



137 North Belt Highway
 St. Joseph, MO 64506
 (816) 271-1247 or (800) 990-9247 – telephone
 (816) 271-7976 – fax

Renewal Date _____

Effective Date _____

Group Application

Type of Transaction: <i>(Please complete all sections)</i>	<input type="checkbox"/> New Group <input type="checkbox"/> Renewal <input type="checkbox"/> Change <input type="checkbox"/> Benefits <input type="checkbox"/> AUTO-RENEW	Group is Subject To the Insurance Laws of: <input type="checkbox"/> Kansas <input type="checkbox"/> Missouri
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A. Employer Information Section: *Please complete appropriate sections. Please print clearly.*

1. Applicant (Company) name [use full legal name]:	Contact Name:
Mailing address (Billing address) (Street, City, State, Zip):	County:
Corporate address (Street, City, State, Zip):	County:
Contact telephone number: Fax number:	
Corporate Contact Name and Title:	
2. Applicant is: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> PC <input type="checkbox"/> LLC <input type="checkbox"/> Other <input type="checkbox"/> Member of association (name): _____	
3. Description of business:	4. Federal Employer ID number (FEIN):
5. Total number of persons employed by your business (include part-time, temporary, seasonal and contract) _____	
6. Total number of eligible employees _____	
a. Total number of employees applying for coverage..... _____ b. Total number of employees waiving coverage _____ c. Total number of employees covered by other plans _____	
7. Total number currently enrolled in Continuation of Coverage (COBRA or State) _____ (Include Name, and date of continuation expiration. Use extra sheet if necessary.)	
8. Are Retirees to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Total Number of Retirees to be enrolled _____	

9. Classes of employees to be enrolled in this group: All eligible employees Salaried Hourly Union
 Non-union Retirees Exempt Non-exempt
 Other (please explain): _____

Are any employees located at a work site other than #1, above? No Yes

If Yes, please complete the following:

Street Address	City, State	Zip Code	County	Number Of Employees
_____	_____	_____	_____	_____

10. Number of hours an employee must work to be eligible for coverage:

- 30 or more hours per week
- Other (specify): _____

B. General Provisions

1. Employee coverage effective and ending dates:

Coverage for current employees begins on group effective date: Yes No

Coverage begins on: Date of hire.

- The day following _____ days of employment.
- The first of the month following _____.
- Other: (please specify) _____.

Coverage ends on:

- The day employment terminates.
- The end of the month employment terminates.

Eligibility is determined by:

- Employer or designated entity
- Community Health Plan

2. Eligible Dependents are covered:

- To age 25
- Other, please specify _____.

3. Level of Employer's contribution to premium (Community Health Plan requires a minimum employer contribution level of 50% of the employee cost):

_____ % of total monthly premium for employees.
 _____ % of total monthly premium for dependents.

4. Is the applicant represented by a licensed Producer: No Yes

If Yes, please complete Section D on Page 5.

5. Name of Workers' Compensation carrier: _____

6. Employee Assistance Program (EAP): _____

7. Plan: HMO:

- Community Choice
- Community Gold
- POS-2

PPO:

- Select Choice
- Quality Choice
- HSA-Eligible High Deductible Health Plan (HDHP)

OTHER:

- Option: _____

Optional Benefits:

- Life? Yes No Vision? Yes No Rx? Yes No
- Dental? Yes No Dental Buy-Up? Yes No
- Elective Pregnancy Termination? Yes No Hearing Aids? Yes No
- Infertility Benefits? Yes No Elective Surgical Sterilization? Yes No
- TMJ and Related Disorders Treatment? Yes No
- Mental Health and Chemical Dependent Benefits? Yes No
Number of OP Mental Health Visits _____
- Beech Street Network? Capitated Travel No
- Orientation? Yes No
- Cards Needed? Yes No

C. Application/Agreement

Applicant applies on behalf of its eligible employees and their dependents to Community Health Plan for a Group Health Policy. Applicant authorizes Community Health Plan to offer such coverages, respectively, to said employees and dependents. The information provided by applicant on this form and in any attachments is accurate and complete.

