INTERNAL USE ONLY		
GROUP NO.	UNDERWRITER NO.	EFFECTIVE DATE

Memorial Hermann Health Plan, Inc.
Memorial Hermann Health Solutions, Inc.
Memorial Hermann Health Insurance Company
Memorial Hermann Commercial Health Plan, Inc.

LARGE GROUP EMPLOYER APPLICATION

For HMO products, 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.

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

COMPANY OR EMPLOYER NAME		**TAX ID NUMBER**	
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)	**EMAIL**	**SIC CODE**

Has the Company ever been insured by MHCHP/MHHIC? …… ☐Yes ☐No
If yes, date when prior coverage was terminated? _____

Has the Company filed for bankruptcy in the past seven years?..... ☐Yes ☐No

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

Are there any other commonly owned businesses not covered under this contract?..... ☐Yes ☐No
If yes, submit the Common Ownership form.

Does this company have an agreement with or do they lease any of their employees from a PEO (Professional Employee Organization) or Employee Leasing Firm?..... ☐Yes ☐No
If yes, Name Organization: _____

Will this contract be terminated?..... ☐Yes ☐No
If yes, date of termination: _____ (copy of termination letter required)

Does the Company have employees outside Texas?..... ☐Yes ☐No

Are the majority of the Company's employees employed in Texas or is the primary location of the business in Texas?..... ☐Yes ☐No

Was the Company in business during the previous calendar year?..... ☐Yes ☐No
If not, what is the average number of employees the Company expects to employ in the calendar year in which this application is submitted?_____

2. MEDICAL COVERAGE SELECTION:

HMO* Consumer Choice Plans		
☐ Select 002 HMO	☐ Select 1500-80 HMO	☐ Select 5000-80 HMO
☐ Select 003 HMO	☐ Select 2000-80 HMO	☐ Select 5000-100 HMO
☐ Select 500-80 HMO	☐ Select 2000-100 HMO	☐ Select 6600-100 Standard HMO
☐ Select 1000-60 HMO	☐ Select 2500-80 HMO	☐ Select 3000-100 HSA HMO
☐ Select 1000-80 HMO	☐ Select 3000-80 HMO	☐ Select 5000-100 HSA HMO
☐ Select 1000-100 HMO	☐ Select 3000-100 HMO	☐ Select 6550-100 HSA HMO

HMO	
☐ Select 001 HMO	

PPO – Select Plan(s) using the checkbox at the left and place and "x" in the box at the right if Buy-up is requested			
	BUY-UP (X)		**BUY-UP (X)**
☐ Select 002 PPO		☐ Select 3000-80 PPO	
☐ Select 1000-60 PPO		☐ Select 5000-80 PPO	
☐ Select 1000-80 PPO		☐ Select 6600-100 Standard PPO	
☐ Select 1000-100 PPO		☐ Select 5000-80 HSA PPO	
☐ Select 1500-80 PPO		☐ Select 6550-100 HSA PPO	
☐ Select 2000-80 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.

4. EMPLOYER MEDICAL CONTRIBUTION OPTION (Choose one)

☐ Traditional Contribution_____Employer selects contribution amount over 50% or more per employee per month.

☐ Contribution to Base Plan_____Base Benefit Plan Name _____

5. EMPLOYEE ELIGIBILITY

Total number of employees (including owners): _____

- Number of **ineligible** employees: _____
- Number of full-time **eligible** (usually 30 hours per week) employees: _____
- Number of **eligible** employees with other coverage and **waiving** coverage: _____
- Number of **eligible** employees with **NO** other coverage and **declining** coverage: _____

Total number of enrolling COBRA/STATE Continuation/FMLA applicants: _____

Total number of eligible enrolling (excluding COBRA/STATE Continuation/FMLA applicants) employees: _____

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

If no, please explain: _____

Is a Tax and Wage form being submitted with this application? …… □ Yes □No

If no, please explain: _____

Eligibility date is on the FIRST DAY of the month following the waiting period. Employees within their waiting or affiliate period will not count towards meeting minimum participation requirements.

Waiting period for all future employees*: □ None □ 30 days □ 60 days

Waiting Period Waiver: □ Waive waiting period at initial group enrollment

□ Waive waiting period at open enrollment

Length of orientation period if applicable*: □ None □ 30 days Concurrent with Waiting Period? □ Yes □No

*Total cannot exceed 90 days.

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 1991: Is your company subject to FMLA legislation?..... □ Yes □ No

6. EFFECTIVE DATE - Actual effective date will be assigned by Underwriting Department if policy/contract is issued.

Requested effective date (Must be first of the Month): _____

Is this plan intended to replace any existing group health coverage? …… □Yes □No

If yes, name of carrier: _____ Proposed termination date: _____

7. CURRENT CARRIERS

A. Will this employer offer any other group Medical benefit plans which will not be terminated?... □Yes □No
If yes, please provide the below:

Name of Group Carrier: _____

Benefit plan description: Summary of Benefits to be submitted with the Application.

