INSURANCE APPLICATION
EMPLOYER APPLICATION FORM

SIHO INSURANCE SERVICES
417 Washington Street
Columbus, IN 47201
800-443-2980

GROUP #: _____

Effective Date: _____

Employer Information

Legal name of Employer: _____

Billing/Mailing address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Tax ID/FEIN: _____

Type of Business: _____ Standard Industry Code (SIC): _____

Administrative Contact: _____ Title: _____ Phone: _____

Email address: _____ Would you like to receive Invoices via email? Yes ☐ No ☐

Coverage Information and Regulatory Notices

Number of employees on COBRA (if any): _____ List participants on Continuation of Coverage/COBRA:

_____

COBRA: Under federal law, Employers with 20+ employees (as determined by the Employer's payroll on at least 50% of the group's working days of the preceding calendar year) must provide its participants with COBRA continuation coverage as applicable. If SIHO administers COBRA on behalf of the Employer, SIHO will charge the Employer a monthly administrative fee (per subscriber per month) depending on the scope of services covered. Upon a member's COBRA election, SIHO will charge each COBRA participant 102% of the relevant premium.

Medicare: Under federal law, Employers with 20+ employees during 20 or more calendar weeks in the preceding calendar year, then the Employer's group health plan is primary and Medicare is secondary.

These statements do not set forth all rules governing COBRA and group level Medicare status. The Employer should contact their legal and/or tax advisor(s) for information regarding other rules that may impact its legal obligations under COBRA and/or Medicare Secondary Payer rules. Under federal law, it is the Employer's responsibility to accurately determine COBRA and Medicare status.

Do you offer coverage to early retirees (under age 65)? Yes ☐ No ☐ If so, how many? _____
(**Early retirees may not be covered by the health plan. Verify with SIHO or your agent)**

Do you offer coverage independent to contractors or 1099 employees? Yes ☐ No ☐ If so, how many? _____
(**Independent contractors or "employees" who are issued a 1099 are not eligible for SIHO benefits**)

Do you have a cafeteria plan under IRC §125? Yes ☐ No ☐ Do you have an FSA? Yes ☐ No ☐ Do you have an HRA? Yes ☐ No ☐

Do you use a spousal carve-out? Yes ☐ No ☐ Are you subject to ERISA? Yes ☐ No ☐ Does §1557 (ACA) apply to you? Yes ☐ No ☐

Name of prior health and/ or life carriers within the last two years (*if more than one carrier, include length of time covered by each*):

_____

Please provide a copy of Employee Quarterly Tax and Wage and/or Participation Affidavit. Please indicate employees by employment status (Full-time (i.e.30+ hours/week), Part-time, Seasonal, Temporary, and Terminated) for verification of participation status.

Do you have more than one business location? Yes ☐ No ☐ If "yes", please list additional physical address for each:

Business Physical Address (Location 2): _____

City: _____ County: _____ State: _____ Zip: _____

Business Physical Address (Location 3): _____

City: _____ County: _____ State: _____ Zip: _____

Plan Selection

Products	Deductible Amts.	
	$500	$3,500
Choice	$1,000	$3,600
HSA	$1,500	$4,000
HRA	$1,700	$5,000
Care Plus]	$2,000	$5,500
	$2,500	$6,000
	$3,000	$6,500

Voluntary Plans (please mark one each):

Dental Plan:	Vision Plan:
___ Paramount	
___ Preferred	____ 12 months/12 months
___ Standard	____12 months/24 months
___ Value	
___ None	____ None

Would you like to offer Dependent Life Insurance?: Yes ___ No ___

Life Insurance Amount: (Please Circle All that Apply):
$15,000 $20,000 $25,000 $50,000 None

Do you currently offer a standalone Dental Plan? Yes _____
No _____

Waiting Period for New Employees

☐ **Option 1:** First of the month following ☐ 0 ☐ 30 ☐ 60 days from date of hire
☐ **Option 2:** On ☐ 0 ☐ 30 ☐ 60 ☐ 90 days from date of hire

Notice of Minimum Contribution

Employer must declare its respective contribution amounts toward their eligible employees' monthly premium: _____. Amount must be provided in either dollars or percentage of premium that Employer commits to contribute and should be as complete and thorough as possible, particularly if contributions differ by enrollment/status tiers.

