

# Small Group Master Application

## I. EMPLOYER INFORMATION

### NAME

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

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

Business name as you would like it to appear on the Billing Invoice and Member ID Cards \_\_\_\_\_

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

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

### MAILING ADDRESS

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

### CONTACT NUMBERS

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

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

### CONTACT PERSON

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

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

### COMPANY PROFILE

Nature of Business or SIC Code \_\_\_\_\_ Date Company Founded (month/day/year) \_\_\_\_\_

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

The Employee Retirement Income Security Act of 1974 (ERISA) is the federal law that regulates employee benefit plans. Plans established or maintained by government entities or churches, or plans which are maintained solely to comply with workers' compensation, unemployment, or disability laws are generally exempt from ERISA.

Based on the definition above, check here if your plan is exempt from ERISA .

## II. ELIGIBILITY INFORMATION

Does your company have leased employees?  Yes  No

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

As defined by state law, eligible employees are those employees that work a minimum of 25 hours per week. An employer may not increase the number of hours an employee is required to work in order to be considered benefit eligible. As long as employees meet the 25 hours per week threshold they are considered full time and eligible for small group benefits / coverage.

Based on this definition, please indicate the total number of eligible employees at time of application \_\_\_\_\_

### WAITING PERIOD

New employees are covered on the first of the month after (select one)  Date of Hire  30  60  90  120  150  180 days

### TEFRA/DEFRA (Medicare Payor)

Under Federal law, it is the group's responsibility to accurately determine Medicare status. Note: Employers are encouraged to consult with legal and/or tax advisor(s) before responding to the question below.

In either the preceding or current calendar year, did the group employ 20 or more full-time and/or part-time employees during 20 or more calendar weeks?  Yes  No

### 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

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

For those employees, please indicate COBRA enrollment type  Federal  State Continuation (MiniCOBRA)

If Federal, please indicate current COBRA administrator \_\_\_\_\_

### EMPLOYER CONTRIBUTION

What percentage of the Employee Only premium (i.e. Single Rate) will the employer be paying? \_\_\_\_\_ %

(Note: AvMed Health Plans requires a minimum of 50%)

### 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 a 5% surcharge. 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)

**IV. COVERAGE SELECTION**

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

**Please Enter All Selected Plan Number(s) Below:**

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

AvMed Health Plans

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

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

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

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

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

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

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

<b>AvMed Business Extras</b>
<input type="checkbox"/> COBRA administration
<input type="checkbox"/> Payroll
<input type="checkbox"/> Premium Only Plan
<input type="checkbox"/> Dental

<b>Employer Contribution on Consumer Accounts</b>
I have selected <input type="checkbox"/> HSA or <input type="checkbox"/> HRA administered through HealthEquity. Below are the employer contributions toward the financial accounts.
Tier 1 (EE) \$ _____
Tier 2 (ES) \$ _____
Tier 3 (CN) \$ _____
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 \_\_\_\_\_

**Signature** \_\_\_\_\_

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

Title \_\_\_\_\_

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

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

**Signature** \_\_\_\_\_

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

Title \_\_\_\_\_

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