

Neighborhood Health Partnership

Large Group Application

INCOMPLETE FORMS DELAY PROCESSING

EMPLOYER INFORMATION

Requested Effective Date

Employer Name (Full Legal Name) _____
Street Address (Main Location) _____

City State Zip
County: _____ How long has business been operating? _____
Contact Person: _____ Phone #:() _____ FAX #:() _____
Owner: _____ Phone #: () _____
Type of Ownership: Proprietorship Partnership Corporation
Nature of business/articles sold, manufactured or services rendered: _____
SIC Code(s): _____

EMPLOYEE/PLAN INFORMATION

1. How many full-time employees do you have? _____
How many employees are in the waiting period for insurance benefits? _____
(Please indicate names and hire dates on UCT-6 or payroll)
2. How many hours per week must employees work to be considered eligible for insurance benefits? (20 is minimum)
 20 or more hours per week _____ hours per week
How many employees do you have that you consider full-time and/or eligible (minimum 20 hours per week) for insurance benefits? _____
3. Enrollment waiting period for new employees: _____
4. Employees to be covered: Active employees only Active and retired employees
If selecting active and retired employees, attach a list of all eligible retired employees.
5. Are any employees to be excluded from the Plan? Yes No If yes, how many? _____
Please explain, and include waiver forms: _____
6. Employer contribution (minimum 25%): _____ Employees \$ _____ / _____ % Dependents \$ _____ / _____ %
7. Is this insurance intended to replace existing *Group* MEDICAL COVERAGE? Yes No
If yes:
Name of Insurance Company: _____
Policy # or Group #: _____
When did Plan become effective? _____
Has coverage been terminated? Yes _____ No _____
Date

Be sure to include most current premium statement listing those currently insured.

DO NOT TERMINATE ANY EXISTING COVERAGE UNTIL THIS APPLICATION IS APPROVED BY NHP's UNDERWRITING DEPARTMENT.

8. Are any employees currently absent due to illness or injury, or receiving disability benefits? Yes No
If yes, please give name(s), date of onset and details: _____
9. Are any former employees or dependents of your firm or of any subsidiary, affiliate or secondary location currently on COBRA. Yes No
If yes, list name(s), and date(s) continuation began. Please indicate type of continuation elected. _____
10. Name and address of Workers' Compensation carrier: _____
11. Is anyone excluded from Workers' Compensation coverage, such as owners/partners/officers? Yes No
If yes, who is not covered and why: _____
12. Do any employees travel outside of the United States for business or pleasure more than 90 days a year? Yes No
If yes, list employee(s): _____

PLAN SELECTION

HMO Co-payment Options

HMO PLAN Access Option: Additional \$20 co-payment for visit to NHP Specialist without a referral

SELECT ONE SET OF COPAYMENTS:

Office Visit Co-payment	Inpatient Co-payment per Admission	Prescription Co-payment 4-Tier	
<input type="checkbox"/> \$5	\$ 0	<input type="checkbox"/> \$ 5/20/35/20%	
<input type="checkbox"/> \$10	\$ 0	<input type="checkbox"/> \$ 7/25/40/20%	
<input type="checkbox"/> \$10	\$ 250	<input type="checkbox"/> \$ 7/25/40/20%	<input type="checkbox"/> \$ 10/30/45/20%
<input type="checkbox"/> \$15	\$ 500	<input type="checkbox"/> \$ 7/25/40/20%	<input type="checkbox"/> \$ 10/30/45/20%
<input type="checkbox"/> \$15	\$ 1,000	<input type="checkbox"/> \$ 7/25/40/20%	<input type="checkbox"/> \$ 10/30/45/20%
<input type="checkbox"/> \$15 PCP/ 25 Specialist	\$ 250 per day (5 day Max)	<input type="checkbox"/> \$ 10/35/50/20%	<input type="checkbox"/> \$ 20/50/80/20%
<input type="checkbox"/> \$25 PCP/ 45 Specialist	\$ 500 per day (5 day Max)	<input type="checkbox"/> \$ 20/40/60/20%	<input type="checkbox"/> \$ 20/60/90/20%
<input type="checkbox"/> \$35 PCP/ 65 Specialist	\$ 750 per day (5 day Max)	<input type="checkbox"/> \$ 20/50/80/20%	
<input type="checkbox"/> No Prescription Drug Coverage			

POS Co-payment Options

POS PLAN Access Option: Additional \$20 co-payment for visit to NHP Specialist without a referral

