Sentara Health Plans

1300 Sentara Park
Virginia Beach, VA 23464
(757) 552-7401

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Employer Group Application

☐ **Sentara Health Plans**
HMO/POS Products Underwritten by Sentara Health Plans

Vantage, Vantage HSA, Vantage Design, Tiered Vantage, Tiered Vantage HSA, Tiered Vantage Design, Tiered POS/POSA, POS/POSA, POS/POSA HSA, POS/POSA Design, Select Vantage, Select Vantage HSA, Select Vantage Design, Select POSA, Select POSA Design, Select POSA HSA

☐ **Sentara Health Insurance Company**
PPO Products Underwritten by Sentara Health Insurance Company

Plus, Plus HSA, Plus Design

Please attach all Employee Applications to this Employer Group Application

SECTION A. GENERAL INFORMATION

1. Legal Name of Employer			
2. Company's Trading As Name	Tax ID	Are you a Sole Proprietor using SSN? ☐ Yes ☐ No	
3. Street Address	City	State	Zip
4. Mailing Address	City	State	Zip
5. Phone Number	Fax Number	Email Address	
6. Business Type ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ LLC ☐ Other:			
7. Nature of Business: ☐ SIC ☐ Ind. Type:_____	In Business Since		
8. Company Owner(s)	Email Address		
	Email Address		
9.Company Contact(s)	Title	Email Address	
	Title	Email Address	

SECTION B. BENEFITS SELECTION

☐ Plan Selection I	☐ Plan Selection II	☐ Plan Selection III

☐ Contract Year	☐ Calendar Year
OPTIONAL BENEFITS: ☐	Plan Selection:

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SECTION C. ENROLLMENT INFORMATION

1. Requested Effective Date: (mmddyyyy) 2. Employer's Contribution will be _____ of the single employee premium, and _____ of the dependent coverage premium.

3. What is the Probationary Period for New Hires?
Salaried Employees: 1st of the month following _____ day(s) of employment.
Hourly Employees: 1st of the month following _____ day(s) of employment.

4. Employer groups must select whether continuation or COBRA benefits will be available to employees who lose eligibility under the group policy. Please select one of the following options:

☐ COBRA ☐ 12 Months of continuation (this option only for groups not eligible for COBRA)

5. Has this Employer ever been covered by a Sentara Plan before? ☐ Yes ☐ No

If yes, dates of coverage: (mmddyyyy)

6. Total number of active full and part-time employees as defined in Section E:

7. Total number of eligible employees as defined in Section E:

8. Total number of eligible employees waiving group health insurance:

9. Total number of eligible employees applying for group health insurance:

10. Are any of the employees or dependents applying for group health insurance totally disabled? ☐ Yes ☐ No

If yes, please explain: _____

Name: _____ Age: _____ Date of Disability: (mmddyyyy)

Name: Age: Date of Disability: (mmddyyyy)

11. Are all eligible employees covered by Worker's Compensation? ☐ Yes ☐ No

12. Who is your company's current health insurance carrier? ☐ No Current Carrier

Years with this carrier:

13. Under the Medicare Secondary Payer rules, which one applies for your group?

☐ Medicare is primary (less than 20 full time and part time employees)

☐ Sentara is primary (20 or more full time and part time employees) Sentara is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

14. Is coverage allowed for Domestic Partners of insured employees?

☐ Yes ☐ No

A domestic partner is categorized as a relationship between two people who meet all of the following criteria:

- Have shared a continuous committed relationship with each other for no less than 6 (six) months; and
- Are jointly responsible for each other's welfare and financial obligations; and
- Reside in the same household; and
- Are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence; and
- Each is over age 18, or legal age of consent in your state of legal residence, and legally competent to enter into a legal contract; and
- Neither is legally married to or legally separated from, nor in a domestic partnership with, a third party.

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SECTION D. EMPLOYER AGENT BROKER DESIGNATION (IF APPLICABLE)

The Employer authorizes the following agent(s)/broker(s) or agency(s) to be the Employer's Agent of Record:

Name of Primary Agent/Broker:	Name of Secondary Agent/Broker:
Name of Agency:	Name of Agency:
Vendor Number:	Vendor Number:

To be completed by Primary Agent or Broker (if splitting commissions)

Primary Agent: %	**Secondary Agent: %**

I as the Agent of record represent that all information contained above is complete and wholly true to the best of my knowledge, and that I know nothing unfavorable about the firm or any individual proposed for insurance except as noted on their Enrollment Application. I have complied with all all applicable eligibility and enrollment rules and have explained in detail the coverages. Any exceptions are detailed here or are referenced to on an additional sheet.

SIGNATURE OF PRIMARY AGENT/BROKER	DATE SIGNED (mmddyyyy)

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SECTION E. EMPLOYEE ELIGIBILITY

An eligible employee is one of the following persons who is determined to be eligible for coverage under this contract by the Employer, subject to acceptance by the plan:

1. A Full-time employee (at least 17 years of age) of the Employer who works at least 25 hours per week as of the effective date and who works 50 weeks or more per year.
2. An employee who enters into full-time employment after the policy's effective date and who completes the required probationary (waiting) period for eligibility.
3. 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.
4. An employee who receives a regular paycheck wherein the Employer deducts social security and/or state and federal income taxes.
5. 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.

SECTION F. EMPLOYER ELIGIBILITY

The Employer certifies that the information on this form is correct to the best of his/her knowledge. The employer further agrees to submit to the following requirements with the application and as may be necessary in the future:

1. The Employer is a corporation, partnership or proprietorship.
2. That the Employer is financially stable and has a minimum of one (1) participating employees.
3. That a payroll deduction system for employee contribution, if any, is in place.
4. That the Employer understands Sentara requires a minimum contribution with groups of 51 or more total employees.
5. That no other group health policy shall be in force.
6. That the employer will permit any eligible employee (as defined in Section E) to enroll.
7. That the Employer's organization was not formed for the sole purpose of obtaining insurance coverage.
8. That the 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.
9. That the Employer will permit an audit by Sentara to verify compliance with all policies, procedures and eligibility requirements as defined by the Plan.

SECTION G. FOR CLIENTS ENROLLING IN A SENTARA HSA PLAN:

The Employer acknowledges that Sentara HSA is an integrated product providing individual subscribers with the option to select Sentara's partner Health Equity to administer a Health Savings Account (HSA) for them. As the sponsor of this benefit plan the Employer will do the following:

1. Enable employees who establish an HSA with Health Equity to make contributions to this account via payroll deduction.
2. Direct employer HSA contributions, if any are to be made, to employee accounts at Health Equity.

SECTION H. EMPLOYER CERTIFICATION

I represent that all information noted on this Employer Group Application and all Employee Applications / Health Questionnaires is true and accurate to the best of my knowledge. I hereby confirm that all Employer and Employee eligibility guidelines have been met and will continue through the contract. I understand that non-payment of premiums may result in a termination of coverage for all parties. I also understand that the proposed insurance coverage shall not become effective until approved by the plan.

PLEASE PRINT NAME	TITLE
AUTHORIZED SIGNATURE	DATE SIGNED (mmddyyyy)

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