PHP

For PHP use Only	Medical	Dental
BPL#:		
Effective Date:		
Renewal Date:		
Rate Basis:		
Approved By:		
Date Approved:		

Employer Group Application

Application is being made for the following benefits: *(check all that apply)*

- ☐ Medical coverage provided by Physicians Health Plan of Northern Indiana, Inc.
- ☐ Dental coverage:
  - Provided by Physicians Health Plan of Northern Indiana, Inc. for companies headquartered in the following Indiana counties: Adams, Allen, DeKalb, Huntington, Noble, Wells and Whitley.
  - Provided by PHP Insurance Company of Indiana, Inc. for companies headquartered in Indiana counties other than those mentioned above.

Effective Date for Beginning Coverage: **Medical** _____ **Dental** _____

Benefit Plan Number(s) Requested: **Medical** _____ **Dental** _____

☐ **I recognize that coverage for the surgical treatment of morbid obesity is part of the standard benefit package of Physicians Health Plan of Northern Indiana, Inc.**

Current Medical Insurance Carrier *(if applicable)*: _____

Current Dental Insurance Carrier *(if applicable)*: _____

☐ **I am not maintaining grandfathered status.**

☐ **I am maintaining grandfathered status.** *According to the Affordable Care Act, I must provide documentation of previous plan terms, including benefits, cost sharing, employer contributions and annual limits to maintain grandfathered status.*

GENERAL INFORMATION

1. Employer Legal Name: _____

   _____ (Name of owner) _____% (Ownership) _____ (Name of owner) _____% (Ownership) _____ (Name of owner) _____% (Ownership)

2. DBA Name *(if applicable)*: _____

3. Plan Administrator *(Primary Contact/Decision Maker)*: _____

   Privacy Contact: _____
   Person authorized to receive protected health information in compliance with HIPAA Privacy

4. Telephone #: _____ Fax #: _____

5. E-Mail Address: _____

6. Type of Business: _____ Industry Code (e.g. SIC): _____

7. Legal Status: ☐ Corporation ☐ Partnership ☐ LLC ☐ Proprietorship ☐ Other _____

   Tax ID #: _____ Date Business Established: _____

8. Physical Address: _____
   Street

   _____
   City State Zip County

9. Billing Contact Name: _____

Billing Address: _____
(If different from physical address) Street or P.O. Box

_____
City State Zip County

10a. Please list any affiliates, subsidiaries, branches, or other companies that can legally be filed under one tax return.

_____
Name Street

_____
City State Zip County

10b. Any affiliates, subdivisions, branches, etc. to be covered under this plan? ☐ Yes ☐ No

If yes: _____
Name of Company # of Total Employees # of Employees to be Covered

10c. How would you like your bill?

One bill: ☐ Divisions combined ☐ Divisions separated

OR

Multiple bills sent to: ☐ Primary Location ☐ Multiple Locations *(if mutliple locations please provide the contact and address(es) on a separate sheet with your signature and date.)*

10d. List the names of the owners of any affiliates, subdivisions, branches, etc. and the percentage of ownership.
(If more space is needed, attach a separate sheet with your signature and date.)

1. _____ _____ _____%
Company Name Name of Owner Ownership

2. _____ _____ _____%
Company Name Name of Owner Ownership

ELIGIBILITY/BENEFITS

11a. Based on your current payroll list, how many employees do you have in each category?

	Enrolling Company	Affiliates/Subsidiaries
Full-time (30 hours or more per week):	_____	_____
Part-time (less than 30 hours per week):	_____	_____
Seasonal/Temporary:	_____	_____
COBRA participants:	_____	_____
Other ***(please identify)***:_____	_____	_____
Total Employees	_____	_____

11b. **Medical** *(if applicable)*
Total Number of Employees: _____
Number of Employees Eligible for Medical Plan: _____
Number of Employees Enrolling in Medical Coverage: _____
Number of Employees Waiving Medical Coverage: _____

Dental *(if applicable)*
Total Number of Employees: _____
Number of Employees Eligible for Dental Plan: _____
Number of Employees Enrolling in Dental Coverage: _____
Number of Employees Waiving Dental Coverage: _____

Covered employees that speak English as a primary language: _____%

If not 100%, provide other languages spoken and at what percent: _____ _____%

12. Do you have union employees? ☐ Yes ☐ No
If yes, are they being covered under the: **Medical Plan?** ☐ Yes ☐ No **Dental Plan?** ☐ Yes ☐ No
Are the benefits the same? ☐ Yes ☐ No

13. Are retirees* being covered by the: **Medical Plan?** ☐ Yes ☐ No **Dental Plan?** ☐ Yes ☐ No
If yes, how many? _____ Define Retiree: _____

Subject to Underwriting approval.

