

### Ohio Group Application

HMO products are underwritten by HealthAmerica Pennsylvania, Inc. 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																																																																											
			Date Company Established																																																																											
Business <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																																																																											
# Of Total Employees _____ <b>Example:</b> 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).			Total Eligible for Medical																																																																											
			# Qualified Beneficiaries under COBRA																																																																											
			# of COBRA Enrollees on Group Policy																																																																											
			# of Employees Out-of-Area																																																																											
<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><b>Total</b></td> <td><b>23</b></td> <td><b>25</b></td> <td><b>26</b></td> <td><b>26</b></td> <td><b>28</b></td> <td><b>30</b></td> <td><b>27</b></td> <td><b>24</b></td> <td><b>24</b></td> <td><b>54</b></td> <td><b>63</b></td> <td><b>61</b></td> <td><b>411</b></td> <td><b>34</b></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		<b>Total</b>	<b>23</b>	<b>25</b>	<b>26</b>	<b>26</b>	<b>28</b>	<b>30</b>	<b>27</b>	<b>24</b>	<b>24</b>	<b>54</b>	<b>63</b>	<b>61</b>	<b>411</b>	<b>34</b>
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Effective Date		Dual Option* <input type="checkbox"/> Yes <input type="checkbox"/> No * For Dual Option must have 10+ 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 _____ <i>HMO and POS plans are also available upon request</i>		Riders <input type="checkbox"/> RX _____ <input type="checkbox"/> Vision _____ <input type="checkbox"/> Dental Plan # _____ ( <a href="http://www.cvydental.com">www.cvydental.com</a> ) Please contact your HealthAmerica Account Executive																																																																												
Employer Medical Contributions _____% of single premium toward the cost of each tier -OR- _____% of premium rates for each coverage tier  Dental Employer Contributions _____%		Terminated employees are covered through: <input type="checkbox"/> end of month - OR - <input type="checkbox"/> last date of employment																																																																												

<p><b>Eligibility</b></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><b>*Not available to OH groups &lt;51 eligible employees</b></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> <p>Are enrollment forms sent to a separate central office prior to being sent to HealthAmerica? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide contact name, address and phone number.</p>
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<sup>1</sup> 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.

**Employer Funding - If enrolling in a C3 product only:**

Please list the amount that the employer is funding toward the employee's single / family deductible.

I certify that I am funding \$\_\_\_\_\_ (single) / \_\_\_\_\_ (family) of my employee's \_\_\_\_\_ plan (ie. Premier PPO \$1000)

Premium rates may be adjusted based on the employer's subsidy of the deductible.

**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)      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

- **PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **OHIO:** 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 Schedule A: Medical Plan Premium Rates**