



CHARTER HEALTH PLAN
A big idea for small business

Employer Application

Check here if you are a member of our Alliance Associates.

Company Name (Legal Name) DBA/Doing Business As (if applicable)

Street Address _____ City _____ State _____ Zip _____

Billing Address (if different than above) _____ City _____ State _____ Zip _____

Company Representative (Authorized to request Enrollment/Termination of Employees) _____ Phone Number _____ Fax Number _____
(____) _____ (____) _____

E-Mail Address _____ Federal Tax ID Number _____ Date Business Established (Mo/Yr) _____

Employer Classification Corporation L.L.C. Non-Profit Partnership Sole Proprietor Other

Employer Contribution:

	Employer's Contribution for Employee coverage	Employer's Contribution for Dependent Coverage
Medical	% Contribution	% Contribution
	_____ %	_____ %

Effective Date: Actual effective date will be assigned by the Charter Health Plan underwriting department if application is approved.

Requested effective date (First of the month only): _____ Actual Effective Date _____

Section 125 Plan Does the group have a flex plan under Section 125 of the Internal Revenue Service code? Yes No

Employee Eligibility: Number of Employees

Full-Time Employees (If total number of employees enrolling is 3 or less, all must work a minimum of 30 hours per week)

Employer's Minimum Hours Required - Please check the appropriate box: 20 hours 25 hours 30 hours

_____ Total number of Full-Time Employees **enrolling** in the Plan

_____ Total number of Full-Time Employees **waiving** Charter Plan benefits but covered through Individual or spouse's health plan

_____ Total number of Full-Time Employees waiving Charter Plan benefits with **no other coverage**

_____ **Total** number of Full-Time Employees

Part-Time Employees

_____ Total number of Part-Time Employees

Eligibility date for new employees will be the first day of the policy month following the **employer required** waiting period.

Employer's Required Waiting Period - Please check the appropriate box: 30 days 60 days 90 days 180 days

This waiting period is for all classes of employees, with no exceptions. There will be no changes until renewal/open enrollment.

Worker's Compensation Information:

Charter Health Plan's coverage is not occupational in nature and consequently, it is not a substitute for Worker's Compensation coverage.

Name of current Worker's Compensation carrier: _____ Renewal Date: _____

Is Worker's Compensation coverage provided on all employees? Yes No

If not, please provide a list of all employees enrolling that are NOT covered by Worker's Compensation or similar legislation (including titles).

24/7 Optional Rider:

For an additional premium charge: 24/7 coverage is offered only to owners, officers and/or directors and adds work related injury or illness coverage to the policy. Please provide a list of the names and titles of those to be covered. Request Rider Yes No

Name: _____ Name: _____ Name: _____

Title: _____ Title: _____ Title: _____

Medical Information:

Is any person to be covered unable to work due to illness or injury? Yes No

Is any person unable to perform the normal duties of another person in the same employment class and same age and sex? Yes No

If yes, is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.

Prior Group Medical Coverage:

Have you, the employer, provided group medical coverage for any of your employees in the last six months? Yes No

If yes, please give the date that coverage began and the date that coverage ended. Coverage began _____ Coverage ended _____

Name of Insurance Carrier: _____

Signature Section:

It is agreed that no coverage shall become effective as to any person who is not then a bona fide full-time employee, regularly performing the duties of his or her occupation, unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). All statements herein shall be deemed representation and not warranties.

The applicant acknowledges that it has selected this plan based upon written information provided by Charter Health Plan and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly to employee's coverage under the Group Agreement or Group Policy available to Charter Health Plan for inspection, at Charter Health Plan's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

Applicant has selected, in accordance with applicable laws, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant's employees and the contribution amounts.

The plan document will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

All data that may have a bearing on coverage or premiums will be open for Charter Health Plan to inspect while the Group Agreement or Group Policy is in force.

Some benefits are subject to limitations or maximums.

Charter Health Plan cannot guarantee any results or outcome.

I hereby apply for the coverage indicated above. I certify that all the information provided in this application is accurate and complete. I understand that this application will form a part of the Group Agreement or Group Policy issued by Charter Health Plan (a sample which may be available on request), and by my signature below I agree to be bound by the terms and conditions of that Group Agreement or Group Policy. I understand that Charter Health Plan may choose this application at its sole discretion.

Signed at (location) _____ City, State _____ Company _____

By: _____ Authorized Applicant Signature _____ Official Title _____

_____ Witness _____ Date _____