



# EMPLOYER GROUP APPLICATION

\*\*\*IMPORTANT\*\*\*

DO NOT TERMINATE CURRENT COVERAGE UNTIL YOU RECEIVE APPROVAL FROM PREFERRED UNITED PLANS OF MICHIGAN

COMPLETE ALL INFORMATION TO AVOID PROCESSING DELAYS. TYPE OR PRINT CLEARLY IN INK.

<b>EMPLOYER INFORMATION</b>
Employer Tax Identification Number (TIN) 38 - _____
Full Legal Name of Employer _____
Street Address _____
City _____ County _____ State _____ Zip _____
Phone Number (_____) _____ Fax Number (_____) _____
Mailing Address (if different) _____
City _____ State _____ Zip _____
Contact Person _____ Title _____
E-Mail Address: _____
Owner/Executive Officer _____
Monthly billings will be available on-line. An e-mail notification will be sent when the billings are available. We need two different e-mails to use for these notifications: Primary E-Mail: _____ Back-up E-Mail: _____
Business Legal Status: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Partnership <input type="checkbox"/> Partnership <input type="checkbox"/> LLC
Nature of Business _____
SIC Code _____ Date Business Began Operating _____
Name and Addresses of Subsidiaries and/or Affiliates to be Included _____
Requested Effective Date of Group Insurance is the 1 <sup>st</sup> day of _____ (Month), _____ (Year)
Employer Premium Contribution (must be a minimum of 25%): Employee _____% Dependents _____%
Are you replacing other Group Health Insurance? Yes ____ No ____ . If Yes, please submit a copy of the current carrier's policy or certificate and last billing statement with the employees' names.
Effective date of Current Group Health Plan _____ Termination Date of Group Current Health Plan _____
Name of current insurance carrier _____ Policy or Group Number _____
Current Rates: EE _____ ES _____ EC _____ FA _____ Renewal Rates: EE _____ ES _____ EC _____ FA _____
<b>Participation Requirements</b> <ul style="list-style-type: none"> <li>All groups require 75% of all full-time eligible employees*.</li> <li>50% of all full-time employees and their dependents must participate for any size group.</li> </ul> <p>*Those waiving due to spousal coverage are not counted as eligible for this participation requirement. A group may be non-renewed if the participation requirements are not met.</p>
<b>Legal Notice</b> Returned Check Fee: If any premium payment made directly by check is returned for nonsufficient funds, a \$50 service fee will be applied. This fee will be due within five days of receipt of the notice from Preferred United Plans of Michigan.

Underwritten by Companion Life Insurance Company  
Administered by SecureOne Benefit Administrators, Inc.  
www.secureoneinc.com



## ELIGIBILITY AND PARTICIPATION

1. 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: \_\_\_\_\_

2. 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 Waiting Period _____		Dental _____
In Ineligible Class _____ (refer to question #1)		

\*Is your group eligible for COBRA Continuation (averaging 20 or more employees in the previous calendar year)?  Yes  No

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

3. If employees numbers were listed under a COBRA or a State Continuation Plan in question #2, please list employees and dependents below. (Attach additional list, if needed):

NOTE: If COBRA eligible or currently on COBRA, an Employee Application must be completed.

Name	EE/DEP	Date Continuation Began or Date Eligible for Continuation	Type of Continuation*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\*Please indicate current enrollment type: Single, Employee/Spouse, Employee/Child(ren), or Family.

4. Are any employees currently absent or are any dependents confined to home or incapacitated due to illness, injury, or total disability?  Yes  No If Yes, please list (Attach additional list, if needed):

Name	EE/DEP	Date Illness, Injury or Total Disability Began	Type of Illness, Injury or Total Disability
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Waiting period for new employees enrolling for coverage (choose only one):

- First of the month, following date of hire
- First of the month, following 30 days
- First of the month, following 60 days
- First of the month, following 90 days
- First of the month, following 120 days



## MEDICAL/Rx BENEFITS SELECTION

Please indicate the medical benefits group health plan and deductible you would like to provide for your employees:

- Medical Plan**
- 100/70 Deductible:  \$250  \$500  \$1,000  \$1,500  \$2,000  \$3,000  \$4,000  \$5,000
- 90/70 Deductible:  \$250  \$500  \$1,000  \$1,500  \$2,000  \$3,000  \$4,000  \$5,000
- 90/60 Deductible:  \$250  \$500  \$1,000  \$1,500  \$2,000  \$3,000  \$4,000  \$5,000
- 80/50 Deductible:  \$250  \$500  \$1,000  \$1,500  \$2,000  \$3,000  \$4,000  \$5,000
- 70/50 Deductible:  \$250  \$500  \$1,000  \$1,500  \$2,000  \$3,000  \$4,000  \$5,000

