Employer Application For Administrative Services

Southern Ohio Chamber Alliance Benefit Plan

Administered by:

Anthem

SOUTHERN OHIO CHAMBER ALLIANCE BENEFIT PLAN

Please complete this form. Use extra sheets of paper if necessary.
Note: Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Anthem use only

☐ New ☐ Termination ☐ Reclass	Group no.	Effective date (MMDDYYYY)	UGT no.

Section 1: Effective date

Requested effective date: _____ (MMDDYYYY)

Section 2: Health plan(s) — The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

☐ Blue Access PPO ☐ Blue Access Options PPO (3-Tier) ☐ Blue Access (PPO) HSA

Section 3: Employer information

Applicant (legal name of group)	Doing business as	Name of chamber (required)
Name of head of firm (authorized signer)	Title	Email
Name of administrative contact (authorized signer)	Title	Email
Name of additional authorized signer	Title	Email

Standard industry code (SIC) code	Home office address	City	State	ZIP code
County	Phone no. (include area code)	Fax no. (include area code)	Tax ID/FEIN (required)	
Business address (if different from above)	City		State	ZIP code

Is any part of group subject to bargaining agreement? ☐ Yes ☐ No	Union name (attach copy of agreement)	Union no.	Union contract expiration date

Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No

Do you want sub-group bills? ☐ Yes ☐ No

Do you have a COBRA administrator? ☐ Yes ☐ No

Name of current health carrier/third-party administrator: _____

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

Legal name	Federal tax ID no.	No. of employees

Group name

Section 4: Eligibility

No. of eligible full-time employees (minimum 30 hours per week including those within their waiting period): _____

Total no. of employees (including part-time): _____ No. of employees enrolling: _____

No. of employees declining: _____ No. of employees ineligible: _____

Total no. of employees residing/working outside of home office state: _____

Eligible enrollees as of this plan's effective date will have coverage (Only one waiting period is allowed per group and will impact all full-time employees.)

☐ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on

The day after: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days of employment OR

First billing date after: ☐ 0 days ☐ 30 days ☐ 60 days

Section 5: Contribution requirements

Contribution and minimum participation requirements

Employer must have at least two employees enrolled in health to maintain benefits under this plan. Group contribution level for health: 50% of the single premium equivalent; at least 25% of total premium equivalent rate. If group contribution is 100%, 100% participation is required. Group minimum participation for health: 75% of Net Eligible Employees and 50% of Total Eligible Employees. Net Eligible Employees = total number of eligible employees less those employees with other valid health coverage. Flat contribution amounts are not allowed.

Group contribution level for health care benefits

Employee: _____% Employee/Spouse: _____% Employee/Child: _____% Employee/Family: _____%

Section 6: Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that Anthem Blue Cross and Blue Shield (hereinafter "Anthem" unless otherwise specified) administer certain health care benefits of employer's self-insured group health plan pursuant to the terms of Anthem's administrative services agreement with the Southern Ohio Chamber Alliance Benefit Plan. Employer, through an authorized representative, understands and agrees by payment of the required premium equivalents, to the following:

1. To comply with all terms and provisions of the administrative services agreement issued to Southern Ohio Chamber Alliance Benefit Plan.
2. To make the health care benefits available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as agreed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the health care benefits.
4. To provide notice of any applicable rights to continue health care benefits under COBRA/State Continuation to eligible employees and eligible dependents.
5. That acceptance of this application may cancel any prior contract(s) or administrative services agreement with Anthem effective immediately preceding the effective date of the administration of health care benefits.
6. To pay Anthem by the invoice due date, the premium equivalent rate on behalf of each member enrolled for health care benefits, to submit applications of employees prior to their date of eligibility to keep all necessary records regarding membership, to assume responsibility for handling the COBRA/State Continuation process, if applicable.
7. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premium equivalent rates are not timely received.
8. If applicable, employer will receive on behalf of the members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
9. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not completed, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The premium equivalent rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such premium equivalent rates upon receipt of all individual applications for employers' employees and to modify the premium equivalent rates, if the enrollment information so warrants.
10. This entire application for administrative services has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
11. All employees applying for benefits are employees of the employer and receive salary or wages documented on state and/or federal payroll reports.
12. The agreement for employer is not in effect unless and until this application is accepted by Anthem and an employee's health care benefits are not in effect unless and until the employee enrolls.
13. The employer acknowledges that it has signed the attached benefit proposals indicating the benefits requested.
14. The broker(s) listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.

Fraud notice: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Authorized signer signature	Title	Date (MMDDYYYY)
X		

Group name

Section 7: Broker certification

I hereby certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
3. I have not signed any of the applications for the employer or any of its eligible employees.
4. I have advised the group that failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date or re-rating of the group's premium equivalent rate retroactive to the effective date. Health care benefits shall not be effective until Anthem reviews and accepts the application.

Broker signature **X**	Broker name	Date (MMDDYYYY)

Writing payable/sub-agent/producer/broker	_____%	**Second writing payable/sub-agent/producer/broker** (if applicable)	_____%

Agency name	Agency tax ID no.	Agency name	Agency tax ID no.
Agent/producer/broker name	Broker license no.	Agent/producer/broker name	Broker license no.
Agent/producer/broker ID no.	Broker encrypted TIN	Agent/producer/broker ID no.	Broker encrypted TIN
Payable/sub-agent/producer/broker ID no. if different		Payable/sub-agent/producer/broker ID no. if different	
Street address		Street address	
City	State / ZIP code	City	State / ZIP code
Phone no.	Fax no.	Phone no.	Fax no.
Email address		Email address	

Signature **X**	Date (MMDDYYYY)	Signature **X**	Date (MMDDYYYY)

For general agent/producer/broker use only

General agent/producer/broker name		Agent/producer/broker ID no.	
Street address		City	State / ZIP code