
SMALL EMPLOYER GROUP APPLICATION

Health Tradition Health Plan

P.O. Box 188

La Crosse, WI 54602

Group Sales Representative _____ Date _____
Sales Office _____

Application is hereby made to Health Tradition Health Plan for issuance of a Master Contract. This Employer Group Application provides the specifics for the administration of the Master Contract and is to be reviewed annually.

Renewal Date _____

SECTION A – GENERAL INFORMATION

Legal Name of Employer _____

Effective Date _____

Employer is: Individual Partnership Corporation Trust

Employer Tax Identification Number (IRS No.) _____

Description of Business _____

SIC Code _____

Name of Subsidiary/Affiliate _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Name of Subsidiary/Affiliate _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Name of Previous Carrier(s): _____ Original Effective Date _____

SECTION B – SUMMARY PLAN DESCRIPTION INFORMATION

1. Plan Administrator

Contact Person _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

E-mail address _____

2. Employer Billing Address

Name _____

Address _____ Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

3. Notice

Any notice sent to the Plan under this Master Contract shall be addressed to:

Health Tradition Health Plan
P.O. Box 188
La Crosse, WI 54602

Any notice sent to the Employer under this Master Contract shall be addressed to:

Employer _____
Address _____
City/State/Zip _____

4. Information Contacts

	Name and Title	Telephone Number
Claim	_____	_____
Subrogation	_____	_____
Billing	_____	_____
Enrollment	_____	_____
Drug	_____	_____

5. Total Employed: _____ (needed for coding COBRA/OBRA/TEFRA)

6. Classes of Employees to be Eligible for Enrollment: _____

7. Number of Eligible Employees: _____

8. Minimum Hours Worked to be Considered Eligible: Eligible Employees must work a minimum of 30 hours per week to be eligible for coverage under the Benefit Plan.

9. Fiscal Record Keeping Year: _____

10. Employer contribution amount _____

SECTION C – BENEFIT PLAN ELECTIONS

1. Type of Plan

_____ HMO – Option _____ POS – Option _____
(attach Summary of Benefits) (attach Summary of Benefits)
Employers electing the POS option will execute two Master Contracts

Multiplan – Option # _____

2. Deductibles

Deductibles are calculated per calendar year (January – December), not on the Employer’s Coverage Year.

3. Employee Effective Date

First day of the month following the completion of the employee waiting period.

4. Employee Waiting Period

Present Eligible Employees are covered on the effective date of this Master Contract

Future Eligible Employees are subject to the following waiting period:

- _____ 1 month
- _____ 2 months
- _____ 3 months
- _____ 6 months
- _____ Other – please specify: _____

5. Employee Termination Policy

End of the month following the date of termination	The full Premium is due through the end of the coverage month
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SECTION D – REQUIRED EMPLOYER ELECTIONS AND INFORMATION

1. Employer Contribution

The minimum employer contribution is 50% of the composite single rate.

_____ % Employer		_____ % Employee
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2. Billing Method

Standard Method

The Plan bills the Employer monthly. Each monthly Contract Charge shall be calculated based on the Plan's records of Subscribers in each Class of Coverage using the Premium rates in effect as listed on the Premium Rate Sheet and as amended or provided in Section IV. The Employer will pay the Contract Charge as listed on the billing and will not make any adjustments to the amount billed. Retroactivity due to Member additions, terminations and Class of Coverage changes will be adjusted by the Plan in the billing immediately following receipt of the Member change forms as stated in Paragraph 3.3.

3. Rate Options

_____ Age		_____ Composite*
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*Composite rate option is available only for groups with 20 or more enrolled Employees

4. Classes of Coverage

Single		Subscriber only
Subscriber plus One		Subscriber and one dependent
Family		Subscriber and dependents

