EMPLOYER GROUP APPLICATION
(Becomes part of the Group Policy)

Underwritten by: **NATIONAL HEALTH INSURANCE COMPANY**
Third Party Administrator: Meritain Health,1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441
800-847-8361
Fax Enrollment/Change Form to: (763)852-5011
Visit our website for more information at: www.meritain.com

COMPANY NAME	GROUP NUMBER (office use)	
STREET ADDRESS (physical address only)	DIVISION NAME AND NUMBER (office use)	
CITY STATE ZIP	REQUESTED EFFECTIVE DATE	
BILLING/MAILING ADDRESS	COUNTY	FEDERAL EMPLOYER I.D. NUMBER
CITY STATE ZIP	TYPE OF INDUSTRY	
CHIEF EXECUTIVE OFFICER OR PROPRIETOR	YEARS IN BUSINESS	
BENEFITS ADMINISTRATOR / TITLE	PHONE	FAX
E-MAIL AND WEBSITE ADDRESS	OTHER LANGUAGE CONSIDERATIONS	

DOES THE APPLICANT OFFER OTHER COVERAGE: ☐ YES ☐ NO☐Don't Know
IF YES, PLEASE LIST THE CARRIERS AND TYPE OF COVERAGE OFFERED AND PREMIUM FOR EACH OPTION

1.	3.
2.	4.
PREVIOUS CARRIER(S) 1.	2.

Are all employees eligible for this plan covered by Worker's Compensation? ☐ YES ☐ NO ☐Don't Know
If NO, please explain: _____

TYPE OF ORGANIZATION: ☐ Corporation ☐ Partnership Other_____
☐ Sole Proprietorship __

ELIGIBLE EMPLOYEES:

1. Total number of employees _____
2. Total number of employees covered under another employer sponsored plan _____
3. Number of part-time, seasonal and temporary employees _____
4. Number of eligible employees (subtract line 2 and3 from line 1) _____
5. Number of employees declining (complete waiver) or covered elsewhere _____
6. Total employees enrolling with National Health Insurance Company (subtract line 5 from line 4) _____

CONTINUATION COVERAGE:

Employer is responsible to contact current carrier to obtain name(s) and address(es) of current COBRA participants.
Please indicate number of current COBRA participants _____ (attach list)
Is employer required to offer: ☐ Federal COBRA ☐ Cal-COBRA

BENEFITS:

☐CA Standard Plan Bronze 4800 HDHP
☐CA Standard Silver 2000 Copay
☐CA Standard Gold 0 Copay
☐CA Standard Platinum 0 Copay]

EFFECTIVE/RENEWAL DATE: _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

OPEN ENROLLMENT: _____ _____ _____ _____ _____

_____

GROUP NAME	GROUP NUMBER (office use)

SELECTED ELIGIBILITY REQUIREMENTS: A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship.

Any employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, in the small employer's regular place of business is an eligible employee. An employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if the following apply: (1) The employee otherwise meets the definition of an eligible employee except for the number of hours worked. (2) All similarly situated individuals are offered coverage under the health benefit plan and (3) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter.

CATEGORIES OF ELIGIBILITY:

☐ **Dependents** spouse, domestic partner, children (including disabled children over 26)

☐ **Retired Beneficiaries** (subject to approval) ☐ **Early Retirees** (under age 65) ☐**Board of Directors** ☐**Other** – provided detailed description

COMMENCEMENT OF COVERAGE:

☐ 1st of the month following Date of Hire

☐ 1st month following _____ days/months from Date of Hire

Service Waiting Period can be no more than 90 days.

Note: All terminations are effective the last day of the month in which Employee ceases to be eligible under group eligibility provisions.

EMPLOYER CONTRIBUTION & PARTICIPATION REQUIREMENTS:

(Employer must contribute a minimum of _____ of Employee only premium)

☐ **Employee Only** **$** _____ **or** _____ **% of Rate**

☐ **Dependents** **$** _____ **or** _____ **% of Rate**

If the California Standard Bronze 4500 HDHP is elected, the permissible range of employer contribution to an employee's health savings account is: $0-182 or $761-$1,145

BROKER INFORMATION:

☐ Existing Broker

☐ New Broker (must complete Carrier Appointment

Broker Name: _____ Phone: _____

Agency: _____ Fax: _____

Broker Number: _____ E-mail: _____

License Number: _____

COMMENTS:

EMPLOYER STATEMENT

We wish to enroll our organization as an employer account with National Health Insurance Company.
We understand the eligibility rules applicable to enrollment and understand the premium requirements.
Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

PREMIUM REQUIREMENTS: Monthly premiums are due and payable in full on the first day [or the fifteen] (to coincide with original effective date) of each calendar month. There is a grace period of 31 days for payment of monthly premium during which grace period the Policy will continue in force, unless We have given prior written notice of discontinuance. We are liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Policy and shall become a part thereof.

We understand that National Health Insurance Company reserves the right to rescind any individual Certificate if an Employee has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the Policy. If National Health Insurance Company intends to rescind an individual Certificate, the Company will send a notice to the Employee via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the Employee of his or her right to appeal that decision to the California Insurance Commissioner pursuant to Section 10273.4, subdivision (b) of the California Insurance Code. After 24 months following the issuance of an individual Certificate,, National Health Insurance Company will not rescind an individual Certificate for any reason, limit any of the provisions of the Policy or Certificate, or raise premiums on the Policy or Certificate due to any omissions, misrepresentations, or inaccuracies in the Employee's enrollment form, whether willful or not.

IMPORTANT NOTICE: HIV TESTING

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

_____ _____

Signature Date

_____

Print Name and Title

BROKER STATEMENT

(1) That to the best of my knowledge, the information on the application is complete and accurate.

(2) I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information. The applicant understood the explanation.

It is understood that if a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

_____ _____

Broker Signature Date

_____ _____

Sales Approval Date Account Executive Date