA? ☐ Yes ☐ No	Renewal Date		

SECTION B. BENEFITS SELECTION

Plan Type	☐ Level Funded	☐ Traditional Self-Funded	
Plan Period	☐ Contract Year Month:	☐ Calendar Year	
Secondary Network	☐ PHCS Side-by-Side		
Pharmacy Benefit Manag	☐ MedImpact	☐ Liviniti	
Is the plan currently grandfathered?	☐ Yes	☐ No	
Coverage Tier Selection	☐ Employee	☐ Employee +1	☐ Employee +Spouse
	☐ Employee +Child(ren)	☐ Family	
Does Carryover Deductible apply?	☐ Yes	☐ No	

Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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SECTION B. BENEFITS SELECTION, COVERAGE OPTIONS

Benefits	Covered	Non-Covered	Recommendation
Infertility testing			Most plans do cover this service
Infertility treatment			Most plans do not cover this service. If covered, must cover testing as well.
Hearing aids			Most plans do cover this service
Weight loss surgery			If covered, will be subject to medical necessity review.
Acupuncture			Most plans do not cover this service
Chiropractic care			Most plans do cover this service
Treatment for sexual dysfunction			Most plans do cover this service

Refer to the signed Wellstar Health Plan proposal for elected medical and pharmacy plan benefits, plan name(s) as well as optional services elected

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SECTION C. ENROLLMENT INFORMATION

1. Requested Effective Date:

2. Employer's Contribution will be:

_____ of the single employee premium, and

_____ of the dependent coverage premium.

3. What is the Probationary Period for New Hires?

Salaried Employees: _____ day(s) of employment.
Hourly Employees: _____ day(s) of employment.

4. Employer groups must select whether continuation or COBRA benefits will be available to employees who lose eligibility under the group policy. Please select one of the following options:

☐ COBRA ☐ 12 Months of continuation (this option only for groups not eligible for COBRA)

5. Has this Employer ever been covered by Wellstar Health Plan before? ☐ Yes ☐ No

If yes, dates of coverage:

6. Total number of active full and part-time employees as defined in Section E:

7. Total number of eligible employees as defined in Section E:

8. Total number of eligible employees waiving group health insurance:

9. Total number of eligible employees applying for group health insurance:

10. Are any of the employees or dependents applying for group health insurance totally disabled? ☐ Yes ☐ No

If yes, please explain: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

If you need additional space, please use the supplemental dependent page provided at the end of this form.

11. Are all eligible employees covered by Worker's Compensation? ☐ Yes ■ No

12. Who is your company's current health insurance carrier?

Carrier phone number: Years with this carrier:

☐ No Current Carrier

13. Under the Medicare Secondary Payer rules, which one applies for your group?

☐ Medicare is primary (less than 20 full time and part time employees)

☐ Wellstar Health Plan is primary (20 or more full time and part time employees) Wellstar Health Plan is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

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SECTION D. EMPLOYER AGENT BROKER DESIGNATION (IF APPLICABLE)

The Employer authorizes the following agent(s)/broker(s) or agency(s) to be the Employer's Agent of Record:

Primary Agent/Broker

Name:	National Producer Number:
Name of Agency:	Email Address:

Secondary Agent/Broker

Name:	National Producer Number:
Name of Agency:	Email Address:

General Agent

Name:	National Producer Number:
Name of Agency:	Email Address:

To be completed by Primary Agent or Broker

Primary Agent PEPM	**Secondary Agent PEPM**

I as the Agent of record represent that all information contained above is complete and wholly true to the best of my knowledge, and that I know nothing unfavorable about the firm or any individual proposed for insurance except as noted on their Enrollment Application. I have complied with all all applicable eligibility and enrollment rules and have explained in detail the coverages. Any exceptions are detailed here or are referenced to on an additional sheet.

☐ Copy of Agent or Broker W-9 included

SIGNATURE OF PRIMARY AGENT/BROKER	DATE SIGNED (mmddyyyy)

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SECTION E. ELIGIBILITY REQUIREMENTS FOR GROUPS COVERING 1099 EMPLOYEES (IF APPLICABLE)

For groups extending coverage to Contract (1099) Employees, the following guidelines will apply:

1. The Company must enroll (and maintain) at least two W-2 taxed employees.
2. No more than 50% of the group's eligible employees may be 1099 employees.
3. Eligible 1099 employees must be employed by the Company full time and year round.
4. Eligible 1099 employees are subject to the same waiting period (s) as all other eligible W-2 employees.
5. All present and future 1099 employees are subject to the same eligibility requirements as W-2 employees.
6. The Company must contribute the same amount for health insurance coverage for the 1099 employees at it contributes for all other eligible W-2 employees.

Please list below all individuals who meet the above qualifications and then sign below.
If you have more than six (6) 1099 employees please attach an additional sheet of paper and continue to fill out the information requested for all eligible 1099 employees.

