



## AMERISHARE/AMERIMED PRELIMINARY EMPLOYER APPLICATION

Administrative Services Provided by American Trust Administrators, Inc.  
All questions must be completed accurately and in detail to avoid unnecessary correspondence and delay.

### PLAN INFORMATION

- (1) Full Legal Name of Proposed Plan Sponsor ("Employer"): \_\_\_\_\_  
(As it is to appear on your Plan Documents)  
 Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)  
 Billing Address (if different): \_\_\_\_\_  
(Street) (City) (State) (Zip)  
 F.I.D. #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_ C.E.O. Name: \_\_\_\_\_  
 Group Contact Name: \_\_\_\_\_ Group Contact Email: \_\_\_\_\_
- (2) Business is: 1 Proprietorship 1 Partnership 1 Corporation 1 Governmental Entity/Church 1 Other \_\_\_\_\_
- (3) Will any part of the Plan be maintained pursuant to a collective bargaining agreement? 1 Yes 1 No
- (4) Do you wish to provide coverage for on the job injuries to corporate officers, partners or sole proprietors? 1 Yes 1 No
- (5) Do you want to adopt a Section 125 Premium Only Plan? 1 Yes 1 No
- (6) Current Health Plan Insurance Carrier: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Rates	Effective Date	Employee	Employee & Spouse	Employee & Children	Family
Current:					
Renewal:					

### INSURANCE & EXCESS LOSS COVERAGE

- (7) Coverage Information:
- | Class | Class of Employees (for Life Insurance benefits) (Please use job title or occupation) | Dental                                       | Vision                                       | Weekly Indemnity                     |
|-------|---|--|--|--------------------------------------|
| A     |   | <input type="checkbox"/> Applies to Spec/Agg | <input type="checkbox"/> Applies to Spec/Agg | <input type="checkbox"/> ASO         |
| B     |   | <input type="checkbox"/> ASO                 | <input type="checkbox"/> ASO                 |                                      |
| C     |   | <input type="checkbox"/> Not Elected         | <input type="checkbox"/> Not Elected         | <input type="checkbox"/> Not Elected |
| D     |   | <i>Check one</i>                             | <i>Check one</i>                             | <i>Check one</i>                     |
- (8) Self-Funded Medical Benefits. The employer hereby certifies that the proposed plan of self-funded medical benefits is described in detail in the Proposal bearing the Reference # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ attached to this Form. The Proposal Reference # appears in the bottom right-hand corner of every page of the Proposal. **The Proposal must be attached to this Form.**

### ELIGIBILITY, PARTICIPATION AND CONTRIBUTION

- (9) Eligible employees are those employees listed on the Employer's Quarterly Wage Report and include only full-time employees working for a salary or wage at least 30 hours per week or 120 hours per month. Persons on COBRA and persons in their COBRA election period are also eligible. Retirees are not eligible. Eligible dependents are the employee's legally married spouse and the employee's unmarried naturally born children, stepchildren or legally adopted children, who rely on the employee for at least half of their support and maintenance and who are less than 19 years old (or less than 23 or 25 years old if enrolled as a full-time student.) Eligible Employees and their Dependents must be resident citizens of the USA or Legal Aliens with legal permission to reside and work in the USA. Please be advised that medical telephone interviews may be conducted.
- A. Please list below any persons on COBRA or any persons in their COBRA election period at this time or indicate "None".

NAME	NATURE OF COBRA QUALIFYING EVENT	DATE COBRA COVERAGE BEGAN	DATE COBRA COVERAGE WILL END

- B. Please list below any employees not at work due to Total & Permanent or Temporary disability at this time or indicate "None".

NAME	DATE OF DISABILITY	NATURE OF DISABILITY	DATE EXPECTED TO RETURN TO WORK

- C. Please list below any employees that the Employer considers full-time employees that are not shown on the Employer's most recent Quarterly Wage Report (for example: owners, new hires, approved leave of absence, temporary layoff, indefinite layoff, part-time, or seasonal) or indicate "None".

NAME	REASON EMPLOYER CONSIDERS THEM FULL TIME EMPLOYEES

- D. Has any individual that is to be covered been absent from work for 10 or more days in the past 12 months due to a medical condition; do any of them have a chronic or ongoing condition; do any of them have test results pending; or have any of them been advised that treatment, tests, hospitalization or surgery is needed (including existing pregnancies & due dates)?

NAME	CONDITION		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

- (10) If the employer pays 100% of the cost of any coverage for the employee and/or dependents, then all eligible employees and dependents must enroll in that coverage even if they have similar coverage elsewhere. If the Employer requires employees to pay any part of the cost of any coverage, then 75% of total eligible employees and dependents must enroll in that coverage. For this calculation, total eligible employees and dependents exclude those with any similar coverage elsewhere, exclude employees in their waiting period and exclude persons on COBRA and persons in their COBRA election period. However, the total number of covered medical employees cannot be less than 50% of the total number of eligible employees including those with similar coverage elsewhere. A waiting period is the time that an eligible employee and their dependents must wait before coverage begins. The waiting period must be in months and cannot exceed 12 months. Coverage may begin the first of the month following the waiting period or the first day following the waiting period. Please indicate below the waiting period and when coverage will begin:

Present Employees (employees hired on or prior to the effective date of this Plan) \_\_\_\_\_ months\*  
 Future Employees (employees hired after the effective date of this Plan) \_\_\_\_\_ months\*

\*A 6-month waiting period for medical coverage applies to late applicants.

