

Association Mutual Health Insurance Company

Group Application

SECTION I: Employer Information

1. Employer (full legal name) _____
2. Main Address _____

3. Contact Name _____
4. Contact Title _____
5. Contact E-mail _____
6. Telephone Number _____
7. Fax Number _____
8. Website Address _____
9. Proposed Effective Date _____
10. Please attach a copy of the IRS Determination Letter that indicates your status as a Non-Profit organization.
11. Please attach a written narrative describing how one of your organizations missions is to support education and/or research including but not limited to early childhood, elementary, secondary, or post-secondary education; training; certification; curriculum development; distance education; continuing education; or professional education.

SECTION II: Proposed Coverage Requests

- Type of Health Coverage PPO Health Plan Kaiser Permanente HMO Plan
- Requested: Network Only Health Plan
- Other Insurance Requested: Dental (Choose one): Premium Standard
- Employee Assistance Plan (must be 100% employer paid)
- Legal Assistance* Flex Reimbursement Plan*
- Spectera Vision
- Short Term Disability* Long Term Disability*
- Life Insurance* 1x annual salary 1.5x annual salary
- 2x annual salary \$50,000 (fixed amount)

*Please attach copies of plan documents

Please contact us about any of the following:

- Property and Liability Insurance
- Directors & Officers Insurance
- Travel or Student Insurance Programs

Property & Liability Insurance Program

Contact Person _____

Renewal Date _____

SECTION III: Current Plan Information

1. Name of current health insurance carrier: _____

2. Name of current dental insurance carrier: _____

3. Current Plan Details

Health Insurance	Employee	Employee/Child	Employee/Spouse	Family
Plan I				
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$
Plan II				
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$
Plan III				
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$
Dental Insurance	Employee	Employee/Child	Employee/Spouse	Family
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$

Number of COBRA Participants _____

Is coverage offered to retirees? (attach policy) _____ Yes _____ No

Number of Retirees: _____ Over 65 _____ Under 65 Expected

enrollment (5 employee minimum) _____

Number of disabled employees _____

4. What other forms of health and welfare plans are available to your employees?

5. Please complete the attached census for all eligible employees.

6. Please attach bill for each employee benefit offered.

SECTION IV: Underwriting

1. To the best of your information and belief, is there any eligible person who has been treated for:

- | | |
|--|-----------------------------|
| _____ AIDS/HIV | _____ Existing Pregnancy |
| _____ Birth Defects or Disorders | _____ Psychiatric Disorders |
| _____ Cancer | _____ Substance Abuse |
| _____ Chronic Heart, Kidney or Liver Disease | |

2. To the best of your information and belief, is there any eligible person who has incurred \$10,000 or more in medical expenses in the last 12 months or expects to be hospitalized for a serious medical condition? _____ Yes _____ No

3. To the best of your information and belief, is there any eligible person to be enrolled for group coverage who has been denied coverage by your current or last health care carrier? ___ Yes ___ No
4. Has the company changed health carriers three (3) times in the past five (5) years? ___ Yes ___ No
5. Has the company's coverage been cancelled or is it in the process of being cancelled by the company's current carrier? ___ Yes ___ No
6. Has the company filed for or is in the process of filing for bankruptcy? ___ Yes ___ No

SECTION V: Request for Quotation:

_____ hereby requests approval to participate in the Employee Benefit Plans(s) offered by AMHIC/SBPA as stated in Section II.

Association	Date	Authorized Signature	Title
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