GROUP APPLICATION FOR SELF-FUNDED PROGRAM

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Sentara Health Plans

BusinessEDGE®

Sentara Health Administration, Inc.
PO Box 66189
Virginia Beach, VA 23466

EMPLOYER INFORMATION *(PLEASE PRINT)*

Legal Name of Plan Sponsor	Doing Business As (DBA) Name of Plan Sponsor
Physical Address	City / State / Zip
Federal Tax ID	Phone Number

AFFILIATED COMPANIES SUBGROUPS TO BE COVERED UNDER PLAN

(Attach additional sheet, if needed)

Full Legal Name	
City, State	
Affiliation	
Federal Tax ID	

Full Legal Name	
City, State	
Affiliation	
Federal Tax ID	

Full Legal Name	
City, State	
Affiliation	
Federal Tax ID	

Full Legal Name	
City, State	
Affiliation	
Federal Tax ID	

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NATURE OF BUSINESS: _____ **IN BUSINESS SINCE:** _____

_____

Mailing Address *(If different from physical address)* City State Zip

Company Owner(s) _____ Email Address _____

_____ Email Address _____

☐ Billing contact ☐ Benefit contact
(Billing contact will receive invoices in the mail. Benefit contact will sign the electronic group contract)

Company Contact(s) _____ Title _____ Email Address _____

_____ Title _____ Email Address _____

☐ Billing contact ☐ Benefit contact
(Billing contact will receive invoices in the mail. Benefit contact will sign the electronic group contract)

Current Carrier (If Sentara Health Plans, please list group numbers) _____

The Employer certifies that, to the best of his or her knowledge, the responses to the statements below are true and correct.

Yes	No	Employer Operational Statement
☐	☐	Employer is a corporation, partnership or proprietorship.
☐	☐	Employer is financially stable.
☐	☐	Employer has 5 to 250 participating employees.
☐	☐	Employer has not filed for Bankruptcy protection, within the past five (5) years.
☐	☐	A payroll deduction system for employee contribution, if any, is (or will be) in place.
☐	☐	Direct Debit - send required ACH form and attach to application. Payment needs to be made on an ongoing basis

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Yes	No	Employer Operational Statement
☐	☐	Employer must have at least 70% of eligible employees participating.
☐	☐	No other group health policy shall be in force.
☐	☐	Employer will permit any eligible employee to enroll.
☐	☐	Employer's organization was not formed for the sole purpose of obtaining insurance coverage.
☐	☐	Employer will assist (or has assisted) Sentara Health Plans to gather and validate Employee and Dependent Health Statements and Eligibility Questionnaires.
☐	☐	Employer will assist the Plan in obtaining a signed statement from the employee or dependents indicating coverage by any other insurance company for coordination of benefits purposes only.
☐	☐	Employer will permit an audit by Sentara Health Plans to verify compliance with all policies, procedures, and eligibility requirements as defined by the Plan.

Explain all NO answers above. *(Attach additional sheets if needed)*

The employer further agrees to provide additional information or proof concerning these statements as requested by Sentara Health Plans.

The Employer certifies that, with the exceptions noted below, the following accurately describes the rules for determining Employee eligibility under the proposed plan:

Yes	No	Employee Eligibility Rules
☐	☐	A Full-time employee (at least 17 years of age) of the Employer who works at least twenty-five (25) hours per week as of the effective date and who works and receives salary for fifty (50) weeks or more per year.
☐	☐	An employee who enters into full-time employment after the policy's effective date and who completes the required probationary (waiting) period for eligibility.
☐	☐	An employee who is employed and at the Employer's usual place of business. Full-time sales personnel with a primary source of income from the Employer are eligible.
☐	☐	An employee who receives a regular paycheck wherein the Employer deducts social security and/or state and federal income taxes.
☐	☐	Partners and owners are eligible only if they are bona fide employees of the organization whose main job is to conduct business for the Employer and they meet all other employee eligibility requirements.

Explain all NO answers above. *(Attach additional sheets if needed)*

The employer further agrees to provide additional information or proof concerning these statements as requested by Sentara Health Plans.

The Employer certifies that, to the best of his or her knowledge, the number of participating Employee and Dependent instances of the following situations is:

# Instances	Situation
	Current pregnancy
	Pending or planned adoption
	Absent on disability leave, family medical leave, or due to injury or illness

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COVERAGE INFORMATION

Effective Date: _____

Will these plan(s) replace current group Major Medical coverage? ☐ Yes ☐ No
If Yes, please attach a copy of the most recent billing statement from the current carrier.

