

Ohio Group Application

HMO products are underwritten by HealthAmerica Pennsylvania, Inc., d.b.a. HealthAssurance HMO, Pennsylvania in-area PPO and POS products are underwritten by HealthAssurance Pennsylvania, Inc., d.b.a. HealthAmerica. Ohio PPO, all Out- of-Area PPO, dental and life insurance products are underwritten by Coventry Health and Life Insurance Company, d.b.a. HealthAmerica

Product Selection (Check all that apply) Medical Dental

| Company Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-----------|-----------|-----------|-----------|------------|---|-----------|------------------|-----------|--|-----------|------------------------|------------|-----------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-------|---------|---------|----|----|----|----|----|----|----|----|----|----|----|----|-----|--|---------|---|---|---|---|---|---|---|---|---|---|---|---|----|--|----------|---|---|---|---|---|---|---|---|---|----|----|----|-----|--|--------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|-----------|
| Street Address | | | | | | | | | | City | | State | | Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Billing Address (if different than street address) | | | | | | | | | | City | | State | | Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone Number | | | | | Fax Number | | | | | Email Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nature of Business | | | | | SIC Code | | | | | Company Tax ID Number | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Business | | | | | | | | | | Date Company Established | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Non-profit <input type="checkbox"/> Union Group <input type="checkbox"/> Other | | | | | | | | | | Current Medical Carrier | | Current Dental Carrier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | Worker's Comp Carrier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | Association: <input type="checkbox"/> Jefferson Co Chamber <input type="checkbox"/> St.Clairsville Chamber <input type="checkbox"/> Penn-Ohio | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Decision Maker | | | | Title | | | | Telephone Number | | | | Fax Number | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Average # Of Employees _____ (The same number as "total employees" field in Benefit Express) | | | | | | | | | | Total Eligible for Medical | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Example: January 1 through December 31, 2009. This average must include all persons employed by the company and any affiliated companies in the preceding calendar year, whether an employee was full-time, part-time, and/or seasonal. Important: the government requires the total average number, regardless of whether employees were eligible to enroll, and/or participated in the group insurance coverage. Only include temporary employees if they are employees of the company (i.e., employees to whom the employer issues a W-2). | | | | | | | | | | # Qualified Beneficiaries under COBRA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | # of COBRA Enrollees on Group Policy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | # of Employees Out-of-Area | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | # of Hours Worked Per Week to be Considered Eligible to Enroll ⁽¹⁾ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #d9ead3;"> <th>Month</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Total</th> <th>Average</th> </tr> </thead> <tbody> <tr> <td>FT Emp.</td> <td>20</td> <td>22</td> <td>23</td> <td>24</td> <td>25</td> <td>27</td> <td>25</td> <td>22</td> <td>23</td> <td>21</td> <td>20</td> <td>18</td> <td>270</td> <td></td> </tr> <tr> <td>PT Emp.</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> <td>3</td> <td>3</td> <td>2</td> <td>2</td> <td>1</td> <td>3</td> <td>3</td> <td>3</td> <td>28</td> <td></td> </tr> <tr> <td>Seasonal</td> <td>1</td> <td>1</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>30</td> <td>40</td> <td>40</td> <td>113</td> <td></td> </tr> <tr style="background-color: #d9ead3;"> <td>Total</td> <td>23</td> <td>25</td> <td>26</td> <td>26</td> <td>28</td> <td>30</td> <td>27</td> <td>24</td> <td>24</td> <td>54</td> <td>63</td> <td>61</td> <td>411</td> <td>34</td> </tr> </tbody> </table> <p style="font-size: small; margin-top: 5px;">Average = the total number of employees for 2009 divided by 12 months (e.g., 411 divided by 12 = 34)</p> | | | | | | | | | | | | | | Month | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total | Average | FT Emp. | 20 | 22 | 23 | 24 | 25 | 27 | 25 | 22 | 23 | 21 | 20 | 18 | 270 | | PT Emp. | 2 | 2 | 2 | 2 | 3 | 3 | 2 | 2 | 1 | 3 | 3 | 3 | 28 | | Seasonal | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 30 | 40 | 40 | 113 | | Total | 23 | 25 | 26 | 26 | 28 | 30 | 27 | 24 | 24 | 54 | 63 | 61 | 411 | 34 |
| Month | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total | Average | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FT Emp. | 20 | 22 | 23 | 24 | 25 | 27 | 25 | 22 | 23 | 21 | 20 | 18 | 270 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PT Emp. | 2 | 2 | 2 | 2 | 3 | 3 | 2 | 2 | 1 | 3 | 3 | 3 | 28 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Seasonal | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 30 | 40 | 40 | 113 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total | 23 | 25 | 26 | 26 | 28 | 30 | 27 | 24 | 24 | 54 | 63 | 61 | 411 | 34 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Effective Date | | | | | | Dual Option* <input type="checkbox"/> Yes <input type="checkbox"/> No * For Dual Option must have 8 enrolling, only one RX option. A rate adjustment may apply. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Plan Requested: (If Dual Option indicate both plans) <input type="checkbox"/> In-area PPO _____ <input type="checkbox"/> OOA PPO _____ <input type="checkbox"/> RX _____ <input type="checkbox"/> Vision _____ <input type="checkbox"/> Dental Plan # _____ (www.cvtydental.com) Please contact your HealthAmerica Account Executive <i>HMO plans are also available upon request</i> | | | | | | Current Plan Rates: | | | | Renewal Plan Rates: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | Single | | | | Single | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | Couple | | | | Couple | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | Parent/Child(ren) | | | | Parent/Child(ren) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | Family | | | | Family | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employer Medical Contributions | | | | | | Terminated employees are covered through: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ % of single premium toward the cost of each tier -OR- | | | | | | <input type="checkbox"/> end of month - OR - <input type="checkbox"/> last date of employment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ % of premium rates for each coverage tier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employer Dental Contributions _____ % | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| <p>Eligibility</p> <p><input type="checkbox"/> date of hire</p> <p><input type="checkbox"/> first of month after date of hire</p> <p><input type="checkbox"/> first of month after (check one) <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90* days of employment</p> <p><input type="checkbox"/> (check one) <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120* <input type="checkbox"/> 180* days after date of hire</p> <p><input type="checkbox"/> Other (please explain) _____</p> <p>Does this apply to all classes of employee? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain. _____</p> <p>*Not available to OH groups <51 eligible employees</p> | <p>Medical Loss Ratio (MLR) Classification. Check the appropriate box below. More information about MLR can be found at www.hhs.gov.</p> <p><input type="checkbox"/> ERISA</p> <p><input type="checkbox"/> Government Group - Non-Federal (A non-Federal governmental plan is plan that is established or maintained by the government of any State or political subdivision thereof for its employees, or by any agency or instrumentality of any government of any State or political subdivision for its employees)</p> <p><input type="checkbox"/> Non-ERISA and not a Government Group (if you choose this option you must complete the Coventry non-ERISA addendum that will be provided and check one of the boxes below)</p> <p style="margin-left: 40px;"><input type="checkbox"/> Non-ERISA - Agree to the terms in the Coventry non-ERISA addendum</p> <p style="margin-left: 40px;"><input type="checkbox"/> Non-ERISA - Don't agree to the terms in the Coventry non-ERISA addendum</p> <p>For groups of 51+ eligible employees, Indicate if retirees are covered: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> pre-65 AND/OR <input type="checkbox"/> post-65.</p> <p>Indicate if domestic partners are covered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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⁽¹⁾ For Ohio groups with fewer than 51 eligible employees, medical coverage must be offered to every employee who works a normal work week of 25 or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

