MEMORIAL HERMANN Health Plan

Medical Coverage underwritten by Memorial Hermann Health Plan, Inc

Large Group Employer HMO Application

FOR Memorial Hermann Health Plan, Inc ("MHHP") USE ONLY		
GROUP NO.	UNDERWRITER NO.	EFFECTIVE DATE

1. EMPLOYER INFORMATION – The employer certifies the following information.

COMPANY NAME			
STREET ADDRESS (P.O. Box not acceptable)	CITY	STATE	ZIP
BILLING ADDRESS	CITY	STATE	ZIP
EMPLOYER IS ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other-Explain:			
COMPANY CONTACT PERSON	PHONE NO. ( )	FAX NO. ( )	
DATE BUSINESS WAS ESTABLISHED (Mo/Yr)	TYPE OF BUSINESS (Be specific)	E-MAIL ADDRESS	SIC CODE

Has the company been insured by MHHP in the last 12 months?......... ☐ Yes ☐ No If yes, date prior MHHP coverage terminated: ____________________

Has the employer filed for bankruptcy in the past seven years?........... ☐ Yes ☐ No Tax Identification Number (TIN) ____________________

2. MEDICAL COVERAGE SELECTION - Select

Zero Deductible Plan	**Choice Benefit Plans** **You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.**	
☐ Select 001 HMO	☐ Select 3000-80 HMO	☐ Select 3000-80 HSA HMO
	☐ Select 5000-80 HMO	☐ Select 5000-80 HSA HMO
	☐ Select 2000-100 HMO	☐ Select 3000-100 HSA HMO
	☐ Select 5000-100 HMO	☐ Select 6450-100 HSA HMO
	☐ Select 6600-100 HMO Premier	☐ Select Premier Copay
	☐ Select 6600-100 HMO Standard	☐ Select Standard Copay
	☐ Custom Plan	☐ Custom Plan

3. ADDITIONAL RIDERS

IN·VITRO FERTILIZATION RIDER ☐ Add rider ☐ Decline rider ☐ N/A

PLEASE NOTE: In-Vitro Fertilization benefits MUST be offered consistently across all plan selections.

FOR MHHP USE ONLY					
DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS

4. RATING

Choose one rating methodology

☐ **Individual Rating -** each enrolling employee's rate depends on the employee's age, area, and family status.

☐ **Composite Rating -** rating factors for all enrolling employees are combined, and average amounts are charged for the four family categories of Employee Only, Employee and Spouse, Employee and Children, or Full Family.

5. EMPLOYER CONTRIBUTION

5A. EMPLOYER MEDICAL CONTRIBUTION OPTION

☐ Traditional Contribution**** ____________________%

**** Employer selects contribution amount over 50% or more per employee per month.

6. EMPLOYEE ELIGIBILITY

Total number of employees (including owners):________________________ Number of **ineligible** employees: ________________________

Number of full-time (usually 30 hours per week) employees: ___________ Number of **eligible** employees **declining** coverage: __________

Total number of eligible **enrolling** employees including COBRA/FMLA applicants: ____

Are all eligible employees subject to withholding as on a W-2 form? ☐ Yes ☐ No

Please explain:____

Eligibility date is on the FIRST DAY of the month following the waiting period.

Waiting period for all future employees: ☐ None, effective first of next month ☐ 30 days ☐ 60 days

☐ No waiting period, effective immediately ☐ Waive waiting period at initial group enrollment only ☐ Waive waiting period at open enrollment

The following is to be completed by groups of 20 or more total employees and/or employer providing continuation of coverage in accordance with Title X of COBRA: Is your group subject to COBRA? ☐ Yes ☐ No

If yes, please complete the COBRA/FMLA questionnaire.

The following question is to be completed by groups of 50 or more total employees and/or for an employer providing coverage in accordance with the Family and Medical leave Act of 1993: Is your group subject to FMLA legislation? ☐ Yes ☐ No

If yes, please complete the COBRA/FMLA questionnaire.

7. CURRENT CARRIER - Is this plan intended to replace any existing group coverage?

HEALTH: ☐ Yes ☐ No If yes, name of group carrier: ________________ Proposed termination date: ____________________________

8. EFFECTIVE DATE - Actual effective date will be assigned by MHHP underwriting department if policy is issued.

Requested effective date: ____

9. LEAVE OF ABSENCE

A. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence:

☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months

B . Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence **(maximum six months)**:

☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

It is the Employer's responsibility to immediately notify MHHP at the beginning of any authorized leave of absence.

10. MEDICAL INFORMATION

To your knowledge:

1. Is any person to be covered unable to work due to Injury or Illness? ☐ Yes ☐ No
2. Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? ☐ Yes ☐ No

If yes to either question, provide names, dates, and degree of recovery: ____

11. WORKERS' COMPENSATION

Name of current Workers' Compensation carrier: ______________________________ Renewal date: ____________

Please list the name and job title of any person to be Included as a subscriber under the MHHP coverage who IS not an employee, for the purpose of Workers' Compensation law or Similar legislation. Please note that under Texas law, partners and corporate officers, or members of boards of directors are employees for Workers' Compensation purposes except under limited Circumstances.

