

Eligibility and Participation

To be completed by the employer

- Affiliated companies are companies that qualify as parent/subsidiary and/or brother/sister controlled groups as defined in IRC section 414, or are eligible to file a combined tax form.

For American's Choice Options only:

- An eligible employee is an employee who works a minimum of 30 hours per week on a permanent basis. Owners, sole proprietors and partners are considered eligible.

For all products except American's Choice Options:

- An eligible employer is an employer who employed an average of at least 2 but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.
- An eligible employee is an employee who works on a full-time basis with a normal week of 30 or more hours. An eligible employee includes an employee who works on a full-time basis with a normal work week of 17.5 to 30 hours, if you so choose, and if this eligibility criterion is applied uniformly among all employees without regard to health-status related factors. Owners and partners are considered eligible.

1. Do you have any affiliated companies? Yes No

If yes, list all affiliated companies (attach additional sheet if more space required)

Company Name _____	Company Name _____
Address _____	Address _____
Nature of Business _____	Nature of Business _____
Include Company in Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Include Company in Plan <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Eligible Employees _____	Number of Eligible Employees _____
Tax ID Number _____	Tax ID Number _____

2. Do you have a class of employees that is ineligible (i.e. union, management, etc.)? Yes No

If yes, list classes of employees to be excluded: _____

3. Please indicate the number of hours per week considered full-time _____

4. Identify the number of employees in the following categories (if not applicable, indicate N/A):

Employee Status:	Currently Covered by:	Number Enrolling in:
Full-time _____	COBRA Continuation _____	Life/AD&D _____
Part-time _____	State Continuation _____	Health _____
Temp or Contract _____	Medicare _____	Weekly Income _____
In Affiliation Period _____	USERRA _____	Dental _____
In Ineligible Class _____ <i>(refer to question #2)</i>		Vision _____

A Group may be non-renewed if it falls below 2 employees, or the participation requirements are not maintained.

5. COBRA Eligibility: All employers who had 20 or more employees on 50% of their typical business days, during the previous calendar year, must comply with COBRA. Part-time employees are counted as a fraction of a full-time employee.

Identify the number of employees in the following categories (if not applicable, indicate N/A):

Full-time _____	Part-time _____
Combined total hours worked per year _____	Number of hours per week considered full-time _____

6. Indicate the percent of premium or dollar amount paid by employer below:

	Life	Weekly Income	Health	Dental	Vision
Employee					
Dependent(s)					

7. **Waiting Period for New Employees (For American’s Choice Options only)**

- 30 days
 60 days
 90 days
 Other _____
 Waive waiting period on original employees

Effective and Termination Dates

- Immediately.** Coverage begins immediately following the waiting period and ends immediately following termination of employment or change in status from eligible to non-eligible employee or dependent.
 1st of month following. Coverage begins on the first of the month following the waiting period and ends on the last day of the month in which employment terminates or status changes from eligible to non-eligible employee or dependent.

8. **Affiliation Period/Waiting Period for new employees*** (For all products except American’s Choice Options)

- 30 Days
 60 days
 90 days
 180 days

Termination Dates

- Immediately.** Coverage ends immediately following termination of employment or change in status from eligible to non-eligible employee or dependent.
 1st of month following. Coverage ends on the last day of the month in which employment terminates or status changes from eligible to non-eligible employee or dependent.

The affiliation period may be changed once every 12 months. If an affiliation period is not selected above, your group will automatically default to a 30-day affiliation period.

*By law, the affiliation period may not be more than 60 days. Any days in excess of 60 days is the employer’s waiting period.

9. In addition to this health plan, will your company provide supplemental health coverage, that is, either a self-funded or insurance program that helps cover all or part of the employees’ deductible under the primary health coverage?

10. Special Requests (please list any special requests here for underwriting considerations):

Agent Information

Employer Name _____

New Case Submission Checklist (required to complete the Underwriting process):

- Employer Group Application MI SGERA 11/07
- Employer Request to Participate Form MI SGR ATRTP 10/05 (Required for American's Preferred Advantage Plan and American's Equity Advantage HSA Plans) or Employer Request to Participate Form ATRTP 7/05 (Required for American's Choice Options Plan)
- Employer Request to Participate Form AT5RTP 4/06 (Required for Next Generation HSA, Triple Tier and APEP Choices plans)
- HSA Employee Enrollment Form (Required for HSA plans)
- Group employee application for all employees and new hires who will be eligible to apply for insurance within 60 days of the effective date. Employees waiving coverage must provide reason for waiving.
- Husband and wife groups need copy of ownership papers
- The **final** proposal (or list the final proposal ID number) indicating the employer's selected benefits, final census and effective date
- Employer's current premium statement from the prior carrier
- Employer's most recent quarterly state wage and tax statement, or current payroll records. For owners not listed on wage and tax statement, we need a copy of ownership papers. For employees not listed on wage and tax statement, we need a copy of current pay stubs.
- Employer's check for the first month's premium made payable to American Community Mutual Insurance

Does this group qualify for JET Issuance? Yes No

All of the above items are required for JET issuance of a group, and:

- No missing information on forms No significant medical conditions
- All of the above received by American Community at least 2 weeks prior to the requested effective date

American Community will contact the agent with a reference number when the new case is received in the Home Office.

Premium submitted \$ _____	Proposal I.D. _____
Requested effective date _____	subject to Home Office approval
Where proposal created: <input type="checkbox"/> Agent Office	<input type="checkbox"/> National Sales Office <input type="checkbox"/> Home Office
Mail new case certificates and ID cards to: <input type="checkbox"/> Agent	<input type="checkbox"/> Employer

AGENT #1

Name _____

Agent # _____

Phone # _____

Fax # _____

Email _____

Split Commission% _____

AGENT #2

Name _____

Agent # _____

Phone # _____

Fax # _____

Email _____

Split Commission% _____

All agents sharing commissions on this application must sign. Example: 50% Agent #1 and 50% Agent #2.

Agent's Statement: I certify that all of the information contained in the Employer Group Application, the employee applications and any attached papers is correct to the best of my knowledge. I have fully explained the provisions of the Group Application and the plan of benefits selected by the employer as described by American Community in its brochure. I know nothing unfavorable about this company or any individuals proposed for insurance. This firm is a bona fide business establishment. The employees applying meet the eligibility requirements and the compensation they receive is their main source of income. I have notified the group that their employees may be contacted by an American Community underwriter to verify information on their application.

Signature of Agent _____ Date _____

Signature of Agent _____ Date _____