14. **Employer Contribution Toward Medical Premium**:
Note: The employer must contribute a minimum of 50% of the 'employee only' costs. If employer pays entire cost, no eligible person may waive coverage.
$ Amount or % of Employee Premium: _____
$ Amount or % of Dependent Premium: _____

15. **Employer Contribution Toward Dental Premium**:
Note: The employer must contribute a minimum of 50% of the 'employee only' cost of dental coverage or 50% of the combined 'employee only' PHP medical and dental premium for each covered employee. If employer pays entire cost, no eligible person may waive coverage.
$ Amount or % of Employee Premium: _____
$ Amount or % of Dependent Premium: _____

16. **Waiting Period** (Period i.e., 30, 60, 90 days or 1, 2, 3 months):
Waiting Period: _____ ☐ Months ☐ Days
Waiting period applies to: ☐ Future employees only ☐ Current employees in waiting period & future employees
Coverage begins: ☐ Day waiting period is satisfied ☐ First of the month following waiting period
☐ Day after waiting period is satisfied ☐ Day of employment

17. When does coverage end for terminated employees? ☐ Date of termination ☐ End of the month after date of termination

18. Are there any other **medical** carriers offered* as an option to employees? ☐ Yes ☐ No
If so, name of carrier: _____
Identify employer contribution: _____
Subject to Underwriting approval.

19. Are there any other **dental** carriers offered* as an option to employees? ☐ Yes ☐ No
If so, name of carrier: _____
Identify employer contribution: _____
Subject to Underwriting approval.

20a. Will this health plan be combined with a Health Savings Account (HSA) ? ☐ Yes ☐ No
20b. If yes, what is the name of the HSA trustee?_____
20c. If yes, what will your employer contribution be toward the employee's HSA?
Single $_____ Family $_____

21a. Will this health plan be combined with a Health Reimbursement Arrangement (HRA) ? ☐ Yes ☐ No
21b. If yes, what is the name of the HRA administrator?_____
21c. If yes, what will your employer contribution be toward the employee's HRA?
Single $_____ Family $_____

22a. Will this health plan be combined with a Flexible Spending Account (FSA) ? ☐ Yes ☐ No

22b. If yes, what is the name of the FSA administrator?_____

22c. If yes, what will your employer contribution be toward the employee's FSA?

Single $_____ Family $_____

23. When an FSA and HRA are both available, describe the reimbursement protocol used between accounts.

_____

_____

24. Do you provide Workers' Compensation for all employees? ☐ Yes ☐ No
If no, please list employees not covered:

Name	Title	Reason Not Covered
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Workers' Compensation Carrier: _____

25a. Are you required by law to offer COBRA coverage to your employees for the current calendar year?
☐ Yes ☐ No

25b. Are any present or former employees or dependents currently on or eligible for COBRA continuation? If yes, please provide the following: ☐ Yes ☐ No

Name	Qualifying Event	Date COBRA Started	Date COBRA Coverage Expires
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

26. Continuation of coverage while on an approved layoff or leave of absence (This layoff or leave of absence provision runs concurrent with COBRA when the employer must comply with COBRA).

☐ 90 Days ☐ Other*: _____

**Subject to Underwriting approval.*

The insurance applied for is not in force until approved by PHP.
The undersigned applicant certifies that all answers contained in this application are true and complete.

_____	_____	_____
Applicant Signature	Print Applicant Name	Date
_____	_____	_____
Licensed Broker Signature	Print Broker Name	Date

Physicians Health Plan of Northern Indiana, Inc.

PHP Insurance Company of Indiana, Inc.

8101 West Jefferson Boulevard ● Fort Wayne, Indiana 46804-4163 ● (260) 432-6690 ● 1-800-982-6257 ● FAX (260) 432-0493
www.phpni.com

Plan Administrator Website
Authorization Form

By completing this form, the Plan Administrator will receive access to specific employer information on PHP's website. Completed forms may be faxed to your Account Manager at (260) 432-0493 or mailed.

General Information *(Please Print)*

Employer Name:_____

Plan Administrator's Name:_____
(person authorized to view protected health information)

Telephone Number:_____ E-mail Address:_____

Additional Individual(s) Requesting Access: *(if applicable)*

Name:_____
(person authorized to view protected health information)

Telephone Number:_____ E-mail Address:_____

By completing this form the individuals listed above will have access to the following information:

Group Specific
- View Employee List
- View Members
- Add/Edit Members
- Order ID Cards
- Terminate Members
- Contracts and Benefits

Additional Resources
- Administrative Forms
- Provider Directory
- Pharmacy Formulary List
- Administration Guide
- My Health 24/7
- Health/Wellness Brochures

By signing below, I agree and acknowledge: 1) to maintain the confidentiality of all information provided via PHP's website in compliance with all applicable laws and PHP's policies; 2) to not allow any other person to learn or use my password; 3) to notify PHP in the event I have reason to believe somebody has my password or has attempted to access the PHP website in my name; 4) to not attempt to alter any information on the website; 5) to notify PHP within 24 hours of my separation from the employer identified above; 6) that PHP reserves the right to limit, suspend or terminate my access to the website; 7) when using the online enrollment, change or termination tool, to obtain from the member a completed paper copy of the enrollment or change form, as applicable, prior to entering the electronic change and shall maintain a paper record of such form which shall be provided to PHP upon request; and 8) that my employer and I will hold PHP harmless in the event I breach any of the above terms.

I also hereby request and agree to obtain the Group Contract and any Amendments electronically on PHP's website at www.phpni.com. I will be notified by PHP when they are available. I understand that at any time I may opt out and request a free paper copy by submitting a written request to PHP.

_____	_____	_____
Plan Administrator's Signature	Print Name	Date
_____	_____	_____
Other Authorized Individual's Signature* (if applicable)	Print Name and Title	Date

*Other information may be required