Name:	**Title:**	Exempt according to above requirements?
______________________	______________	☐ Yes ☐ No
______________________	______________	☐ Yes ☐ No

12. SIGNATURE/DISCLOSURE STATEMENT

Check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA, apply to obtain the coverage indicated.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan, which is a church plan or governmental plan as defined under ERISA and therefore not subject to ERISA, apply to obtain the coverage indicated.

☐ We, the employer, agree that MHHP can provide an electronic copy of the Certificate of Coverage document to us for distribution to our employees, rather than issue a paper copy to each covered employee.

We represent that all information on this Application is true and complete, and that MHHP may rely on this Application in its decision to evaluate our group for eligibility and rating purposes. If not complete, MHHP reserves the right to reject the Application and notify us in writing. We understand and agree that coverage will be effective only if we have paid our first month's premium and have met eligibility criteria. We understand that we will be informed of acceptance and effective date in writing if this Application is issued, that we should keep prior coverage in force until so notified and that no agent or broker has the right to accept this Application or bind coverage. This Application becomes a part of our contract with MHHP. **We verify that these answers are true and that coverage may be re-evaluated for eligibility and rating purposes should it be determined at a future date that there are misstatements in these Application forms. MHHP can only terminate your coverage for 1) failure to pay premiums, 2) fraud or intentional misrepresentation of material fact, 3) noncompliance with the terms of the plan, 4) not having employees that live or work in MHHP's service area, or 5) your membership in an association terminates (if you have joined MHHP by being in an association). We understand that termination is subject to the notice requirements and provisions in the Group Agreement. We have provided the individual, or the person through whom the Individual was eligible to be covered as a dependent, prior to declining coverage with an explicit written notice in bold type, specifying that failure to elect coverage during the initial enrollment period permits the plan to impose at the time of the Individual's later decision to elect coverage, an exclusion from coverage until the next open enrollment period and received signed acknowledgement of the notice.**

Composite rates may be recalculated if a change in membership would otherwise result in a premium change for the group of more than 10%.

ARBITRATION AGREEMENT: We understand that any dispute between us and MHHP may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing such arbitration. The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the policyholder or, if applicable, the beneficiary resides. By signing this Application, we are not agreeing to binding arbitration.

Dated at ______________________________ on the ________ day of ____________ 20________

By X ______________________________ Title ______________________________

(Signature of Company Officer / Owner)

13. CONDITIONAL RECEIPT - Agent, please photocopy and give to your client.

This will acknowledge receipt of $ ______________ from ______________________________

as a deposit against the insurance premiums that would become payable if Memorial Hermann Health Plan, Inc accepts this Application for group coverage. This check will be held in trust by MHHP pending acceptance or rejection of the Application. I have fully explained to the employer that in no event will benefits be payable for any loss incurred before the effective date assigned by Memorial Hermann Health Plan, Inc and that the company should retain any other coverage until then.

14. AGENT'S CERTIFICATION

☐ I hereby certify that I am not aware of any Information not disclosed in this Application by the employer which may have bearing on this risk.

☐ I hereby certify that I have advised the employer not to terminate any existing coverage until receiving written notification from MHHP that the coverage being applied for by this Application is issued.

1 NAME OF WRITING AGENT (Print or Type)	% Commission to be Paid	AGENT TAX I.D. NO.	(CHECK ONE) ☐ E = EIN ☐ S = SS#
AGENT ADDRESS	PHONE NO. ( )	FAX NO. ( )	
CITY / STATE / ZIP			
SIGNATURE OF AGENT X		DATE	

2. NAME OF ☐ SUB-AGENT ☐ SECOND WRITING AGENT (Print or Type)	% Commission to be Paid	AGENT TAX I.D. NO.	(CHECK ONE) ☐ E = EIN ☐ S = SS#
AGENT ADDRESS	PHONE NO. ( )	FAX NO. ( )	
CITY / STATE / ZIP			
SIGNATURE OF AGENT X		DATE	
3. NAME OF GENERAL AGENT		AGENT TAX I.D. NUMBER	

Send Administration Kit to: ☐ **Agent** ☐ **Group**

Insurance coverage is underwritten by Memorial Hermann Health Plan, Inc. The Memorial Hermann Health Plan, Inc logo is a registered trademark of Memorial Hermann Health System.

For MHHP Internal Use Only:
Sales Director
Account Executive

As of the Effective Date indicated above on page one of this Application, MHHP hereby agrees to issue coverage to the above named Employer, pursuant to the terms and conditions of the attached Group Policy. This is the signature page for the Group Policy.

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Chief Financial Officer