



Group Application

HMO products are underwritten by HealthAmerica Pennsylvania, Inc. Pennsylvania in-area PPO and POS products are underwritten by HealthAssurance Pennsylvania, Inc., d.b.a. HealthAmerica. Dental and life insurance products are underwritten by Coventry Health and Life Insurance Company, d.b.a. HealthAmerica.

Product Selection (Check all that apply) Medical Dental

Company Name																																																																																								
Street Address										City		State		Zip																																																																										
Billing Address (if different than street address)										City		State		Zip																																																																										
Telephone Number					Fax Number					Email Address																																																																														
Nature of Business					SIC Code					Company Tax ID Number																																																																														
Business <input type="checkbox"/> Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Non-profit										Date Company Established		Current Medical Carrier		Current Dental Carrier																																																																										
<input type="checkbox"/> Municipality <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Other										Worker's Comp Carrier																																																																														
										Association: <input type="checkbox"/> LVBCH <input type="checkbox"/> LVBCH-WFG <input type="checkbox"/> MANP <input type="checkbox"/> Penn-Ohio <input type="checkbox"/> REHA																																																																														
Decision Maker				Title				Telephone Number				Fax Number																																																																												
Average # of Employees (The same number as "total employees" field in BenefitExpress) _____												Total Eligible for Medical																																																																												
<p>Example: January 1 through December 31, 2009. This average must include all persons employed by the company and any affiliated companies in the preceding calendar year, whether an employee was full-time, part-time, and/or seasonal. Important: the government requires the total average number, regardless of whether employees were eligible to enroll, and/or participated in the group insurance coverage. Only include temporary employees if they are employees of the company (i.e., employees to whom the employer issues a W-2).</p>												# Qualified Beneficiaries under COBRA																																																																												
<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>Month</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Total</th> <th>Average</th> </tr> </thead> <tbody> <tr> <td>FT Emp.</td> <td>20</td> <td>22</td> <td>23</td> <td>24</td> <td>25</td> <td>27</td> <td>25</td> <td>22</td> <td>23</td> <td>21</td> <td>20</td> <td>18</td> <td>270</td> <td></td> </tr> <tr> <td>PT Emp.</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> <td>3</td> <td>3</td> <td>2</td> <td>2</td> <td>1</td> <td>3</td> <td>3</td> <td>3</td> <td>28</td> <td></td> </tr> <tr> <td>Seasonal</td> <td>1</td> <td>1</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>30</td> <td>40</td> <td>40</td> <td>113</td> <td></td> </tr> <tr> <td>Total</td> <td>23</td> <td>25</td> <td>26</td> <td>26</td> <td>28</td> <td>30</td> <td>27</td> <td>24</td> <td>24</td> <td>54</td> <td>63</td> <td>61</td> <td>411</td> <td>34</td> </tr> </tbody> </table> <p>Average = the total number of employees for 2009 divided by 12 months (e.g., 411 divided by 12 = 34)</p>												Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average	FT Emp.	20	22	23	24	25	27	25	22	23	21	20	18	270		PT Emp.	2	2	2	2	3	3	2	2	1	3	3	3	28		Seasonal	1	1	1	0	0	0	0	0	0	30	40	40	113		Total	23	25	26	26	28	30	27	24	24	54	63	61	411	34	# of COBRA Enrollees on Group Policy	
Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average																																																																										
FT Emp.	20	22	23	24	25	27	25	22	23	21	20	18	270																																																																											
PT Emp.	2	2	2	2	3	3	2	2	1	3	3	3	28																																																																											
Seasonal	1	1	1	0	0	0	0	0	0	30	40	40	113																																																																											
Total	23	25	26	26	28	30	27	24	24	54	63	61	411	34																																																																										
												# of Employees Out-of-Area																																																																												
Effective Date						Dual Option* <input type="checkbox"/> Yes <input type="checkbox"/> No * For Dual Option must have 10+ enrolling, only one RX option. A rate adjustment may apply.																																																																																		
Plan Requested: (If Dual Option indicate both plans) <input type="checkbox"/> In-area PPO _____ <input type="checkbox"/> OOA PPO _____ <i>HMO and POS plans are also available upon request</i>						Riders <input type="checkbox"/> RX _____ <input type="checkbox"/> Vision _____ <input type="checkbox"/> Dental Plan # _____ (www.cvtydental.com) Please contact your HealthAmerica Account Executive																																																																																		
Employer Medical Contributions _____ % of single premium toward the cost of each tier –OR– _____ % of premium rates for each coverage tier Dental Employer Contributions _____ %						Terminated employees are covered through: <input type="checkbox"/> end of month - OR - <input type="checkbox"/> last date of employment Provide adult dependent coverage through age 29? (Act 4 of 2009, SB 189) <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please have the adult dep complete a separate SOH.																																																																																		



Eligibility

- date of hire
 - first of month after date of hire
 - first of month after (check one) 30 60 90 days of employment
 - (check one) 30 60 90 120 180 days after date of hire
 - Other (please explain) _____
- Does this apply to all classes of employee? Yes No
If no, please explain. _____

For groups of 51+ eligible employees, Indicate if retirees are covered:
 Yes No If yes, pre-65 AND/OR post-65.

Indicate if domestic partners are covered: Yes No

Are enrollment forms sent to a separate central office prior to being sent to HealthAmerica? Yes No

If yes, please provide contact name, address and phone number.

Employer Funding - If enrolling in a C3 product only:

Please list the amount that the employer is funding toward the employee's single / family deductible.

I certify that I am funding \$ _____ (single) / _____ (family) of my employee's _____ plan (i.e., Premier PPO \$1000)

Premium rates may be adjusted based on the employer's subsidy of the deductible.

Agent Agreement *(if applicable)*

If you wish to recognize a broker to represent your HealthAmerica of PA - a Coventry Health Care Plan coverage, please provide the following information.

To be completed by the broker:

Writing Agent Name: _____ (required) Social Security Number: _____ (required)

Agency Name: _____ (if applicable)

Commission Payable To: _____ (required) Tax ID Number: _____ (required)

Telephone Number: _____

WHOLESALE INFORMATION (if applicable. Commissions will be paid to wholesale agency)

Wholesaler: _____ Tax ID Number: _____ (required, when applicable)

To be completed by the employer's authorized company representative:

Authorized Company Representative Signature: _____

Authorized Company Representative Title: _____ Date: _____

Group Name: _____ Group Number: _____ Effective Date: _____

Your signature above as the **authorized company representative** allows the individual listed above to act as an agent of HealthAmerica and to receive compensation in the form of monthly commission payments for his/her services. **You further understand and agree** that the broker does not have the authority to approve your coverage and/or effective date and may not accept premiums on our behalf. The broker of record listed above will remain in force until HealthAmerica receives formal written notice of cancellation from your company.

Authorized company representative signature is required to execute agent agreement.

Execution of Group Application

The terms and conditions contained in this Group Application (Application) are hereby made an integral part of the Group Contract between HealthAmerica and the Group named below. These terms and conditions will remain in effect until the Group Contract is non-renewed or terminated in accordance with its termination provisions.

Group Information & Applicant Group Signature

Application should only be signed once rates and benefits have been finalized.

Group Name _____ Group Number _____ Effective Date of Coverage _____

Authorized Signature – REQUIRED _____

Print Name _____ Title _____ Date of Signature _____

Fraud Warning

- **PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attach Schedule A: Medical Plan Premium Rates