MEMORIAL HERMANN Health Insurance Co

Medical Coverage underwritten by Memorial Hermann Health Insurance Company

GROUP EMPLOYER APPLICATION SMALL GROUP METAL PLANS

FOR Memorial Hermann Health Insurance Company ("MHHIC") USE ONLY		
GROUP NO.	UNDERWRITER NO.	EFFECTIVE DATE

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

COMPANY OR EMPLOYER 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 COMPANY WAS ESTABLISHED (Mo/Yr) | TYPE OF BUSINESS (Be specific) | E-MAIL ADDRESS | SIC CODE

Has the Company been insured by MHHIC in the last 12 months? ..... ☐ Yes ☐ No If yes, date prior MHHIC coverage terminated: _____

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

Has the Employer been without group health coverage for at least 2 months prior to the requested Effective Date?"..... ☐ Yes ☐ No

2. MEDICAL COVERAGE SELECTION - Metal Plans

Platinum	☐ **Select Platinum 500 PPO**
Gold	☐ **Select Gold 1000 PPO** ☐ **Select Gold 1500 PPO** ☐ **Select Gold 2000 PPO** ☐ **Select Gold 2000-3500 PPO** ☐ **Select Gold Copay PPO**
Silver	☐ **Select Silver 3000 PPO** ☐ **Select Silver 4500 PPO** ☐ **Select Silver 5000 PPO** ☐ **Select Silver 4000 HSA PPO**
Bronze	☐ **Select Bronze 6850 PPO** ☐ **Select Bronze 5000 HSA PPO** ☐ **Select Bronze 6550 HSA PPO**

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

4. EMPLOYER CONTRIBUTION

4A. EMPLOYER MEDICAL CONTRIBUTION OPTION

☐ Traditional Contribution**** _____%

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

5. 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: ☐ 1 month ☐ 2 months ☐ waive waiting period during group initial enrollment

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

If yes, please complete the COBRA/FMLA questionnaire.

The following question is to be completed by employers 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 company subject to FMLA legislation? ☐ Yes ☐ No

If yes, please complete the COBRA/FMLA questionnaire.

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

Requested effective date:_____

Current Carrier - Is this plan intended to replace any existing group coverage?

Health ☐ Yes ☐ No If yes, name of carrier: _____ Proposed termination date: _____

7. LEAVE OF ABSENCE

A. Number of months employees are eligible to continue health 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 health 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 MHHIC at the beginning of any authorized leave of absence.

8. 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 (use another page if necessary):_____

9. 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 MHHIC 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

10. SIGNATURE/DISCLOSURE STATEMENT

Check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA, apply for the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to binding arbitration only after the ERISA appeals procedure has been completed.

☐ 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 for the coverage indicated.

☐ We, the employer, agree that MHHIC 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 MHHIC may rely on this Application in its decision to evaluate our group for eligibility and rating purposes. If not complete, MHHIC 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 and the signature page become a part of our contract with MHHIC. **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. 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.**

ARBITRATION AGREEMENT: We understand that any dispute between us and MHHIC 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 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)

11. 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 MHHIC accepts this Application for group coverage. This check will be held in trust by MHHIC 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 MHHIC and that the company should retain any other coverage until then.

12. 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 MHHIC 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

For MHHIC Internal Use Only:
Sales Director
Account Executive

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

_____

Company Officer Name, Title