

---

# SMALL 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 Person \_\_\_\_\_

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:** Eligible Employees must work a minimum of 30 hours per week to be eligible for coverage under the Benefit Plan.

9. **Fiscal Record Keeping Year:** \_\_\_\_\_

10. **Employer contribution amount** \_\_\_\_\_

**SECTION C – BENEFIT PLAN ELECTIONS**

1. **Type of Plan**

\_\_\_\_\_ HMO – Option \_\_\_\_\_ POS – Option \_\_\_\_\_  
(attach Summary of Benefits) (attach Summary of Benefits)  
*Employers electing the POS option will execute two Master Contracts*

**Multiplan – Option #** \_\_\_\_\_

2. **Deductibles**

Deductibles are calculated per calendar year (January – December), not on the Employer's Coverage Year.

**3. Employee Effective Date**

First day of the month following the completion of the employee waiting period.

**4. Employee Waiting Period**

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

Future Eligible Employees are subject to the following waiting period:

- \_\_\_\_\_ 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
--	---

**SECTION D – REQUIRED EMPLOYER ELECTIONS AND INFORMATION**

**1. Employer Contribution**

The minimum employer contribution is 50% of the composite single rate.

_____ % Employer		_____ % Employee
------------------	--	------------------

**2. Billing Method**

**Standard Method**

The Plan bills the Employer monthly. Each monthly Contract Charge shall be calculated based on the Plan's records of Subscribers in each Class of Coverage using the Premium rates in effect as listed on the Premium Rate Sheet and as amended or provided in Section IV. The Employer will pay the Contract Charge as listed on the billing and will not make any adjustments to the amount billed. Retroactivity due to Member additions, terminations and Class of Coverage changes will be adjusted by the Plan in the billing immediately following receipt of the Member change forms as stated in Paragraph 3.3.

**3. Rate Options**

_____ Age		_____ Composite*
-----------	--	------------------

\*Composite rate option is available only for groups with 20 or more enrolled Employees

**4. Classes of Coverage**

Single		Subscriber only
Subscriber plus One		Subscriber and one dependent
Family		Subscriber and dependents

