417 Washington Street
Columbus, IN 47201
800-443-2980

INSURANCE APPLICATION
EMPLOYER APPLICATION FORM

Requested effective date: ____________________________________

Employer Information

Legal name of Business: ____

Business Address: ____

City: ______________________________ County: _________________________________ State: __________ Zip: _____________

Phone: ____ Fax: ____

Administrative Contact Name: _______________________________ Title: _______________________ Phone: __________________

Email address: ____

Billing address (*if different from above*): ____

Type of Business: ____

Standard Industry Code (SIC): _________________________________ Tax ID/FEIN: _____________________________________

Affiliates/ subsidiaries/ divisions to be included under coverage (*list names, locations, number employed at each location*):

____

Total number of employees: ___________________________ Total number of ELIGIBLE employees: __________________________

Does group have a cafeteria plan under IRS Section 125: ❑ Yes ❑ No

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

____

List employees/ dependents on Continuation of Coverage/ COBRA:

____

Please provide a copy of Quarterly Tax and Wage Statement or Participation Affidavit (*if you do not file Quarterly Tax and Wage Statements*). Please indicate which employees are full-time, part-time, terminated and add new hire names. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligibility waiting period.

Plan Section

1) Prime Care Choice Plan
❑ Choice 250 ❑ Choice 500 ❑ Choice 750 ❑ Choice 1000 ❑ Choice 2500

2) SIHO BasicCare
❑ 500 Ded. Plan ❑ 1000 Ded. Plan ❑ 2500 Ded. Plan

3) SIHO Select Savings
❑ HDHP $1000 ❑ HDHP $2500 ❑ SDHP $250 ❑ SDHP $500 ❑ SDHP $750

4) Life Insurance/ AD&D: ❑ $15,000 ❑ $30,000 ❑ $45,000 ❑ other ______________________________

❑ Dependent Life *($5,000 for spouse and $2,000 for children)*

5) Optional Maternity: ❑ Yes ❑ No (groups of 2-14 employees)

Waiting period for new employees:

❑ **Option 1**: First of the month following ❑ 0 ❑ 30 ❑ 60 ❑ 90 days of employment

❑ **Option 2**: ❑ 0 ❑ 30 ❑ 60 ❑ 90 days from the date of hire

❑ **Other** : ____

Employer Contribution

Employer's declaration of contribution toward monthly premium (*indicate the amount—either in dollars or percentage in premium—employer is committing to; please make this as complete and as thorough as possible, particularly relative to the different enrollment/ status tiers if there is some contribution toward them*):

____

____

____

Agreement

As the representative of the above Company, I acknowledge and declare that I have been made aware of the requirements for the above total replacement coverage including a continuous minimum employer contribution or payment of premium, and a continuous minimum eligible employee participation requirement for this to be considered an eligible group. I understand that in calculating the participation percentage of total full-time employees that ultimately elect coverage, that employees covered under spousal coverage do not count but that under no circumstances will coverage be available if less than 50% of all full-time employees do not elect to participate. Also, I understand that two employees who are husband and wife, or otherwise related in such a way that they can be combined for personal tax purposes under the code of the Internal Revenue Service will be considered as one employee for determining participation compliance for this group to be considered eligible for coverage.

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 or within the related application 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.

I understand that any claims for benefits or disputes relative to any coverage placed with SIHO will be resolved according to Group Policy.

Are you a member of the Chamber of Commerce? ❑ Yes ❑ No

If yes, which one? ____

Date: ____

Authorized Signature: ____

Employee's Position with Company: ____

Agent's Name: ____

Agent's Signature: ____

Agent's Phone: _______________________ Fax: _______________________

Agent's email address: ____