<i>SELECT ONE OF EACH:</i>			<i>SELECT ONE OF EACH:</i>	
Office Visit Co-payment	Inpatient Co-payment Per Admission	Prescription Co-payment 4-Tier	Deductible	Coinsurance Percentage
<input type="checkbox"/> \$ 5	\$ 0	<input type="checkbox"/> \$ 5/20/35/20%	<input type="checkbox"/> \$250	<input type="checkbox"/> 50%
<input type="checkbox"/> \$10	\$ 0	<input type="checkbox"/> \$ 7/25/40/20%	<input type="checkbox"/> \$250	<input type="checkbox"/> 70%
<input type="checkbox"/> \$10	\$ 250	<input type="checkbox"/> \$ 7/25/40/20% <input type="checkbox"/> \$10/30/45/20%	<input type="checkbox"/> \$300*	<input type="checkbox"/> 60%
<input type="checkbox"/> \$15	\$ 500	<input type="checkbox"/> \$ 7/25/40/20% <input type="checkbox"/> \$10/30/45/20%	<input type="checkbox"/> \$500	<input type="checkbox"/> 70%
<input type="checkbox"/> \$15	\$ 1,000	<input type="checkbox"/> \$ 7/25/40/20% <input type="checkbox"/> \$10/30/45/20%	*Only available with 10/250 In-Network	
<input type="checkbox"/> \$15 PCP/ 25 Specialist	\$ 250 per day (5 day Max)	<input type="checkbox"/> \$10/35/50/20% <input type="checkbox"/> \$20/50/80/20%	\$500	50% (3,000 OOP)
<input type="checkbox"/> \$25 PCP/ 45 Specialist	\$ 500 per day (5 day Max)	<input type="checkbox"/> \$20/40/60/20% <input type="checkbox"/> \$20/60/90/20%	\$500	50% (5,000 OOP)
<input type="checkbox"/> \$35 PCP/ 65 Specialist	\$ 750 per day (5 day Max)	<input type="checkbox"/> \$20/50/80/20%	\$500	50% (7,500 OOP)
<input type="checkbox"/> No Prescription Drug Coverage				

Point of Service Plus

Option 1 Option 2 Option 3 Statewide

Neighborhood Health Partnership Deductible Option

Select one set of Deductibles:

<input type="checkbox"/>	NONE		
<input type="checkbox"/>	\$ 500 Medical	\$ 100 Pharmacy	
<input type="checkbox"/>	\$ 1,000 Medical	\$ 200 Pharmacy	
<input type="checkbox"/>	\$ 2,500 Medical	\$ 500 Pharmacy	
<input type="checkbox"/>	\$ 5,000 Medical	\$ 1,000 Pharmacy	

The Family Deductible is 2 times the Individual Deductible

We hereby request that we be approved for coverage in the Neighborhood Health Partnership, Inc. (NHP) HMO or POS Plan (the "Plan"). We request that group health coverage be made available to our eligible employees in accordance with the terms of the Group Service Agreement ("GSA" or "Contract").

We have read the Group Service Agreement and we understand the eligibility, participation, and termination requirements of the Plan.

Enrollment requirements may be changed from time to time by the Plan with proper notice to the Group. Acceptance of this Large Group Application for GSA by the Plan and coverage under the GSA is conditioned upon such enrollment requirements being met and maintained by the Group.

We have read the materials for the Plan we are selecting, including any Neighborhood Health Partnership Summary of Benefits, and understand the coverages they describe. We agree to contribute a minimum of 25% of the employees' premium.

We also agree that the Group will remit to NHP, in advance, all required premium payments. Enclosed is the Group's check for the initial required amount, and the necessary enrollment forms. **Make all checks payable to Neighborhood Health Partnership, Inc.**

We understand that the Group is required to provide tax records and/or other records that NHP may request from time to time, to verify status as a bonafide employer group, or bonafide eligibility of employees. We further understand that failure to provide such records or submission of fraudulent or intentionally misrepresenting facts by the Group will result in denial of this application or termination of the Contract retroactive to the effective date.

COMPLIANCE WITH EMPLOYMENT LAWS: We further understand and agree that, as an employer, we may be subject to local, state and/or federal laws such as COBRA, age, disability and sex discrimination. We further understand and agree that we are solely responsible for compliance with such laws.

We understand that the agent does not have authority to approve effective dates or to change or modify the coverages or conditions relating to coverage under the Plan.

We understand that any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

DO NOT TERMINATE ANY EXISTING COVERAGE UNTIL THIS APPLICATION IS APPROVED BY NHP's UNDERWRITING DEPARTMENT

Date _____

(Full Legal Name of the Group)

At _____

By _____

(Signature and Title)

Writing Agent/Broker _____

(Signature and Date)

LARGE GROUP APPLICATION CHECKLIST

New Business deadlines are 10 days prior to the 1st and the 15th of each month

This checklist must be complete!
Underwriting will return this application, if ALL of the following items are not included:

- | | |
|--|--|
| <input type="checkbox"/> Completed and signed LARGE GROUP APPLICATION | <input type="checkbox"/> CHECK made payable to Neighborhood Health Partnership, Inc. |
| <input type="checkbox"/> Completed and signed EMPLOYEES' ENROLLMENT FORM(S) | <input type="checkbox"/> Completed and signed WAIVER(S) (copy of current ID card) |
| <input type="checkbox"/> Full-time STUDENT DOCUMENTATION for dependents age 19 and over must be included with the enrollment form | <input type="checkbox"/> UCT-6 (Most recent quarter). <i>The contact person must sign if any changes are made</i> |
| <input type="checkbox"/> Copy of the most current PREMIUM STATEMENT | <input type="checkbox"/> Completed and signed GSA (Group Service Agreement) |

FLORIDA LICENSED AGENT INFORMATION

Agent Name _____ Social Security # _____
Agent Number _____ Commission split (if secondary agent) _____ %
Agency/Company Name _____
Street Address* _____
City _____ State _____ Zip _____
Phone # (_____) _____ Fax # (_____) _____

*PO Boxes not acceptable for mailing purposes. Please use street address.

Sales Rep Name _____
Sales Rep # _____
Account Exec Name _____

FOR OFFICE USE ONLY

Check # _____ Check amount _____
Group # _____ Confirmed eff. date ____/____/____
AC date ____/____/____
Member handbook(s) mailed _____



NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

7600 Corporate Center Drive, Miami, FL 33126 / PO Box 025680, Miami FL 33126-5680
305-715-2500 / 1-800-354-0222