Employer Contributions: _____

Rates: _____

Renewal Date of Coverage: _____

B. Will this employer be contributing to an HRA or an HSA? …… □Yes □ No
If yes, please provide the below:

Name of Administrator: _____

Amount of Contributions: _____

C. Will this employer be implementing a GAP or MEC benefit plan, or self-funding any part of the benefit plan? …….. ☐ Yes ☐ No

If yes, please provide the below:

Name of Administrator: _____

Benefit plan description: Summary of Benefits to be submitted with the Application.

8. 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 MHCHP/MHHIC at the beginning of any authorized leave of absence.

9. MEDICAL INFORMATION

To your knowledge:

A. Is any person to be covered unable to work due to injury or illness? ……. ☐ Yes ☐ No

B. 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):

_____

_____

10. COBRA AND MEDICARE STATUS

Cobra Status:

A. How many full-time employees did your company have for at least 50% of the business days in the preceding calendar year? _____

B. How many part-time employees did your company have for at least 50% of the business days in the preceding calendar year? _____

Based on above information, please indicate group's Cobra status:

☐ Non- federal COBRA eligible (less than 20 full-time equivalents)

☐ Federal COBRA eligible (20 or more full-time equivalents)

Medicare Status:

A. How many employees did your company have for at least 20 or more calendar weeks during the year? _____

Based on the information above, please indicate your group's Medicare status:

☐ Medicare Prime (Less than 20 Full-Time and Part-Time Employees)

☐ Memorial Hermann Health Insurance Company/ Commercial Health Plan (20 or more Full-Time and Part-Time Employees)

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 MHCHP/MHHP coverage who is not an employee, for the purpose of worker's compensation law and similar legislation. Please note that under Texas law, partners and corporate officers, or members of boards of directors are employees for Worker's compensation purposes except under limited circumstances.

A. Name of Exempt Employees	Title	Exempt according to above requirement?
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

B. Name of Employees Receiving Compensation Benefits	Title
_____	_____
_____	_____
_____	_____
_____	_____

12. SIGNATURE/ACKNOWLEDGEMENTS/DISCLOSURE STATEMENTS

Check all boxes below that apply. One box must be checked for items 1 and 2; if not applicable, please explain why:_____

_____

☐ 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, intend to treat the health benefit plan as part of a plan or program under the federal Internal Revenue Code, 26 U.S.C. Section 106 (Concerning Contributions by Employer to Accident and Health Plans) or Section 162 (Concerning Trade or Business Expenses).

☐ We the employer, agree that MHCHP/MHHIC can provide an electronic copy of the Evidence of Coverage/Certificate of Coverage document to us rather than issue a paper copy. We, the employer, understand that we can withdraw our consent to receive the EOC/COC electronically at any time by calling MHCHP/MHHIC at 855-645-8448.

We the employer, understand and agree that MHCHP/MHHIC reserves the right to review the employee's payroll/ wage and tax records at any time to confirm eligibility. MHCHP/MHHIC may request the employer's most recent wage and payroll records. The employer agrees to furnish MHCHP/MHHIC with all requested information and documentation which may be reasonably required with regard to eligibility of coverage. The employer understands they will have approximately 10 business days from the date of request to provide all requested information.

We acknowledge that changes in the state or federal laws or regulations or interpretations thereof may change the terms and conditions of coverage. We acknowledge and agree that the Final Proposal and Acceptance Agreement shall be incorporated by reference and be made a part of the Policies/Contracts with MHCHP/MHHIC.

The employer, while not an agent of MHCHP/MHHIC, will be responsible for collection of premiums from employees, will notify employees of the termination of their coverages and will forward to employees notices and/or amendments sent by MHCHP/MHHIC to the Employer.

We represent that all information on this application is true and complete, and that MHCHP/MHHIC may rely on this application in its decision to evaluate our group for eligibility and rating purposes. If not complete, MHCHP/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 applications 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 MHCHP/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 MHCHP/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 policy holder or, if applicable, the beneficiary resides. By signing this application, we are not agreeing to binding arbitration.

For reference: Memorial Hermann Health Insurance Company (MHHIC); Memorial Hermann Commercial Health Plan (MHCHP)

Dated at _____ on the _____ day of _____ 20 _____

Signed by X _____ Title _____

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

14. AGENT'S CERTIFICATION (must be completed)

☐ 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 MHCHP/MHHIC that the coverage being applied for by this application is used.

1. NAME OF WRITING AGENT (Print or Type)	% TO BE PAID	AGENT TAX ID 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)	% TO BE PAID	AGENT TAX ID NO.	(Check one) ☐ E= EIN ☐ S= SS#
AGENT ADDRESS	PHONE NO.	FAX NO.	
CITY/STATE/ZIP			
SIGNATURE OF AGENT x		DATE	

NAME OF GENERAL AGENT	AGENT TAX ID NUMBER

For reference: Memorial Hermann Health Insurance Company (MHHIC); Memorial Hermann Commercial Health Plan (MHCHP)

Insurance coverage is underwritten by Memorial Hermann Health Insurance Company/Memorial Hermann Commercial Health Plan, Inc.

INTERNAL USE ONLY:					
SALES DIRECTOR					
ACCOUNT EXECUTIVE					
DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS

As of the effective date indicated above on page one of the application, MHCHP/MHHIC hereby agrees to issue coverage to the above named employer, pursuant to the terms and conditions of the attached group agreement or policy.

_____

MHCHP/MHHIC Officer Name, Title