GROUP APPLICATION FORM

Thank you for choosing AllWays Health Partners. Please complete all required information, sign this form and return it to your Sales Executive no later than 5 business days prior to the effective date.

Employer Name: ______________________________

Other "DBA" or Alias Name(s):______________________________

Company Address

Street:______________________________

City:____________________ State: __________ Zip: __________

Phone: ____________________ Fax: ____________________

Billing Address (if different from above)

Street:______________________________

City:____________________ State: __________ Zip: __________

Phone: ____________________ Fax: ____________________

Contact Information

	NAME	PHONE	EMAIL
Executive:			
Billing:			
Administrator:			

Company Information

Tax ID: ______________________ SIC Code: ______________________

Date company established: ______________

☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other (explain) ____________

Are any subsidiaries or affiliates to be covered? ☐ yes ☐ no

If yes, name of subsidiary or affiliate and address:

____

____

Total # of employees: ________ # of part time: ________ # of full time: ________

Total # of eligible employees: ______________ # of full-time equivalent (FTE) ____________

# of COBRA employees: ________________ # working aged ______________________

retirees over 65 ______________________ # retirees under 65 ____________________

Employer Contribution Amounts

Notes:

1. *Minimum requirement is 50% for individual and 33% for all other tiers*
2. *For Merged Market groups, amounts must be included for all four tiers.*

Individual: ______________________________

Employee/Spouse: ______________________________

Employee/Children: ______________________________

Family: ______________________________

New Hire Waiting Period (not to exceed 90 days): ______________________________

Minimum Hours per Week Required for Insurance Eligibility: ______________________

Domestic Partner Coverage (please select one option only)

☐ None ☐ Same and opposite sex ☐ Opposite sex only ☐ Same sex only

PLAN COVERAGE

Requested effective date: ____________________ If prior coverage, anniversary date: ______________

Please list prior carrier(s): ____

Will you also offer coverage through another group health plan? ☐ yes ☐ no

If yes, name of other carrier: ____

AllWays Health Partners Selected Plans

Merged Market accounts may offer up to three plan designs. Large Group accounts may offer up to five plan designs.

Plan 1 Type: ☐ HMO ☐ PPO

Plan 1 Name: ________________________________ # enrolling: ______________

Plan 2 Type: ☐ HMO ☐ PPO

Plan 2 Name: ________________________________ # enrolling: ______________

Plan 3 Type: ☐ HMO ☐ PPO

Plan 3 Name: ________________________________ # enrolling: ______________

Plan 4 Type: ☐ HMO ☐ PPO

Plan 4 Name: ________________________________ # enrolling: ______________

Plan 5 Type: ☐ HMO ☐ PPO

Plan 5 Name: ________________________________ # enrolling: ______________

Health Reimbursement Account – HRA (if applicable)

HRA Administrator: ____

Amount Funded: $____________________ or ____________________%

BROKER DESIGNATION (if applicable)

I hereby authorize__________________________of____________________________to obtain and
NAME OF BROKER BROKERAGE AGENCY

receive information from AllWays Health Partners on behalf of_____________________________and to
EMPLOYER NAME

receive fee and/or commission compensation on the group health insurance plan(s) established by this

application. This designation is effective______________________and will remain in effect until
EFFECTIVE DATE

rescinded in writing by an authorized representative of___________________________.
EMPLOYER NAME

I understand that…

1. Coverage is not effective until approved by AllWays Health Partners.
2. Requested effective date of coverage may be declined or deferred if the information submitted is incomplete.
3. Existing coverage should not be canceled until this request is approved.
4. No broker or consultant may make or modify a contract from AllWays Health Partners.
5. Final premium rates are subject to current AllWays Health Partners underwriting guidelines and final enrollment.
6. All enrolled groups are subject to enrollment eligibility review at any time.
7. All groups must verify their enrollment on an annual basis at renewal.
8. Groups found to have misrepresented eligibility of subscriber(s) are subject to immediate cancellation, with no conversion privileges, and are liable for all benefits paid for inappropriate enrolled subscribers.

I certify that the information in this application is true and complete.

Signature: ______________________________ Date: ______________
AUTHORIZED EMPLOYER REPRESENTATIVE

Print name: ______________________________ Title: ______________

Employer group: ____

Broker signature: ______________________________ Date: ______________

Brokerage agency: ____