Coverage begins: 1 first of the month following **or** 1 first day following (check one only)

**Note: Open enrollment periods are not allowed.**

- (11) The Excess Loss Policy covers the Employer and not the Employees and Dependents. Therefore, payment of the excess loss premium must be made solely from the Employer's general account and should not be made from any account containing Plan Assets or employee contributions. **The Employer must contribute 100% of the Employee and Dependent Health Plan Fixed Costs and at least 25% of the cost of any life, accidental death and dismemberment, and weekly indemnity insurance.**

Indicate below the percentage of the cost the **EMPLOYER** will contribute for each benefit:

	<b>Employee Coverage</b>	<b>Dependent Coverage</b>	
Health Plan Fixed Costs	100%	100%	(must be 100%)
Health Plan Self-Funded Claim Costs	_____%	_____%	
Employee Life and AD&D	_____%	N/A	(must be at least 25%)
Dependent Life	N/A	_____%	(must be at least 25%)
Weekly Income	_____%	N/A	(must be at least 25%)

**OTHER INFORMATION**

- (12) Other Companies: Provide the following information for other Subsidiary/Affiliate companies whose employees are to be covered under the Plan. **ALL BRANCH LOCATIONS MUST BE COVERED UNDER THE PLAN.** Attach a separate sheet, if necessary.

If none, check 1 and skip to Question 13.

Name Address Nature of Business F.I.D. # Subsidiary/Affiliate/Branch

In order for us to determine whether the proposed employer group meets the guidelines to be considered a single employer group, please have the owner of the company complete the following. An Affiliated Company is any company the employer wishes to cover under its plan of which it owns less than 80% of the voting interests or shares of stock.

Owner	PERCENT OF OWNERSHIP				
	Company Name _____ (Employer)	Company Name A. _____	Company Name B. _____	Company Name C. _____	Company Name D. _____
	%	%	%	%	%
	%	%	%	%	%
	%	%	%	%	%
	%	%	%	%	%

- (13) Will any other health plan cover employee out-of-pocket expenses while this plan is in force? 1 Yes 1 No

If Yes, please explain the other health plan's reimbursement levels and provide a copy of the plan of benefits. \_\_\_\_\_

- (14) Financial Information

- (a) Has your firm ever been denied credit? 1 Yes 1 No  
 (b) Has your firm ever filed bankruptcy or is your firm now in the process of filing for bankruptcy or considering filing for bankruptcy? 1 Yes 1 No  
 (c) If (a) or (b) is yes, please explain: \_\_\_\_\_

- (15) **ACCESS to Protected Health Information of employees and their covered dependents.**

If you do not currently self fund your medical benefits, the Health Insurance Portability and Accountability Act (HIPAA) requires you to appoint individuals to perform plan administrative functions for your Health Plan. These will be the only individuals at your company who may view protected health information on your employees. The Privacy Official will be the person at your company who is in charge of protecting and administering matters dealing with the protected health information of your employees. Other employees disclosed below are the only other employees at your group who will be allowed to view your employees' protected health information.

If you are currently self funded you should have already appointed the necessary individuals to receive the minimum necessary Protected Health Information (PHI) to carry out the administration of your group health benefit plan. Please disclose those individuals below.

**IN THIS SECTION, PLEASE LIST ALL EMPLOYEES OF THE PLAN SPONSOR WHO ARE AUTHORIZED TO USE PHI FOR HEALTH PLAN ADMINISTRATIVE FUNCTIONS**

Name or title of Privacy Official: \_\_\_\_\_  
**(your plan must have a privacy official)**

**OTHER EMPLOYEES ENTITLED TO RECEIVE PHI**

**Complete for only as many employees as you want to have access to PHI. Add a separate sheet if necessary.**

Name or title of Employee: \_\_\_\_\_

Name or title of Employee: \_\_\_\_\_

Name or title of Employee: \_\_\_\_\_

Name or title of Employee: \_\_\_\_\_

If there are any changes to be made to this list, additions or deletions, the plan sponsor is required to notify American Trust Administrators, Inc. within 30 days of the change.

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I certify that the representations and elections made on this Form are true and correct as of the date signed below. I understand that the truth and veracity of my answers will form the basis for issuance of weekly indemnity insurance, group term life and AD&D insurance and Excess Loss Reimbursement Coverage. I acknowledge that no benefits are in force and I should not cancel my present insurance until I have been notified of acceptance in writing by the Service Organization on behalf of the insurance company and I have adopted the proposed health benefit plan. I hereby certify that the Employer will pay 100% of the Employee and Dependent Health Plan Fixed Costs.

I understand that any material misstatement or failure to provide sought for information may be used as a basis for rescission of the weekly indemnity insurance, group term life and AD&D insurance or Excess Loss Reimbursement Coverage in which event the sole liability of the insurer would be to refund any or all unused premiums.

The Preliminary Employer Application must be dated on the date it is completed by the authorized owner/officer. This Preliminary Employer Application will not be accepted if it is more than 60 calendar days old from the requested effective date.

Print or Type Name of Proposed Participant ("Employer") \_\_\_\_\_

Authorized Owner/Officer Signature \_\_\_\_\_ Date Signed (mm/dd/yyyy) \_\_\_\_\_

Print or Type Name and Title of Authorized Owner/Officer \_\_\_\_\_