Applicant understands and agrees that:

1. This application/proposal is contingent upon the acceptability of the group by Community Health Plan, and a cancellation notice should not be submitted to the current carrier until Community Health Plan has notified the applicant of the acceptance of the group.
2. The coverages applied for shall not become effective until:
 - (a) A Group Policy (including Schedule of Eligibility and Certificate for selected benefits) is accepted by Community Health Plan for the respective coverages; and
 - (b) The effective date specified herein arrives. [The effective date is subject to any limitations on the Group Service Agreement.]
3. No Producer is authorized to waive a complete answer to any question in the application, determine eligibility, make or alter any contract, or waive any of the applicant's other rights or requirements. All contract terms must be in writing, signed or accepted in writing by an authorized employee of Community Health Plan.

4. After acceptance of the Group by Community Health Plan and coverage has become effective, either the applicant or Community Health Plan may terminate the Group Policy and coverage by giving 31 days prior written notice to the other. If the Group Policy is terminated without 31 days' prior notice to Community Health Plan and claims are paid for services received after the date of termination, the Group Policyholder will be liable for premium and service charges for that billing period or periods during which claims were paid.
5. At the discretion of either party, this contract may be automatically renewed on a month-by-month basis at the benefit levels described above, so long as the company pays the renewal premiums as proposed by Community Health Plan within their grace period.
6. Any future assignments by the applicant to independent Producers or consultants giving them "Agent of Record" status will be subject to agreement by Community Health Plan.
7. Minimum participation requirements are met and will continue to be met:
 - (a) For groups of three (3) or less eligible employees, the participation requirement is one hundred percent (100%) of eligible employees and 50% of eligible dependents.
 - (b) For groups of more than three (3) eligible employees, the participation requirement is seventy-five (75%) of eligible employees and 50% of eligible dependents.
8. The group will notify Community Health Plan in writing of any changes to the employer contribution level.
9. All employees who enroll are eligible employees who have met the waiting period and work the minimum number of hours as specified in the Group Application.
10. Community Health Plan reserves the right to require verification of eligibility coverage, which may include on-site audits.
11. If enrollment changes more than 10%, Community Health Plan reserves the right to adjust rates.
12. A completed enrollment form must be submitted for each eligible employee, even if the employee is declining coverage.

Open enrollment:

- (a) There is an open enrollment period with coverage effective as of renewal date.

By _____
Signature and Title of Officer or Person Authorized to make this Application Date Signed

By _____
Signature of Community Health Plan Team Leader Client Services Date Signed

By _____
Signature of Community Health Plan Administrator Date Signed

D. Producer/Consultant Information

Business Entity Insurance Producer (Agency) Name: _____

Agency Address: _____
Street City State Zip Code

Telephone Number: _____

Producer's Name: _____
First Name Middle Initial Last Name

Producer's Address: _____
Street City State Zip Code

Telephone Number: _____ **Social Security No:** _____

Missouri/Kansas Producer No: _____ **Producer E-mail:** _____

Commission Level: Community Health Plan Commission Schedule Other (please attach)

Pay Commission Checks to: Producer Agency **Taxpayer ID Number (for payee):** _____

Producer Statement

I hereby certify that I hold a valid Insurance License issued by the State of _____ and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about the applicant or any individual applying for coverage, unless fully described. (Please attach description)

Furthermore, I certify that:

1. This applicant is a bona fide business establishment as described in the proposal.
2. Participation and contribution requirements have been met.
3. Eligibility provisions and pre-existing condition limitations applicable to this program have been fully explained to, and understood by, the employer.

Are you completing this form because you wish to change information previously provided to Community Health Plan? Yes No

Whether you answered yes or no, please complete all the information requested on this form. If you answered yes, also please make a check at the right of any information being changed.

Also give date you would like change(s) to be effective: _____
Month Day Year

By _____
Signature of Writing Producer Date Signed

Office Use Only:	
Mailed to Group _____	Mailed to Producer _____