Waiting/Affiliation Period: *(the length of time future employees must be employed before becoming eligible for coverage)*
First of Month Following: ☐ 0 days ☐ 30 days ☐ 60 days

Waive the waiting period for all employees during the initial enrollment? ☐ Yes ☐ No

EMPLOYER'S METHOD OF CONTRIBUTION: Employees _____

Dependents _____

NUMBER OF EMPLOYEES: **In Waiting Period?** _____ **On COBRA?** _____

		# Total Employees		# Eligible Employees		Estimated # Enrolling	
Company Name	**City, State**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
	Total						

Plan open enrollment dates: _____

Define employee eligibility: Full-Time: _____ hours

Part-Time: _____ hours (if eligible)

Cobra administered by: _____

Domestic Partners: ☐ Yes ☐ No

Same Sex Marriage: ☐ Yes ☐ No

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EMPLOYEE BENEFIT PLAN SELECTION - *(no more than 4)*

Plan Selection 1 _____ **Pharmacy Option** _____

Plan Selection 2 _____ **Pharmacy Option** _____

Plan Selection 3 _____ **Pharmacy Option** _____

Plan Selection 4 _____ **Pharmacy Option** _____

Stop Loss selection

☐ $15,000 ☐ $50,000
☐ $25,000 ☐ $75,000

Refund Option

☐ 100% ☐ 66.67% ☐ 50%

PLAN TRUSTEE

Is there a Plan Trustee? ☐ Yes ☐ No

If Yes:

Name: _____

Principle Business Address: _____

BALANCE BILLING

Did employer opt-in to Balance Billing directly on the State Corporation Commission (SCC) website?

☐ Yes ☐ No

If yes, what is the selected effective date?
(must opt-in at least 30 days prior to effective date)

Group effective date: _____

Select an Electronic Enrollment Type:

☐ e3 Web enrollment

☐ Employee Navigator

☐ 834 Electronic Enrollment (EDI 834)

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RELIANCE ON APPLICATION AND EMPLOYEE STATEMENTS

- Sentara Health Plans will rely on the data included in this application to assist in underwriting the Employer for Insurance.
- The Employee Eligibility Statement, Employee Application, Employee Enrollment Form or other similar form, which captures information regarding medical conditions and treatment of eligible persons, is made part of this application for insurance and shall be relied upon in determining rates and eligibility for coverage.
- The Company has the right to revise the rates (retroactively or prospectively) for the Stop Loss Insurance Contract, or rescind or terminate the Stop Loss Insurance Contract if a person completes the Employee Statement, Employee Application, Employee Enrollment Form or other similar form (collectively "Form") with false, incomplete or misleading information or fails to notify the Company of any changes to the answers to the medical information question in any Form resulting in a material misrepresentation affecting the assessment of the risk or the terms or conditions for coverage.

BROKER/AGENT CERTIFICATION

I certify that all of the information contained in the Employer Application and any additional documents submitted are correct to the best of my knowledge. I have complied with all of the underwriting rules and have fully explained the Program and Stop Loss Coverage to the employer.

Broker/Agent's Signature: _____ Date: _____

Print Broker/Agent's Name: _____ Broker/Agent's #: _____

Broker/Agent's Address: _____ Broker/Agent's Phone #: _____

Broker/Agent's City, State, Zip: _____ Broker/Agent's Fax #: _____

Broker/Agent's Email Address: _____

SECONDARY BROKER/AGENT CERTIFICATION (IF APPLICABLE)

I certify that all of the information contained in the Employer Application and any additional documents submitted are correct to the best of my knowledge. I have complied with all of the underwriting rules and have fully explained the Program and Stop Loss Coverage to the employer.

Broker/Agent's Signature: _____ Date: _____

Print Broker/Agent's Name: _____ Broker/Agent's #: _____

Broker/Agent's Address: _____ Broker/Agent's Phone #: _____

Broker/Agent's City, State, Zip: _____ Broker/Agent's Fax #: _____

Broker/Agent's Email Address: _____

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GENERAL CONDITIONS AND ACCEPTANCE

- The Employer is financially sound, with sufficient capital and cash flow to accept the risks inherent in a “self funded” health care plan.
- The Third Party Administrator retained by the Employer will be considered the Employer’s Agent and not the Company’s Agent.
- All documentation, including the Employee Eligibility Statement and an executed copy of Employee Benefit Plan Document, requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within thirty (30) days of the Effective Date.
- The Company will evaluate the Employer’s risk, and may require adjustments of rates, factors and or special limitations to accommodate for abnormal risks.
- Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in sections AGGREGATE STOP LOSS DEDUCTIBLES AND RATES AND SPECIFIC STOP LOSS DEDUCTIBLES AND RATES.

In making this application, the Employer acknowledges and accepts the General conditions cited above and represents that the information contained herein accurately reflects the true facts and that the undersigned has authority to bind the Employer to the proposed Contract. Accordingly, this request will be part of the Contract if accepted by the Company. Coverage is in effect for the period shown in Stop Loss Coverage Administration. Renewal of this for a further period must be submitted on a new form.

Accepted for Sentara Health Plans Insurance Company

By _____
Authorized Signature

Title _____

Date _____

Accepted for Applicant/Employer

By _____
Authorized Signature

Title _____

Date _____

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