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| <p><u>Employer Funding - If enrolling in a C3 product only:</u></p> <p>Please list the amount that the employer is funding toward the employee's single / family deductible.</p> <p>I certify that I am funding \$_____ (single) / _____ (family) of my employee's _____ plan (ie. Premier PPO \$1000)</p> <p>Premium rates may be adjusted based on the employer's subsidy of the deductible.</p> |
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Agent Agreement (if applicable)

If you wish to recognize a broker to represent your HealthAmerica of PA - a Coventry Health Care Plan coverage, please provide the following information.

To be completed by the broker:

Writing Agent Name: _____ (required) Social Security Number: _____ (required)

Agency Name: _____ (if applicable)

Commission Payable To: _____ (required - must mirror HAPA appointment) Tax ID Number: _____ (required)

Telephone Number: _____

WHOLESALE INFORMATION (if applicable. Commissions will be paid to wholesale agency)

Wholesaler: _____ Tax ID Number: _____ (required, when applicable)

To be completed by the employer's authorized company representative:

Authorized Company Representative Signature: _____

Authorized Company Representative Title: _____ Date: _____

Group Name: _____ Group Number: _____ Effective Date: _____

Your signature above as the *authorized company representative* allows the individual listed above to act as an agent of HealthAmerica and to receive compensation in the form of monthly commission payments for his/her services. **You further understand and agree** that the broker does not have the authority to approve your coverage and/or effective date and may not accept premiums on our behalf. The broker of record listed above will remain in force until HealthAmerica receives formal written notice of cancellation from your company.

Authorized company representative signature is required to execute agent agreement.

Execution of Group Application

The terms and conditions contained in this Group Application (Application) are hereby made an integral part of the Group Contract between HealthAmerica and the Group named below. These terms and conditions will remain in effect until the Group Contract is non-renewed or terminated in accordance with its termination provisions.

Group Information & Applicant Group Signature

Application should only be signed once rates and benefits have been finalized.

Group Name _____ Group Number _____ Effective Date of Coverage _____

Authorized Signature – REQUIRED _____

Print Name _____ Title _____ Date of Signature _____

Fraud Warning

- **OHIQ:** Any person, who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Attach Final Medical Plan Premium Rates and Contingency