Name	Social Security Number	Date of Hire	Hours per Week

COMPANY NAME (PLEASE PRINT)

AUTHORIZED SIGNATURE

DATE SIGNED (mmddyyyy)

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SECTION E. EMPLOYEE ELIGIBILITY

An eligible employee is one of the following persons who is determined to be eligible for coverage under this contract by the Employer, subject to acceptance by the plan:

1. A Full-time employee (at least 17 years of age) of the Employer who works at least 30 hours per week as of the effective date and who works 50 weeks or more per year.
2. An employee who enters into full-time employment after the policy's effective date and who completes the required probationary (waiting) period for eligibility.
3. An employee who is employed and at the Employer's usual place of business. Full-time sales personnel with a primary source of income from the Employer are eligible.
4. An employee who receives a regular paycheck wherein the Employer deducts social security and/or state and federal income taxes.
5. Partners and owners are eligible only if they are bona fide employees of the organization whose main job is to conduct business for the Employer and they meet all other employee eligibility requirements.

SECTION F. EMPLOYER ELIGIBILITY

The Employer certifies that the information on this form is correct to the best of his/her knowledge. The employer further agrees to submit to the following requirements with the application and as may be necessary in the future:

1. The Employer is a corporation, partnership or proprietorship.
2. That the Employer is financially stable and has a minimum of two (2) participating employees.
3. That a payroll deduction system for employee contribution, if any, is in place.
4. That the Employer understands Wellstar Health Plan requires a minimum contribution with groups of 25 or more total employees.
5. That no other group health policy shall be in force.
6. That the employer will permit any eligible employee (as defined in Section E) to enroll.
7. That the Employer's organization was not formed for the sole purpose of obtaining insurance coverage.
8. That the Employer will assist the plan in obtaining a signed statement from the employee or dependents indicating coverage by any other insurance company for coordination of benefits purposes only.
9. That the Employer will permit an audit by Wellstar Health Plan to verify compliance with all policies, procedures and eligibility requirements as defined by the Plan.

SECTION G. FOR CLIENTS ENROLLING IN WELLSTAR HEALTH PLAN HSA PLAN:

The employer acknowledges that Wellstar Health Plan HSA is an integrated product providing individual subscribers with the option to select Wellstar Health Plan's partner [HealthEquity] to administer a Health Savings Account (HSA) for them. As the sponsor of this benefit plan the employer will do the following:

1. Enable employees who establish an HSA with [HealthEquity] to make contributions to this account via payroll deduction.
2. Direct employer HSA contributions, if any are to be made, to employee accounts at [HealthEquity].

SECTION H. NON-PAYMENT OF PREMIUMS AND FUTURE COVERAGE

Your premiums must be paid in full on time in order for your coverage to remain in effect. In accordance with the plan's grace period provisions, your coverage will be cancelled for non-payment of premiums. If you later decide to apply for enrollment in another Wellstar Health Plan, before the new coverage will start, we will require that you pay all past due premium owed to us for coverage you were enrolled in during the twelve-month period prior to the effective date of the new coverage. This will apply to annual open enrollment periods and special enrollment periods. You will also have to pay any applicable initial binder payments for your new coverage.

SECTION I. EMPLOYER CERTIFICATION

I represent that all information noted on this Employer Group Application and all Employee Applications / Health Questionnaires is true and accurate to the best of my knowledge. I hereby confirm that all employer and employee eligibility guidelines have been met and will continue through the contract. I understand that non-payment of premiums may result in a termination of coverage for all parties. I also understand that the proposed insurance coverage shall not become effective until approved by the plan.

PLEASE PRINT NAME	TITLE
AUTHORIZED SIGNATURE	DATE SIGNED (mmddyyyy)

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Supplemental Form for Dependents (page 2, item 10)

Page 2, Item 10, continued: Are any of the employees or dependents applying for group health insurance totally disabled? If so, list them below

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

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HIPAA and Privacy Authorization Form

Group Name _____ Group Number _____

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA), requires express permission before we may discuss/release your protected health information (PHI) to the employer's representative, insurance agent or any other delegated entity. This authorization is needed to document the group's intent and to identify the person(s) who have your permission to contact us on behalf of the group for claims status, benefit information, and/or other matters pertaining to the Plan.

TERMS

The individuals designated below are authorized to access reports, enrollment data, claims information of enrolled individuals and/or have access to the web portal on behalf of the Employer Group to conduct administrative activities as set forth in the HIPAA Privacy Provisions and applicable state data security laws. The Group/Employer Group and designated individuals are responsible to train personnel, take the appropriate and reasonable safeguards to protect the confidentiality, integrity, and availability of PHI of individuals, report to the Employer and Wellstar Health Plan any use or disclosure of an individual's PHI made in violation of or inconsistent with HIPAA or any applicable state data security laws. The Group/Employer Group and designated individuals will report to Wellstar Health Plan in a timely manner of any changes to previously submitted listing of employees and/or Business Associates allowing them with access to PHI data.

AUTHORIZATIONS FOR EMPLOYEES

Name	Job Title	Last 4 digits of SSN	Signature	Reports Including Claims	Eligibility	E-mail Address

AUTHORIZATIONS FOR BUSINESS ASSOCIATES

Name	Job Title*	Last 4 digits of SSN	Signature	Reports Including Claims and Eligibility		E-mail Address
				With PHI	Without PHI	

*Please indicate the organization this individual represents, e.g., your Broker/Agent. Please note Wellstar Health Plan will require any designated Business Associate to also sign a Confidentiality & Non-Disclosure Agreement with Wellstar Health Plan.

Completed form should be returned to [EMAIL ADDRESS] or your Wellstar Health Plan representative.