



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

Ohio PPO, all Out- of-Area PPO, dental and life insurance products are underwritten by Coventry Health and Life Insurance Company, d.b.a. HealthAmerica

Product Selection Medical Dental
(Check all that apply)

General Information

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	
				Date Company Established	
Business		<input type="checkbox"/> Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Non-profit <input type="checkbox"/> Union Group <input type="checkbox"/> Other		Current Carrier	
				Worker's Comp Carrier	
				Association	
Employee Benefits Representative (for legal notification)			Telephone Number		Fax Number
Total Employed <i>(Part Time+Full Time + Waivers)</i>	Total Eligible for Medical	# of Qualified Beneficiaries under COBRA	# of COBRA Enrollees on Group Policy	# of Employees Out - of-Area	Part Time Not Covered

Medical Selection (For Medical Plan Premium Rates, see attached Schedule A)

Check here and skip to the next section if NOT selecting medical coverage

Effective Date	Dual Option* <input type="checkbox"/> Yes <input type="checkbox"/> No * For Dual Option must have 10+ enrolling, only one RX option
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"/> Other _____
Employer Contributions _____ % of single premium toward the cost of each tier –OR– _____ % of premium rates for each coverage tier Eligibility <input type="checkbox"/> date of hire <input type="checkbox"/> first of month after date of hire <input type="checkbox"/> first of month after (check one) <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days of employment <input type="checkbox"/> (check one) <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120* <input type="checkbox"/> 180* days after date of hire <input type="checkbox"/> Other (please explain)	Terminated employees are covered through: <input type="checkbox"/> end of month <input type="checkbox"/> last date of employment For groups of 51+ eligible employees, indicate the age that dependent child eligibility ceases: The earlier of the end of month dependent marries or reaches age (check one) <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> Other _____ For groups of 51+ eligible employees, Indicate if retirees are covered: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> pre-65 AND/OR <input type="checkbox"/> post-65. Indicate if domestic partners are covered: <input type="checkbox"/> Yes <input type="checkbox"/> No Are enrollment forms sent to a separate central office prior to being sent to HealthAmerica? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide contact name, address and phone number.
Does this apply to all classes of employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.	
*Not available to OH groups <51 eligible employees	
Are any divisions billed to a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify division and provide contact name, address and phone number	

Coventry Dental Selection

Check here and skip to next section if NOT selecting dental coverage

For groups of 2-50 eligible employees

Prior dental coverage within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental plan Code requested:	
Employer Contributions (Dental only) _____% For all eligible employees, the employer agrees to contribute an amount equal to at least 50% of the employee premium. For contributions amounts less than 50%, the rates may be adjusted to voluntary levels.		

For Dental Plan Premium Rates, see attached Schedule B

For groups of 51 or more eligible employees

Current Dental Carrier	How long with current dental carrier
Dental Plan Code Requested	
Employer Contributions (Dental only) _____% For all eligible employees, the employer agrees to contribute an amount equal to at least 50% of the employee premium. For contributions amounts less than 50%, the rates may be adjusted to voluntary levels.	

For Dental Plan Premium Rates, see attached Schedule B

Agent Agreement *(if applicable)*

Your signature below as the **authorized company representative** allows the individual listed below 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.

Writing Agent Name: _____ Social Security Number: _____

Commission Payable To: _____ Tax ID Number: _____

Mailing Address: _____

Telephone Number: _____

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

Wholesaler: _____ Tax ID Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Company Name: _____ Effective Date: _____

Group Number: _____

Authorized Company Representative Signature: _____

Authorized Company Representative Title: _____ Date: _____

Fraud Warning

OHIO: Any person, who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

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.

Execution

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.

Applicant Group Signature	
(Print Group Name)	
(Authorized Signature)	
(Print Name)	
Title:	Date:

Schedule A: Medical Plan Premium Rates

Schedule B: Dental Plan Premium Rates

Schedule B – Dental Plan Premium Rates

Option 1

Dental Plan Name: _____ Dental Plan Code: _____ Employer Contribution: _____%
Rates: EE _____ EE + Spouse: _____ EE+Child(ren): _____ Family: _____

Option 2 (if applicable; dual options 51+ eligible employees only)

Dental Plan Name: _____ Dental Plan Code: _____ Employer Contribution: _____%
Rates: EE _____ EE + Spouse: _____ EE+Child(ren): _____ Family: _____

Prior Dental Coverage: Yes No

For all eligible employees, the employer agrees to contribute an amount equal to at least 50% of the employee premium. For contributions amounts less than 50%, the rates may be adjusted to voluntary levels.