

9. Billing Contact Name: _____

Billing Address: _____

Street or P.O. Box

City

State

Zip

County

10a. Please list any affiliates, subsidiaries, branches, or other companies that can legally be filed under one tax return.

Name

Street

City

State

Zip

County

10b. Any affiliates, subdivisions, branches, etc. to be covered under this plan? Yes No

If yes: _____

Name of Company

of Total Employees

of Employees to be Covered

ELIGIBILITY/BENEFITS

11a. Based on your current payroll list, how many employees do you have in each category?

| | Enrolling Company | Affiliates/ Subsidiaries |
|--|----------------------|-----------------------------|
| Full-time (30 hours or more per week): | _____ | _____ |
| Part-time (less than 30 hours per week): | _____ | _____ |
| Seasonal/Temporary: | _____ | _____ |
| Other (<i>please identify</i>): _____ | _____ | _____ |
| Total Employees | _____ | _____ |

11b. **Medical** (if applicable)

Number of Employees
Enrolling in Medical Plan: _____

Number of Employees
Eligible for Medical Coverage: _____

Number of Employees
Waiving Medical Coverage: _____

Dental (if applicable)

Number of Employees
Enrolling in Dental Plan: _____

Number of Employees
Eligible for Dental Coverage: _____

Number of Employees
Waiving Dental Coverage: _____

12. Do you have union employees? Yes No

If yes, are they being covered under the: **Medical Plan?** Yes No **Dental Plan?** Yes No

Are the benefits the same? Yes No

13. Are retirees* being covered by the: **Medical Plan?** Yes No **Dental Plan?** Yes No

If yes, how many? _____ Define Retiree: _____

*Subject to Underwriting approval.

14. **Employer Contribution Toward Medical Premium:** By Class (e.g., hourly, salary, union, if different)
Note: The employer must contribute a minimum of 50% of the 'employee only' costs. If employer pays entire cost, no eligible person may waive coverage.

Class 1 _____ \$ Amount or % of Employee Premium: _____ \$ Amount or % of Dependent Premium: _____

Class 2 _____ \$ Amount or % of Employee Premium: _____ \$ Amount or % of Dependent Premium: _____

15. **Employer Contribution Toward Dental Premium:** By Class (e.g., hourly, salary, union, if different)
Note: The employer must contribute a minimum of 50% of the 'employee only' cost of dental coverage or 50% of the combined 'employee only' PHP medical and dental premium for each covered employee. If employer pays entire cost, no eligible person may waive coverage.

Class 1 _____ \$ Amount or % of Employee Premium: _____ \$ Amount or % of Dependent Premium: _____

Class 2 _____ \$ Amount or % of Employee Premium: _____ \$ Amount or % of Dependent Premium: _____

16. **Waiting Period** (By Class e.g., hourly, salary, union, if different from each other) (Period i.e., 30, 60, 90 days or 1, 2, 3 months):

Class 1 _____ Waiting Period: _____ (circle one) Months Days Years

Waiting period applies to: Future employees only Current employees in waiting period & future employees

Coverage begins: Day waiting period is specified First of the month following waiting period
 Day after waiting period is specified Day of employment

Class 2 _____ Waiting Period: _____ (circle one) Months Days Years

Waiting period applies to: Future employees only Current employees in waiting period & future employees

Coverage begins: Day waiting period is specified First of the month following waiting period
 Day after waiting period is specified Day of employment

17. When does coverage end for terminated employees? Date of termination End of the month after date of termination

18. Are there any other **medical** carriers offered* as an option to employees? Yes No

If so, name of carrier: _____

Identify employer contribution: _____

**Subject to Underwriting approval.*

19. Are there any other **dental** carriers offered* as an option to employees? Yes No

If so, name of carrier: _____

Identify employer contribution: _____

**Subject to Underwriting approval.*

- 20a. Will this health plan be combined with a Health Savings Account (HSA) ? Yes No

20b. If yes, what is the name of the HSA trustee? _____

20c. If yes, what will your employer contribution be toward the employee's HSA?
 Single \$ _____ Family \$ _____

21a. Will this health plan be combined with a Health Reimbursement Arrangement (HRA) ? Yes No

21b. If yes, what is the name of the HRA administrator? _____

21c. If yes, what will your employer contribution be toward the employee's HRA?
Single \$ _____ Family \$ _____

22a. Will this health plan be combined with a Flexible Spending Account (FSA) ? Yes No

22b. If yes, what is the name of the FSA administrator? _____

22c. If yes, what will your employer contribution be toward the employee's FSA?
Single \$ _____ Family \$ _____

23. When an FSA and HRA are both available, describe the reimbursement protocol used between accounts.

24. Do you provide Workers' Compensation for all employees? Yes No

If no, please list employees not covered:

| <u>Name</u> | <u>Title</u> | <u>Reason Not Covered</u> |
|-------------|--------------|---------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Current Workers' Compensation Carrier: _____

25a. Are you required by law to offer COBRA coverage to your employees for the current calendar year? Yes No

25b. Are any present or former employees or dependents currently on or eligible for COBRA continuation? If yes, please provide the following: Yes No

| <u>Name</u> | <u>Qualifying Event</u> | <u>Date COBRA Started</u> | <u>Date COBRA Coverage Expires</u> |
|-------------|-------------------------|---------------------------|------------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

26. Continuation of coverage while on an approved layoff or leave of absence (This layoff or leave of absence provision runs concurrent with COBRA when the employer must comply with COBRA).

60 Days Other*: _____

**Subject to Underwriting approval.*

The insurance applied for is not in force until approved by PHP.

The undersigned applicant certifies that all answers contained in this application are true and complete.

Applicant Signature Print Applicant Name Date

Licensed Broker Signature Print Broker Name Date

**Physicians Health Plan
of Northern Indiana, Inc.**

**PHP Insurance Company
of Indiana, Inc.**

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