If Employer chooses to pay 100% of its employees' cost of health care coverage, then all eligible employees must enroll in this Health Plan for the Employer to be considered eligible for its chosen coverage options.

***Please note:* SIHO requires at least 50% of employee only medical coverage to be paid by the Employer.**

Employer Agreement

As an authorized representative of the Employer, I affirm and declare that the Employer complies with all laws, rules, and regulations applicable to Employer to the extent that such compliance is within its control, including requiring that restrict eligibility to only eligible employees who work 30+ hrs. per week, are actively at work, and have satisfied any applicable eligibility waiting period will be allowed to participate in applicable plans.

I further certify that I have read the above statements and I declare and agree that the above responses/answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any policy of coverage issued. I understand and agree that no agent has the authority to waive a complete answer to any question of this application or any other which is involved in this acquisition of coverage process, nor to pass on coverage/insurability, make or alter any contract, or waive any of the rights or requirements of SIHO. I hereby agree that no coverage will be effective until the date specified by SIHO on the policy of coverage after this application has been accepted. I understand that any misrepresentation contained herein, within any related applications, as a part of the process of confirming eligibility to participate, or that is not otherwise reasonably corrected upon actual or constructive notice to the Employer which is relied on by SIHO may be used to modify or void the contract within the contestable period if such misrepresentation materially affects the acceptance or the evaluation of the risk. 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 is guilty of a crime and may be subject to fines and confinement in prison.

I understand that any requests for benefit determinations, claims for benefits or disputes relative to any coverage placed with SIHO will be resolved according to the relevant Certificate of Coverage, any additional plan documents, and SIHO's internal policies and procedures as applicable and necessary under the circumstances.

Chamber/Trade Association Memberships/Affiliations (if any): _____

Employer's Name and Position: _____

Employer's Signature: _____ Date: _____

Agent's Name: _____ Agent's Signature: _____

Agent's Phone: _____ Fax: _____ Agent's email address: _____

Please note for Dental and Vision Coverage (if selected): The Employer hereby requests participation in the plans indicated below through SIHO Insurance Services to insure eligible persons under the Policy (Policy No. 112618) issued by Health Resources Inc., Evansville, Indiana, and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

For Dental and Vision, as an agent are you appointed by HRI Dental and EyeMed Vision? Yes ☐ No ☐

SIHO Ancillary Plan Elections

SIHO Dental

If Employer wishes to offer dental coverage and has fewer than 50 eligible employees, group can only select one plan option. If Employer has 50 or more eligible employees, then the group MAY offer 2 plan options.

Plan Selection: Paramount ☐ Preferred ☐ Standard ☐ Value ☐

Increase to Annual Maximum: Increase by $500 ☐ Increase by $1,000 ☐
(Available for Preferred and Standard Plans only)

Initially, there are _____ employees enrolled in the Dental Plan

Current Dental Plan

Is the Employer currently enrolled under another group dental program? Yes ☐ No ☐
For current participants, is a waiting period waiver requested? Yes ☐ No ☐ If Yes, please include a copy of the current plan benefits and last billing.

Agreement

Employer agrees to make such benefits available to all eligible employees (whether eligible currently or in the future) and to make payroll deductions as required by the plan as applicable to its employees. Employer agrees that at least two (2), non-spouse employees must be enrolled in the plan to prevent cancellation of coverage. This voluntary plan does not require any premium contribution from the Employer.

Employer declares that, to the best of its knowledge and belief, the statements and answers provided above are complete and true. 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 is guilty of a crime and may be subject to fines and confinement in prison

Authorized Signature_____ Date_____

Employee's Position with Company_____

SIHO Vision

If Employer wishes to offer vision coverage and has fewer than 50 eligible employees, group must select one plan option. If Employer has 50 or more eligible employees, then the group MAY offer 2 plan options.