Coinsurance:  % of 12,500 (Not available for 100/70 plans.)  % of 15,000  % of 20,000

Co-Pay:  \$20.00  \$30.00

Ded. and Coins. COMBINED in and out of Network  Ded. and Coins. SEPARATE in and out of Network

or

- HSA Plan**
- 100/70 HSA Deductible:  \$1,200  \$1,500  \$2,000  \$2,500
- 80/60 HSA Deductible:  \$1,200  \$1,500  \$2,000  \$2,500

Ded. and Coins. COMBINED in and out of Network  Ded. and Coins. SEPARATE in and out of Network

The PPO will be Cofinity with MultiPlan being used for non-Michigan claims.

Prescription Drug (Rx) Program:  \$10 Generic/\$40 Brand\* (Standard)  \$10 Generic/\$50 Brand\*  \$5 Generic/\$50 Brand\*  
 \$5 Generic/\$25 Brand/\$50 Preferred Brand \*

\* 25% co-pay for all Level IV drugs, limited to \$3,500 per member co-pay per calendar year.

(For Mail Order prescriptions, co-pays are double the retail co-pays listed above.)

## LIFE INSURANCE, DEPENDENT LIFE AND AD&D BENEFITS

Life Insurance is mandatory, with a minimum amount of \$15,000.

Please indicate the Life Insurance benefit amount.  Minimum \$15,000  Other \_\_\_\_\_

Note: Guaranteed issue amounts vary by size of group. Standard ADEA age reduction starting at age 65 applies.

Do you wish to provide Dependent Life Insurance? (\$7,500 Spouse, \$2,000 Child 6 months and older, \$100 Child 14 days-6 mo.)  Yes  No

## COBRA OPTION (Only available to Employers with 20 or more employees)

Do you want SecureOne to administer your COBRA?  Yes  No

SecureOne's fee is \$.75 PEPM.

Upon election of COBRA, SecureOne will keep the additional 2% surcharge applied to the participant's premium.

## SUBMISSION MATERIALS

The following materials must be completed and submitted to avoid delays in final underwriting:

- Group Enrollment Application for each Participating Employee\*
- Copy of Current Policy or Certificate
- Copy of Current Billing Statement
- Copy of Renewal Notification with Rates from Current Carrier
- Copy of Certificates of Creditable Coverage, as soon as available
- Copy of Employer's Most Recent Wage & Tax Report
- Binder Check for First Month's Premium \$ \_\_\_\_\_  
(Payable to Preferred United Plans of Michigan)
- Claims Experience
- Copy of Final Proposal

\*Employees in their waiting periods must be included and/or complete the appropriate enrollment form.



## EMPLOYER AGREEMENT

The Employer has read and understands the entire Employer Application for Group Insurance and all provisions, limitations, and exclusions of the insurance coverage for which he or she is applying. The Employer also understands that, as an Employer, they may be subject to State and/or Federal laws, such as those regarding COBRA, age discrimination, sex discrimination, or any other discrimination prohibited by State and/or Federal law.

The Employer has explained to all employees that the insurance coverage, if approved, becomes effective as of the effective date approved by the Preferred United Plans of Michigan. The Employer understands that the agent does not have any authority to approve effective dates or to change, modify or cancel any insurance coverage or conditions relating to coverage under any Group Policy that may be issued to the Employer.

The Employer agrees to submit the first month's premium with the Employer Application for Group Insurance. All premiums must be made payable to Preferred United Plans of Michigan and must be paid with the Employer's business check. Total first month premium: \$ \_\_\_\_\_

The Employer understands that the submission of false or misleading information may result in the adjustment of rates back to the original effective date or the immediate termination of the group and/or employee.

Dated at \_\_\_\_\_, Michigan Dated on \_\_\_\_\_  
City (Month, Day, Year)

Full Legal Name of Employer \_\_\_\_\_  
Type or Print

Typed/printed name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_

## AGENT INFORMATION

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 Preferred United Plans of Michigan 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 underwriter to verify information on their application.

Licensed Agent Name \_\_\_\_\_

Agent Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Agent Phone Number (\_\_\_\_\_) \_\_\_\_\_ Agent Fax Number (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

Agent License Number \_\_\_\_\_ Agent Social Security Number \_\_\_\_\_

Agent Tax Identification Number (Agent TIN) \_\_\_\_\_

Licensed Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Agency License Number \_\_\_\_\_

Agency Tax Identification Number (Agency TIN) \_\_\_\_\_

Agency Name \_\_\_\_\_

Agency Address \_\_\_\_\_