Small Group Master Application

I. Employer Information

Exact Legal Name of Company:

Doing Business As:	Employer Federal Tax ID Number:

Business Name (As it will appear on Billing Invoice and Member ID Cards - 24 Character Limit):

Street Address (Principal place of business in Florida)

Street:	City:	State:
Zip:	County:	

Mailing Address (If different than above)

Street:	City:	State:
Zip:	County:	

Group Contact Information

Employer Telephone Number:	Employer Fax Number:

Primary Contact Information

Name:	Title:
Phone Number:	Email:

Additional Online Group Administrator

Name:	Title:
Phone Number:	Email:

Company Profile

Nature of Business or SIC Code:	Date Company Founded (mm/dd/yyyy):

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 governmental entities, churches, etc. are examples of plans that may be exempt from ERISA. If you are unsure of your ERISA status, we encourage you to consult with your ERISA counsel. Check here if your plan is exempt from ERISA. ☐

If your plan is not exempt, please provide your ERISA Plan Number: ____________________

Is your company required to file form 5500? ☐ Yes ☐ No

Is this organization part of a group of related businesses that have common ownership? ☐ Yes ☐ No

If "YES", will you be requesting that coverage be extended to the employees of the related businesses under this common ownership? ☐ Yes ☐ No

Is this organization structured as a Non-Profit? ☐ Yes ☐ No

You will be required to supply your most recent payroll report and, if less than 15 employees are enrolling, a copy of your most recent IRS Form 941.

II. Eligibility Information

Total average number of employees including part-time, seasonal or temporary in prior calendar year ______
Total number of employees at time of application (include any eligible leased and/or 1099 or Owners, etc.) ______
Total number of employees on the current RT-6 or Payroll ______
Total number of terminated employees since the last RT-6 or Payroll ______
Total number of new hires not on the current RT-6 or Payroll ______
Total number of other eligible employees not on RT-6 or Payroll (1099, Owners, etc.) ______
Total Number of Eligible Employees ______
Ineligible - Part-time ______
Ineligible- In waiting period ______
Ineligible - Out of Area ______
Other ineligible employees not on RT-6 or Payroll (COBRA, Visa, Etc.) ______
Total Number of Ineligible Employees ______
Total number of employees waiving with other coverage ______
Total number of employees waiving without other coverage ______
Total Number Of Enrolling Employees ______

Note: As defined by state law, an eligible employee is an employee who works full-time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements. An employer may not increase the number of hours an employee is required to work in order to be considered benefit eligible. Employees who meet the 25 hours per week threshold are considered full-time and eligible for small group benefits / coverage.

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Waiting Period

New employees are covered on the first of the month following (select one): ☐ Date of Hire ☐ 30 days ☐ 60 days

Waive Waiting Period during initial Open Enrollment? ☐ Yes ☐ No

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: ____

Note: If left blank, AvMed will enroll the group with WageWorks as your COBRA administrator.

Employer Contribution

How much will the Employer be contributing each month toward employee-only coverage? $_____ or _____ % (Note: AvMed requires a minimum of 50%.)

Other Coverage

Do you currently have group coverage? ☐ Yes ☐ No If yes, name of current group carrier: ____________________

III. Coverage Selection

Requested Effective Date: ______________

Please enter all selected plan name(s) below:

Plan Type ________________ Plan Number ________________

Plan Type ________________ Plan Number ________________

Plan Type ________________ Plan Number ________________

HSAQ Plans Only:

Please complete this section if you have selected an HSAQ plan.
Do you wish for your Health Savings Account (H.S.A.) to be administered by our partner Health Equity? ☐ Yes ☐ No

If Yes, please indicate below the monthly employer contribution amount toward the financial accounts:

Per Subscriber: $ ______________

Per Family: $ ______________

NOTE: All of AvMed's Small Group plans include Pediatric Dental coverage as required by the Affordable Care Act. We have entered into an alliance with Delta Dental Insurance Company to provide this essential health benefit.

IV. Agent/Broker Information

General Agency (if applicable):	Agent Name:		
Insurance License Number:	Agency Name:	State:	Zip:
Street Address:	City:		
Telephone Number:	Fax Number:		
Agent E-mail Address:			

Is Agent Primary Contact for Agency? ☐ Yes ☐ No - If "No", please provide Agency Contact information below:

Name and Title of Designated Contact: ________________________________

Phone Number of Contact: ______________ Email Address of Contact: ________________

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V. Premium Payment Information

Please indicate your choice of payment options:

☐ **Business Check**
☐ Initial Payment ☐ Ongoing Payment

☐ **Electronic Funds Transfer (EFT)**
☐ Checking Account ☐ Savings Account

Name on Account: ____________________ Account Number: ____________________

ABA 9-Digit Routing Number: ____________________ Name of Financial Institution:____________________

Account Holder Signature: ____________________

☐ Initial Payment - We authorize AvMed to initiate a one-time debit entry for our initial monthly premium to our checking or savings account indicated above, and we authorize the named financial institution to debit this entry from our account. We understand that our account will be debited when coverage is approved.

☐ Ongoing Payment - If we are approved and accept coverage, we authorize AvMed to initiate recurring electronic debit entries to our checking or savings account at the financial institution indicated above for our monthly premium payment. We understand that our account will be debited based on the date we select during this application process.
Date of Recurring Payment by Electronic Debit (between 1st and 10th of month):

Monthly Statement Billing

☐ Electronic Billing - If we are approved and accept coverage, we wish to be billed electronically for our monthly premium. We understand that our premium bills will be sent electronically to the email address we supplied in the Contact Information & Online Account Registration section unless we provide a different billing email address below.

Different billing email address? ☐ Yes ☐ No If 'Yes', provide billing email address: ____________________

☐ Paper Billing - If we are approved and accept coverage, we wish to receive paper bills through the U.S. Postal Service for our monthly premium. We understand that our bill will be sent to the mailing address if different from group location address' if supplied in the Employer Information section. We understand that if we did not supply a different mailing address our bill will be sent to the group location address.

VI. Certification

We 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 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year.

We certify that the information provided above is true and correct to the best of our knowledge.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing an y 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.

Subscribing Group:	**AvMed:**
Signature:	Signature:
Print Name:	Print Name:
Title:	Title:
Date (month/day/year):	Date (month/day/year):
Agent Signature:	

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.