Plan Selection: ☐ 12/12 Plan (1263) ☐ 12/24 Plan (1261)

Initially, there are _____ employees enrolled in the Vision Plan

Agreement

Employer agrees to make such benefits available to all present employees and all employees becoming eligible in the future and to make payroll deductions as required by the plan as applicable to its employees. Employer agrees that at least two (2), non-spouse employees must be enrolled in the plan to prevent cancellation of coverage. This voluntary plan does not require any premium contribution from the Employer.

Employer declares that, to the best of its knowledge and belief, the statements and answers provided above are complete and true. 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 is guilty of a crime and may be subject to fines and confinement in prison.

Authorized Signature_____ Date_____

Employee's Position with Company_____

HIPAA Group Health Plan Certification

The _____ Group Health Plan ("Plan"), through its fiduciary, does hereby certify to the following:

1. That the Plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2. That the Plan documents you distribute to employees informing them about their benefits **or** the Plan documents you are legally required to maintain for your employee benefits plans have been amended, as required by 45 CFR 164.504(f) of HIPAA, to incorporate the following provisions and you, as the Plan Sponsor, agreed to:

   a. Not use or further disclose health information protected under HIPAA ("PHI") other than as permitted or required by the plan documents or as required by law;
   b. Ensure that any agents, including subcontractors, to whom you provide PHI agree to the same restrictions and conditions that apply to you with respect to such information;
   c. Not use or disclose PHI for employment-related actions and decisions;
   d. Not use or disclose PHI in connection with any other benefit or employee benefit plan;
   e. Report to Plan's designee any PHI use or disclosure that you become aware of that is inconsistent with the uses or disclosures provided for;
   f. Make PHI available to an individual based on HIPAA's access requirements;
   g. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
   h. Make available the information required to provide an accounting of disclosures;
   i. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U. S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
   j. Ensure that adequate separation between the Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and
   k. If feasible, return or destroy all PHI received from the Plan that you, as the Plan Sponsor, still maintain in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, you will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

3. The undersigned further certifies that he or she has the authority to sign on behalf of the Plan.

_____	_____
Printed Name of Plan Fiduciary Representative	Delta Dental Group Number(s)
_____	_____
Signature of Plan Fiduciary Representative	Date

OR We decline to sign this Group Health Plan Certification and will not create, maintain, receive or access PHI for our group members.

_____	_____
Printed Name of Plan Fiduciary Representative	Delta Dental Group Number(s)
_____	_____
Signature of Plan Fiduciary Representative	Date

Please fill in the name of your group health plan, sign and date this Certification, and return one original to Delta Dental, P.O. Box 30416, Lansing, MI 48909.

AGREEMENT

The undersigned client hereby adopts and subscribes to the terms and provisions in this form and certifies to the best of his/her knowledge and belief, all the responses are true, correct and complete. It is agreed that the client has 15 days from the date of delivery of the contract to return the contract to Delta Dental's corporate headquarters for a full refund. If the client exercises this right, the contract will terminate on the effective date as if no coverage were ever in force, and all money received will be returned.

In addition to the commissions and/or fees identified specifically for your plan, the Agency/Agent may qualify for additional compensation payments from Delta Dental related to your purchase of a Delta Dental benefit plan. This additional compensation is not charged to your plan. The Agent/Agency of Record has full authority to act on the client's behalf in all matters concerning the client's dental benefits administration, including but not limited to contractual matters and changes to the client's contract.

Misrepresentation or fraud will cause your contract to be null and void from the start and may be violating state law.

Payment of the first month's rate for the proposed Delta Dental program(s) and a copy of the proposal must accompany this form.

Signature of Client's Authorized Official:_____ Date:_____

Printed Name: _____

Title: _____

Signature of Agent or Delta Dental Representative: _____ Date: _____

Amount Received: $_____ Check Number: _____