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- Unity Health Plans Insurance Corporation
- New Group
- Renewing Group/Change*

EMPLOYER GROUP APPLICATION

You, the Employer and Policyholder, wish to establish and sponsor an Employee Benefit Plan, the terms of which are set forth in the applicable Unity policy. You understand and agree that the Policyholder is not an insurer with respect to paying claims for benefits under the policy. Unity has the discretion to interpret policy terms, make decisions regarding eligibility and resolve factual questions. For you to remain eligible under the policy, the following participation requirements must be maintained. If you fail to maintain participation requirements, Unity will terminate your coverage under the policy. Other termination provisions are stated in the policy.

We may require an employee or dependent to complete a Health Questionnaire based on our standard underwriting practice. **INSURANCE COVERAGE WILL NOT BE EFFECTIVE UNTIL WE APPROVE THE GROUP APPLICATION IN WRITING.** For Groups with more than 50 eligible employees, we have the right to decline coverage for the Group based upon the information contained in the Group Application. For Groups with 50 or fewer employees, we have the right to decline coverage only if the Group does not meet participation or contribution requirements listed below.

1. For groups with more than 15 eligible employees:

<u>Eligible Employees</u>	<u>Unity as Exclusive Carrier</u>
15 – 50	70%
51 or more	75%

When considering participation levels, we do not count as “eligible employees” those employees who have other coverage that is qualifying coverage. Qualifying coverage includes Medicare, Medicaid or other group spousal coverage with benefits similar to those being applied for. An individual plan *may* be qualifying coverage if it has been in force for at least one (1) year.

2. For groups with 2-10 eligible employees, you may select either an HMO Plan or a Point of Service Plan if you meet the following requirements:

<u>Eligible Employees*</u>	<u>Participating Employees*</u>	*Note: The limits will be strictly enforced.
2 – 4	2	
5 – 6	3	
7	4	
8 – 9	5	
10	6	
11-14	70%	

3. The employer is required to contribute at least 50% of a single premium and 25% of a family premium for each employee.
4. Unity reserves the right to change the above stated participation requirements in the event that the Employer offers multiple options for health insurance coverage.

*If an existing Group changes any information contained within this document, for example: legal name, probationary period, benefits, contribution amount, etc., the Group must complete Sections A, B, C, D, E and F of a new Employer Group Application and send it to Unity. Benefit changes must be submitted to Unity at least 30 days prior to an existing Group’s anniversary date in order for the changes to be effective on the anniversary date.

Unity may terminate coverage if participation falls below the minimum requirements. **UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR WRITTEN NOTICE OF APPROVAL BY UNITY’S UNDERWRITING DEPARTMENT.**

Section A - General Employer Information

1. Exact Legal Name of Employer (Policyholder): _____
Federal Tax ID: _____ Name of d/b/a (doing business as): _____
 2. Street Address: _____ City: _____ State: _____ Zip Code: _____
 3. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
 4. County: _____ Phone Number: (_____) _____ Fax Number: (_____) _____
 5. Email: _____
 6. Is this group affiliated with any other group? Yes No If so, is the other group insured by Unity? Yes No
If Yes, Name of Group: _____
 7. Parent Company, if any: _____
Parent Company Federal Tax ID: _____ Number of employees at Parent Company: _____
 8. Do you want coverage for any subsidiaries? Yes No
 - a. If Yes, give legal name and address of each: _____
 - b. If No, give legal name and address of each affiliate not included and identify number of employees and insurance carrier for each: _____
 9. Is this coverage part of a union negotiated agreement? Yes No If Yes, Expiration Date: _____
 10. Nature of Business: _____
 11. How long has your company been in business? _____
 12. Employer Human Resources Contact Person: _____
Title: _____ Email: _____
 13. Employer Billing Contact Person: _____
Title: _____ Email for electronic billing*: _____
- *Please note that there is a billing charge if you do not provide an email address for electronic billing.*
- For groups with 2-50 employees, please attach your Quarterly Wage and Tax Form (Worker's Compensation Quarterly Report or Unemployment Compensation Report – Form UC 101).**

