

# Small Group Master Application



## I. EMPLOYER INFORMATION

### NAME

Exact Legal Name of Company \_\_\_\_\_

Doing Business As \_\_\_\_\_ Employer Federal Tax ID Number \_\_\_\_\_

### STREET ADDRESS (Principal place of business in FL)

Street \_\_\_\_\_ City/State/ZIP \_\_\_\_\_ County \_\_\_\_\_

### MAILING ADDRESS

Street \_\_\_\_\_ City/State/ZIP \_\_\_\_\_ County \_\_\_\_\_

### CONTACT INFORMATION

Employer Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Employer Fax Number (\_\_\_\_\_) \_\_\_\_\_

### CONTACT PERSON

Name and Title of Designated Contact \_\_\_\_\_

Phone Number of Contact (\_\_\_\_\_) \_\_\_\_\_ E-mail Address of Contact \_\_\_\_\_

### COMPANY INFORMATION

Industry and Type of Business or SIC Code \_\_\_\_\_ Date Company Founded (month/date/year) \_\_\_\_\_

Organized as:  Sole Proprietor  Partnership  Self-Employed  Corporation  Other \_\_\_\_\_

*The Employee Retirement Income Security Act of 1974, otherwise known as ERISA, is the comprehensive federal law that regulates pensions and employee benefit plans.*

Is the plan subject to ERISA? Yes  No

## II. ELIGIBILITY INFORMATION

Total number of employees at time of application (include any eligible leased employees) \_\_\_\_\_

Total number of eligible employees at time of application \_\_\_\_\_

Definition of Eligible Employees:  All employees that work 25+ hours per week  Other (describe in detail) \_\_\_\_\_

### WAITING PERIOD (not to exceed 180 days)

New employees are covered on the first of the month after \_\_\_\_\_ days, Other (describe in detail) \_\_\_\_\_

### COBRA/Mini COBRA INFORMATION

Number of former employees currently enrolled in Cobra \_\_\_\_\_

In the preceding calendar year, did the group employ 20 or more (full-time and/or part-time) employees on at least 50% of its typical business days?  Yes  No

### CONTRIBUTION INFORMATION

What percentage of the employees' premium will the employer be paying? \_\_\_\_\_%

What percentage of the employees' dependents' premium will the employer be paying? \_\_\_\_\_%

### OTHER COVERAGE

Do you currently have group coverage?  Yes  No If yes, name of current group carrier \_\_\_\_\_

Is Worker's Compensation coverage provided on all employees?  Yes  No

Proof of coverage is required to avoid 5% sur charge. Attach a copy of the Declaration Page, including effective dates.

## III. REJECTION OF COVERAGE

Please indicate below that you were offered and hereby reject the following coverage: (Check only if applicable)

Florida Small Group Health Benefit Contract (Standard Plans)

Florida Small Group Health Benefit Contract (Basic Plans)

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## IV. COVERAGE SELECTION

Requested Effective Date \_\_\_\_\_

Please Enter Selected Plan(s) Number Below: (if dual - option, please write both plan numbers)

DFS Plans: HM-CL \_\_\_\_\_ or

AvMed Health Plans

HM-OA \_\_\_\_\_

PS-OA \_\_\_\_\_

CH-CH \_\_\_\_\_

HD-OA \_\_\_\_\_

HD-CH \_\_\_\_\_

CD-OA \_\_\_\_\_

CD-CH \_\_\_\_\_

### AvMed Business Extras

- COBRA administration
- Payroll
- Premium Only Plan
- Dental

### Employer Contribution on Consumer Accounts

If selecting an HSA- or HRA-compatible plan, please indicate below the employer contribution amount toward the financial account.

Tier 1 (EE) \$ \_\_\_\_\_ Tier 2 (ES) \$ \_\_\_\_\_

Tier 3 (EC) \$ \_\_\_\_\_ Tier 4 (FAM) \$ \_\_\_\_\_

Note: The provisions contained in the Schedule of Benefits applicable to this Contract and all Exhibits and Amendments executed by the parties and attached hereto are, by reference, made part of this Contract.

## V. AGENT/BROKER INFORMATION

In order to receive correspondence related to this case and proper commission credit, this form must be completed in its entirety. For faster processing, please enclose a copy of the quote.

General Agency (if applicable) \_\_\_\_\_

Agent Name \_\_\_\_\_ FL License ID # \_\_\_\_\_

Agency Name \_\_\_\_\_ Agency Tax ID # \_\_\_\_\_ AvMed Vendor # (if assigned) \_\_\_\_\_

Street \_\_\_\_\_ City/State/ZIP \_\_\_\_\_ County \_\_\_\_\_

Telephone Number (\_\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

Agent E-mail Address \_\_\_\_\_

Agent Signature \_\_\_\_\_

## VI. CERTIFICATION

### I attest that:

- This group is a valid small employer and is not formed for the purpose of securing health benefit coverage.
- The individuals in the small employer group are employees and have not been added for the purpose of securing health benefit coverage.
- The employer has its principal place of business in Florida, employed an average of at least one but not more than 50 eligible employees on business days during the preceding calendar year and employs at least one eligible employee on the first day of the plan year.
- I have been offered the Florida Basic and Standard Plans for small employers and have chosen the plan(s) indicated above.

I certify that the information provided above is true and correct to the best of my knowledge.

**Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

Agreed to and Accepted by the parties the day and year hereinafter written. The Effective Date of this Contract is \_\_\_\_/\_\_\_\_/\_\_\_\_.

Subscribing Group \_\_\_\_\_

AvMed Health Plans \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Print Name \_\_\_\_\_

Title \_\_\_\_\_

Title \_\_\_\_\_

Date (month/day/year) \_\_\_\_\_

Date (month/day/year) \_\_\_\_\_