Small Group Master Application

AvMed

I. Employer Information

Exact Legal Name of Company:		
Doing Business As:	Employer Federal Tax ID Number:	
Business Name (As it will appear on Billing Invoice and Member ID Cards - 24 Character Limit):		
Street Address (Principal place of business in Florida)		
Street:	City:	State:
Zip:	County:	
Mailing Address (If different than above)		
Street:	City:	State:
Zip:	County:	
Group Contact Information		
Employer Telephone Number:	Employer Fax Number:	
Primary Contact Information		
Name:	Title:	
Phone Number:	Email:	
Billing Contact Information		
Name:	Title:	
Phone Number:	Email:	
Company Profile		
Nature of Business or SIC Code:	Date Company Founded (mm/dd/yyyy):	

Organized as: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Other

Most Employer Plans are subject to ERISA (The Employee Retirement Income and Security Act of 1974).
Check here if your plan is **EXEMPT** from ERISA ☐
If EXEMPT, is this a: ☐ church, or controlled by or affiliated with a church or ☐ a governmental entity

If your plan is not exempt, please provide your ERISA Plan Number:

Is this organization part of a group of related businesses that have common ownership? ☐Yes ☐ No
If "YES", will you be requesting that coverage be extended to the employees of the related businesses under this common ownership? ☐ Yes ☐No

Is this organization structured as a Non-Profit ☐Yes ☐No
You will be required to supply your most recent payroll report and, if less than 15 employees are enrolling, a copy of your most recent IRS Form 941.

II. Eligibility Information

Total average number of employees including part-time, seasonal or temporary in prior calendar year	_____
Total number of employees at time of application (include any eligible leased and/or 1099 or Owners, etc.)	_____
Total number of employees on the current RT-6 or Payroll	_____
Total number of terminated employees since the last RT-6 or Payroll	_____
Total number of new hires not on the current RT-6 or Payroll	_____
Total number of other eligible employees not on RT-6 or Payroll (1099, Owners, etc.)	_____
Total Number of Active Employees	_____
Ineligible – Part-Time	_____
Ineligible – In Waiting Period	_____
Ineligible – Out of Area	_____
Other ineligible employees not on RT-6 or Payroll (COBRA, Visa, etc.)	_____
Total Number of Ineligible Employees	_____
Total Number of employees waiving with other coverage	_____
Total Number of employees waiving without other coverage	_____
Total Number of Enrolling Employees	_____

Note: As defined by state law, an eligible employee is an employee who works full-time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements. An employer may not increase the number of hours an employee is required to work in order to be considered eligible. Employees who meet the 25 hours per week threshold are considered full-time and eligible for small group coverage benefits.

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Waiting Period

New employees are covered on the first of the month following (select one): Date of Hire 30 days 60 days

Waive Waiting Period during initial Open Enrollment? Yes No

Tefra/Defra (Medicare Payor)

Under Federal law, it is the group's responsibility to accurately determine Medicare status. Note: Employers are encouraged to consult with legal and/or tax advisor(s) before responding to the question below.

In either the preceding or current calendar year, did the group employ 20 or more full-time and/or part-time employees during 20 or more calendar weeks? Yes | No

COBRA

In the preceding calendar year, did the group employ 20 or more (full-time and/or part-time) employees on at least 50% of its typical business days?

☐Yes ☐No

Number of former employees currently enrolled in COBRA: _____

For those employees, please indicate COBRA enrollment type: ☐Federal ☐State Continuation (MiniCOBRA)

If Federal, please indicate current COBRA administrator: _____

Note: If left blank, AvMed will enroll the group with [WageWorks] as your COBRA administrator.

Employer Contribution

How much will the Employer be contributing each month toward employee-only coverage? $_____or_____% (Note: AvMed requires a minimum of 50%.)

Other Coverage

Do you currently have group coverage? Yes ☐No If yes, name of current group carrier: _____

III. Coverage Selection

Requested Effective Date: _____

Please enter all selected plan name(s) below:

Plan Type_____Plan Number _____

Plan Type_____Plan Number _____

Plan Type_____Plan Number _____

HSAQ Plans Only:

Please complete this section if you have selected an HSAQ plan.

Do you wish for your Health Savings Account (H.S.A.) to be administered by our partner Health Equity?

☐Yes ☐No If Yes, please indicate below the monthly employer contribution amount toward the financial accounts: Per Subscriber: $ _____

Per Family: $ _____

NOTE: All of AvMed's Small Group plans include Pediatric Dental coverage as required by the Affordable Care Act. We have entered into an alliance with [Delta Dental Insurance Company] to provide this essential health benefit.

IV. Agent/Broker Information

Agent Name:	Insurance License Number:		
Agency Name:	Street Address		
Street Address:	City	State:	Zip:
Telephone Number:	Fax Number:		
Agent E-mail Address:			

General Agency Name (if applicable): _____

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VI. Certification

We attest that:

- This group is a valid small group employer and is not formed for the purpose of securing health benefit coverage.
- The individuals in the small group employer group are employees and have not been added for the purpose of securing health benefit coverage.
- The employer has its principal place of business in Florida, employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year.

We certify that the information provided above is true and correct to the best of our knowledge.

Any person who willingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Agreed to and Accepted by the parties the day and year hereinafter written.

Subscribing Group:	**AvMed:**
Signature:	Signature:
Print Name:	Print Name:
Title:	Title:
Date (month/day/year):	Date (month/day/year):
Agent Signature:	

The provisions contained in the Schedule of Benefits applicable to this Contract and all Exhibits and Amendments executed by the parties and attached hereto are, by reference, made part of this Contract.