



APPLICATION FOR GROUP COMPREHENSIVE HEALTH INSURANCE

Employer Information-Group Policyholder			
Legal Name of Group			
Address		City	State
Billing Address (If Different)		City	State
Primary Phone Number () _____ - _____	Tax ID Number	Group Email Address	
Type of Business (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 _____		Date Business Established	
		SIC Code	
Group Contact		Phone Number () _____ - _____	
		Email Address _____	
Effective Date of Policy _____/01/_____		Annual Open Enrollment Period <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: From (mm/dd/yy) _____ To (mm/dd/yy) _____	
Employer Contribution (\$ or %) Employee \$ _____ or _____ % Dependents \$ _____ or _____ %		Initial Enrollment Number of Full-Time Employees _____ Number of Employees Enrolling _____ Number of Employees Waiving _____	
Enrollment Eligibility Active Employees working _____ hours per week Include: (choose one) <input type="checkbox"/> Spouse and Dependents <input type="checkbox"/> Dependents only		Probationary Period: First of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days	
IDAHO Benefit Plan Selection			
LINK			
<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Silver HDHP <input type="checkbox"/> Bronze <input type="checkbox"/> Bronze HDHP			
PEAK PPO			
<input type="checkbox"/> Gold <input type="checkbox"/> Gold HDHP <input type="checkbox"/> Silver <input type="checkbox"/> Silver HDHP <input type="checkbox"/> Bronze <input type="checkbox"/> Bronze HDHP			

MONTANA Benefit Plan Selection

PEAK PPO

Gold Gold HDHP Silver Silver HDHP Bronze Bronze HDHP

PLUS (CO-OP PLUS)

Plus Gold Plus Gold HDHP Plus Silver Plus Silver HDHP

Plus Bronze Plus Bronze HDHP

ROCKY MOUNTAIN

Gold Gold HDHP Silver Silver HDHP Bronze Bronze HDHP

ACH/EFT (Recurring Payments)

Checking/Savings
Account Number

Name of Financial Institution

Routing Number

Premiums are withdrawn between the 18th and 25th of the month (or next business day)

depending on the date you choose:

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

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 _____