Section B - Plan Information

1. Employees working at least 30 hours per week are eligible for coverage.
Total number of employees: _____ Total number of seasonal or part-time employees: _____
Total number of employees on payroll eligible for coverage: _____ Total number of employees enrolling: _____
 2. If your hourly requirement is less than 30 hours per week, and if you have 10 or more employees enrolling for coverage, you may reduce the hourly requirement to be not less than 20 hours per week.
State your hourly requirement for hours per week _____. (May not exceed 30 hours.)
 3. Do you currently have any former employees who have elected coverage and are covered under COBRA or state continuation?
 Yes No If Yes, indicate names of individuals and their expiration dates: _____
 4. Name of Workers' Compensation Carrier: _____
Do you wish to have 24-hour coverage for owners, officers, or partners not covered by Workers' Compensation?
 Yes No If Yes, name(s): _____
 5. Are you applying for replacement of your current group medical coverage? Yes No
If Yes, you must furnish the following information:
 - a. Name of current group carrier: _____
 - b. Original effective date: _____
 - c. **Attach your most recent billing statement.**
 6. Percent of medical insurance premium paid by Employer: Single: _____ % Family: _____ %
 7. Probationary Period for new employees: 0 days 30 days 60 days 90 days Other _____
Effective Date Provision for New Employees: First of the month following probationary period, if any
 Immediately following probationary period, if any
 8. Is the probationary period the same for employees in the following situations:
Changing from Part-time to Full-time: Yes No If no, please explain eligibility guidelines _____
Return from leave of absence: Yes No If no, please explain eligibility guidelines _____
Return from layoff: Yes No If no, please explain eligibility guidelines _____
Rehire within _____ months (6 month maximum): Yes No If no, please explain eligibility guidelines _____
- * The employee termination date will be the first of the month following the date of termination.**
9. Are you requesting domestic partner coverage? Yes No
 10. Requested effective date: _____ (COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING)

Section C - Retired Employees

If you want to provide medical benefits to retired employees, please give attained age and years of service for retiree class eligibility. A retiree class will be considered only if you have 20 or more employees enrolled for medical coverage. Medical benefits will be effective for retirees if approved by Unity.

Age: _____ Years of Service: _____ Classification: _____

Section D - Benefits

1. **The Rate Proposal Sheet must be attached.**

2. **Benefit Plan:** HMO POS PPO Other: _____

3. **Benefit Riders:** Prescription Drug Domestic Partner Dental Other: _____

4. **Rates:**

Single: _____	Single: _____	Single: _____
Employee + 1: _____	Employee + 1: _____	Employee + 1: _____
Employee/Children: _____	Employee/Children: _____	Employee/Children: _____
Family: _____	Family: _____	Family: _____

Section E - Employer Agreement

You, the Employer and Policyholder, understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE Unity will take action on the Application. Insurance coverage is not in effect unless and until you receive written notification from Unity. If Unity does not accept this Application, we will return the premium deposit submitted with the Application. UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE UNTIL YOU RECEIVE PRIOR WRITTEN NOTICE OF APPROVAL FROM UNITY'S UNDERWRITING DEPARTMENT.

As an authorized representative of this Employer, I do hereby agree to the terms and conditions stated herein and in the policy forms. I further attest and certify that all the statements included herein are true and correct to the best of my knowledge.

Dated on: _____ By: _____
(Month, Day, Year) (Print Employer Name)

By: _____
(Employer Signature)

Title: _____

Dated at: _____
(City and State)

Section F - Agent/Agency Information

Direct Sale, skip the Agent of Record Information. Don't forget to sign the application

Agency Sale, please complete the Agent of Record Information. Don't forget to sign the application

AGENT OF RECORD (Agent/Agency to receive commissions)

Agent License Number : _____ SS#: _____ OR Tax ID Number: _____

Agency Name: _____ Phone Number: (_____) _____ Fax Number: (_____) _____

Street: _____ City: _____ State: _____ Zip Code: _____

You, the agent, certify that you have met with the Employer submitting this Application and that you have fully explained its contents. You have discussed coverage, eligibility, late enrollee delayed effective date, the effect of misrepresentations and terminations provisions.

Date: _____ **Agent's Name:** _____
(Please Print)

Agent's Signature: _____

Agent Check List:

Schedule of Benefits Applicable Riders Employee Applications Current Prior Carrier Statement

Small Employer Compliance Forms Quarterly Wage & Tax Forms Premium Quote

Comments: _____
