
LARGE EMPLOYER GROUP APPLICATION

Health Tradition Health Plan
P.O. Box 188
La Crosse, WI 54602

Group Sales Representative _____ Date _____
Sales Office _____

Application is hereby made to Health Tradition Health Plan for issuance of a Master Contract. This Employer Group Application provides the specifics for the administration of the Master Contract and is to be reviewed annually.

Renewal Date _____

SECTION A – GENERAL INFORMATION

Legal Name of Employer _____

Effective Date _____

Employer is: Individual Partnership Corporation Trust

Employer Tax Identification Number (IRS No.) _____

Description of Business _____

SIC Code _____

Name of Subsidiary/Affiliate _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Name of Subsidiary/Affiliate _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Name of Previous Carrier(s): _____ Original Effective Date _____

SECTION B – SUMMARY PLAN DESCRIPTION INFORMATION

1. Plan Administrator

Contact Name _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

E-mail address _____

2. Employer Billing Address

Name _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

3. **Notice**

Any notice sent to the Plan under this Master Contract shall be addressed to:

Health Tradition Health Plan
P.O. Box 188
La Crosse, WI 54602

Any notice sent to the Employer under this Master Contract shall be addressed to:

Employer _____
Address _____
City/State/Zip _____

4. **Information Contacts**

	Name and Title	Telephone Number
Claim	_____	_____
Subrogation	_____	_____
Billing	_____	_____
Enrollment	_____	_____
Drug	_____	_____

5. **Total Employed** _____ (needed for coding COBRA/OBRA/TEFRA)

6. **Classes of Employees to be Eligible for Enrollment** _____

7. **Number of Eligible Employees** _____

8. **Minimum Hours Worked to be Considered Eligible** _____

Standard is a minimum of 30 hours per week. Less than 30 hours per week may require a rate adjustment.

9. **Fiscal Record Keeping Year** _____

10. **Employer contribution amount** _____

SECTION C –BENEFIT PLAN ELECTIONS

1. **Type of Plan**

_____ HMO (attach Summary of Benefits) _____ POS (attach Summary of Benefits)
Employers electing the POS option will execute two Master Contracts

2. **Classes of Coverage**

_____ Single	Subscriber only
_____ Subscriber plus One	Subscriber and one dependent
_____ Subscriber plus Spouse	Subscriber and his/her lawful spouse
_____ Subscriber plus Children	Subscriber and one or more dependent excluding his/her lawful spouse
_____ Family	Subscriber and dependents

3. **Employee Effective Date**

- _____ First day of the month following the completion of the employee waiting period
- _____ Date coinciding with completion of the employee waiting period (requires rider – see section D.7)
- _____ Date of hire (requires rider – see section D.7)

If employee effective date is from the 1st to the 15th, Premium is due for the month. If employee effective date is from the 16th to the 31st, no Premium is due.

4. **Employee Waiting Period**

_____ Present Eligible Employee are covered on the effective date of this Master Contract

Future Eligible Employees are subject to the following waiting period:

- _____ None – covered date of hire (requires rider – see section D.7)
- _____ 1 month
- _____ 2 months
- _____ 3 months
- _____ 6 months
- _____ Other – please specify: _____

5. **Employee Termination Policy**

- | | |
|---|---|
| _____ End of the month following the date of termination | The full Premium is due through the end of the coverage month |
| _____ Date of termination/last day of employment (requires rider – see section D.7) | If date of termination is from the 1 st to the 15 th , no Premium is due for the month. If date of termination is from the 16 th to the 31 st , the full month Premium is due |

SECTION D – REQUIRED EMPLOYER ELECTIONS AND INFORMATION

1. **Open Enrollment**

Open Enrollment Period

- _____ Annual _____
- _____ Other: _____

2. **Minimum Participation Requirement**

_____ % of Eligible Employees must participate

3. **Deductible Credit** (limited to off-cycle sales only)

- _____ None
- _____ 3 months/retroactive to January (whichever is shorter)
- _____ Other (attach exception approval)

7. **Riders**

Covered Services

- _____ **[Dental Benefit** – provides coverage for limited preventive, diagnostic and restorative services]
- _____ **Elective Sterilization** – removes coverage for elective sterilization such as: vasectomy and tubal ligation
- _____ **Foreign Travel Immunizations** – provides coverage for immunizations for foreign travel, not including employment related immunizations
- _____ **Preventive Health Services (Premier Plus only)** – provides coverage for preventive health services out-of-network
- _____ **Rehabilitation Services** – removes limitation of [50] combined visits per year
- _____ **Vision Care** – provides coverage for lenses, contacts and frames

Eligibility/Termination

- _____ **Dependent Eligibility** –provides flexibility with regard to termination date (i.e., end of month; end of calendar year; or on dependent’s birthday)
- _____ **Must specify termination date requested** _____
- _____ **Effective Date of Coverage (Waiting Period)** – provides coverage immediately following waiting period rather than on the first of the month following the waiting period
- _____ **Effective Date of Coverage (Date of Hire)** – provides coverage on date of hire
- _____ **Termination Date** – coverage terminates on last day worked rather than the end of the month

[Other]

_____ **No Riders Selected**

SECTION E – SIGNATURES

IN WITNESS WHEREOF, each party hereto has caused this Employer Group Application to be signed by its duly authorized representatives and is effective on the date shown on the cover page of the Master Contract

EMPLOYER

HEALTH TRADITION HEALTH PLAN

By _____

By _____

Title _____

Title _____

Date _____

Date _____