

GROUP RENEWAL APPLICATION



Renewal Date: _____

EMPLOYER INFORMATION

Employer Legal Name _____

D/B/A _____ Tax I.D. Number _____

Street Address _____ Mailing Address _____

City _____ State _____ Zip _____

Type of Entity: Corporation Partnership Sole Proprietor Non-Profit Other _____

CONTACT INFORMATION

CEO/President _____ Phone # _____ Email _____

CFO _____ Phone # _____ Email _____

Owner _____ Phone # _____ Email _____

Billing contact _____ Phone # _____ Email _____

Benefits contact _____ Phone # _____ Email _____

Business telephone number _____ Business fax number _____

BENEFIT/ENROLLMENT INFORMATION

Are you renewing with your current benefit? Yes No If no, please attach copy of alternate renewal quote/rates.

Open enrollment period: from _____ to _____ Employer contribution: _____% of single _____% of family

Total number of employees (include FT & PT): _____ Total number of eligible employees: _____

Eligible employees must work a minimum of _____ hours per week.

Waiting period: 1st day of the month following _____ days of eligible service.

Do you currently have a Health Reimbursement Arrangement? Yes No If yes, administered by _____

Do you currently have an Employee Assistance Program? Yes No If yes, administered by _____

Do you currently subsidize any COBRA premiums? Yes No If so, for whom _____, subsidized: _____%

Other policies: (i.e. retiree or alternate benefit in lieu of health insurance.) Yes No If policy is new or has changed in last plan year, please *attach a copy*.

Digital Health Plan Enrollment On-line: Yes No

Date of employee meeting: _____ # of new hire packets: _____ # of renewal packets: _____

Special agreements/comments: _____

SIGNATURE

Authorized Signature _____ Print Name _____ Title _____ Date _____

Agent Signature _____ Agency Name _____ Date _____