

SHADED AREAS ARE FOR PCHP USE ONLY.

ACTIVE GROUP #	PCHP ACCOUNT REP
----------------	------------------

SECTION A. EMPLOYER INFORMATION

COMPANY NAME		REQUESTED EFFECTIVE DATE	
ADDRESS	Street	City	State Zip Code
CONTACT PERSON	PHONE NUMBER ()	FAX NUMBER ()	
BILLING ADDRESS (if different than above)		E-MAIL ADDRESS	
ANY PRIOR GROUP COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide carrier name		WORKERS' COMPENSATION CARRIER	
MEDICAL PRODUCT	DENTAL PRODUCT	<input type="checkbox"/> Comprehensive (<input type="checkbox"/> w/Orthodontia) <input type="checkbox"/> Basic (<input type="checkbox"/> w/Orthodontia) <input type="checkbox"/> Choice (<input type="checkbox"/> w/Orthodontia)	

SECTION B. ELIGIBILITY AND PARTICIPATION

1. **Contributions.** The employer must contribute at least 50% of the employee cost.

Employee _____ % Dependent _____ %

2. How many employees, including owners, work 20 or more hours per week? _____

3. Indicate the number of hours an employee needs to work in order to be eligible for coverage.

20 hours per week (*minimum allowed*) 30 hours per week 40 hours per week Other _____

4. How many employees currently work the number of hours indicated in question 3? _____

5. How many eligible employees are waiving due to a spouse's group plan, MCHA, Medicare, or Medical Assistance? _____

6. **Probationary Period.** (New Employee/Late Entrant): 30 days 60 days 90 days Other _____

The **new employee** probationary period begins from date of hire. The **late entrant** probationary period begins from the date the completed enrollment form is received by PreferredOne Community Health Plan. There is no probationary period for late entrants who have a qualifying event.

Effective Date of Coverage. First day of the calendar month following completion of the required probationary period, provided that application for coverage is received within 31 days of date of eligibility.

7. **Effective Date of Termination of Coverage.** Last day of the month in which the member eligibility ends. In no event will a refund of premiums for more than 60 days be made to the employer for termination of a member's coverage when the employer has failed to notify PCHP of such change.

8. Rate Table _____ Quarter _____ Year _____ UW _____

IT IS UNDERSTOOD AND AGREED THAT:

1. Coverage will not become effective until the completed application has been approved by PreferredOne Community Health Plan and one month's premium has been received;
2. The employer agrees to be bound by all the terms of the Contract and any amendments to such Contract; and
3. No existing coverage should be cancelled until written notice of approval for this application is received by the employer.

Employer Signature (or Authorized Signature)	Title	Date
--	-------	------

Broker/Agent Signature	Phone	Fax	Date
------------------------	-------	-----	------

BROKER INFORMATION (check one of the following) Soc. Sec. No. _____ Tax ID No. _____

Agency _____ Broker _____

Address _____

Brokers/Agents are not authorized to approve this application, determine the effective date of coverage, or waive or alter any provision of this application or the Contract. Payment of the first month's premium does not mean the application has been approved.