



**APPLICATION FOR GROUP COMPREHENSIVE HEALTH INSURANCE**

<b>Employer Information-Group Policyholder</b>			
<b>Legal Name of Group</b>			
<b>Address</b>		<b>City</b>	<b>State</b>
<b>Billing Address (If Different)</b>		<b>City</b>	<b>State</b>
<b>Primary Phone Number</b>	<b>Tax ID Number</b>	<b>Email Address</b>	
<b>Type of Business</b> (Select One) <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Limited Liability Company (LLC) <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Other _____		<b>Date Business Established</b>	
		<b>SIC Code</b>	
<b>Human Resource Contact</b>		<b>Phone Number</b>	
<b>Proposed Effective Date of Policy</b>		<b>Annual Open Enrollment Period</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: From (mm/dd/yy)_____ To (mm/dd/yy)_____	
<b>Employer Contribution</b> (Select One) <input type="checkbox"/> None <input type="checkbox"/> Employer Contribution Employee \$ _____ or _____ % Dependents \$ _____ or _____ %		<b>Initial Enrollment</b> Number of Full-Time Employees _____ Number of Employees Enrolling _____ Number of Employees Waiving _____	
<b>Enrollment Eligibility</b> (Indicate all that apply) <input type="checkbox"/> All Full-Time Active Employees working _____ hours per week <input type="checkbox"/> All Part-Time Active Employees working _____ hours per week <input type="checkbox"/> Dependents <input type="checkbox"/> Other _____		<b>Probationary Period:</b> First of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days	
<b>IDAHO Benefit Plan Selection</b>			
<input type="checkbox"/> <b>LINK</b> <input type="checkbox"/> <b>ENGAGE</b> (Must Select Link OR Engage)			
<input type="checkbox"/> Gold <input type="checkbox"/> Gold Option 2 <input type="checkbox"/> Silver <input type="checkbox"/> Silver HSA <input type="checkbox"/> Silver Option 2 <input type="checkbox"/> Bronze <input type="checkbox"/> Bronze HSA <input type="checkbox"/> Expanded Bronze			

***MONTANA Benefit Plan Selection***

***[ ] CONNECTED CARE***

Gold     Silver     Silver HSA     Bronze     Bronze HSA     Expanded Bronze

***[ ] ACCESS CARE***

Gold     Silver     Silver HSA     Bronze     Bronze HSA

***[ ] CO-OP PLUS***

Gold     Silver     Silver HSA

Bronze     Bronze HSA

***WYOMING Benefit Plan Selection***

***[ ] HIGH PLAINS***

Gold     Silver     Silver HSA     Bronze

**Payment Method:**

**ACH/EFT (Reoccurring Payments)**

Checking/Savings  
Account Number

Name of Financial Institution

Routing Number

\_\_\_\_\_

Premiums are withdrawn between the 18<sup>th</sup> and 25<sup>th</sup> of the month (or next business day) depending on the date you choose:

18th     19th     20th     21st     22nd     23rd     24th     25th

*If you would like an alternate payment method, please contact us at 855-488-0622*

**Representations-Agreement**

I agree: (1) that the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) that this application will be part of the group policy for which I apply; (3) I will notify Mountain Health Cooperative (the Company) if any statements or answers given in this application change prior to policy delivery.

I understand that that the group policy will be renewed each year on the policy anniversary date, unless I notify the Company to terminate the group policy. Such notification will be provided to the Company at least 45 days prior to the termination date. I understand that termination of group policy is subject to the terms and conditions provided in the group policy.

I understand and agree that I may only elect one open enrollment period per year for the group policy. I understand and agree that the annual open enrollment period I indicated for **Annual Open Enrollment Period** in this Application will be applied every year, unless I give a written request to the Company to change the annual open enrollment period at least 90 days in advance of the next policy anniversary date. I agree to notify my employees of the open enrollment period.

I understand and agree that the fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application *before* action can be taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return any premium deposit submitted with this application. I understand that the Company will rely on the information I provide in this application in determining eligibility for the group policy coverage for which I apply, setting premium rates, and other enrollment purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, or other consequences as permitted by law. I agree that the Company will be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under the group policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any insurer rights or requirements; and (c) waive any information that the insurer requests.

**READ YOUR POLICY CAREFULLY.**

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison, and may result in denial of coverage under the Group Policy.**

\_\_\_\_\_  
Signature of Group Policyholder (Employer)

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
State in which Group Policy will be delivered

\_\_\_\_\_  
State in which Group Policyholder  
Signed Application

\_\_\_\_\_  
Printed Name of Licensed Insurance Agent

\_\_\_\_\_  
Signature of Licensed Insurance  
Agent

Agent License Number \_\_\_\_\_