SIHO INSURANCE SERVICES

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

INSURANCE APPLICATION
EMPLOYER APPLICATION FORM

GROUP #: _____

Effective Date: _____

Employer Information

Legal name of Business: _____

Billing/Mailing address: _____

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

Business Physical Address: _____

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

Phone: _____ Fax: _____

Administrative Contact Name: _____ Title: _____ Phone: _____

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

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 (Actively Working) employees: _____

Total number of employees on COBRA: _____ List employees/ dependents on Continuation of Coverage/ COBRA:

_____

COBRA: Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
Medicare: Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact their legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine Medicare status.

Do you offer coverage to early retirees under age 65 who are currently working more than 30 hours a week?_____ How many?_____

Do you offer coverage to 1099 contract employees:_____ How many?_____
(Early retirees working less than 30 hours full time per week and contracted 1099 employees are not eligible for SIHO benefits)

Do you have a cafeteria plan under IRS Section 125?: Yes ☐ No ☐ Do you have a Flexible Spending Plan? Yes ☐ No ☐
Do you have spousal carve out for your health plan?: 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*):

_____

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.

Do you have more than one business location? Yes ☐ No ☐ If "yes" list physical and billing/mailing address for each.

Billing/Mailing address (Location 2):_____

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

Business Physical Address (Location 2): _____

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

Phone: _____ Fax: _____

Administrative Contact Name: _____ Title: _____ Phone: _____

Plan Section

Select Product	Landmark Combined		HMO Product	
Prime Care Choice	Yes	No	Yes	No
HSA	Yes	No	Yes	No
HRA	Yes	No	Yes	No
Care Plus	N/A		Yes	No

Employer Contribution*

$750
$1,700

* Only applicable for select HRA/HSA products.

Deductible Amount

$500	$3,500
$1,000	$3,600
$1,300	$4,000
$1,500	$5,000
$1,700	$5,500
$2,000	$6,000
$2,500	$6,300
$3,000	

Life Insurance Amount: (Please Circle All that Apply)

$15,000 $20,000 $25,000
$30,000 $40,000 $50,000

Voluntary Plan(s) Selected:

Choose one Dental Plan:

____ Preferred
____ Standard
____ Value

Choose one Vision Plan:

____12 months/12 months

____12 months/24 months

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

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

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.* ***Please note, SIHO requires 50 percent of employee only medical coverage paid by employer):***

_____

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.

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 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: _____

Employer's Signature: _____ Date: _____

Agent's Name:_____

Agent's Signature:_____

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

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

For Dental and Vision Coverage (if selected): The Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-39160 insured by Security Life Insurance Company of America, Minnetonka, MN 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 Security Life? Yes ☐ No ☐

SIHO Dental and Vision Plan Election

SIHO Dental

If employer group has fewer than 50 eligible employees, group must select one plan option. If group has 50 or more eligible employees the group MAY offer 2 plan options.

Plan Selection: Preferred ☐ Standard ☐ Value ☐

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

There are initially _____ employees enrolled in the Dental Plan

Current Dental Plan

Is the Group currently enrolled under another group dental program? Yes ☐ No ☐
Is Credit for Previous Time (CPT) requested? Yes ☐ No ☐
If Yes, please include a copy of the current plan benefits and last billing.

Agreement

The undersigned Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-39160 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

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 the employees. The employer agrees that at least two (2) employees must be enrolled in the plan to prevent cancellation of coverage. The plan does not require any premium contribution from the employer.

Authorized Signature_____ Date_____

Employees Position with Company_____

SIHO Vision

If employer group has fewer than 50 eligible employees, group must select one plan option. If group has 50 or more eligible employees the group MAY offer 2 plan options.

Plan Selection: ☐ 12/12 Plan (9657966) ☐ 12/24 Plan (9657974)

There are initially _____ employees enrolled in the Vision Plan

Agreement

Employers 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 the employees. The employer agrees that at least two (2) employees must be enrolled in the plan to prevent cancellation of coverage. The plan does not require any premium contribution from the employer.

Employer declares that to the best of their knowledge and belief that statements and answers 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_____

Employees Position with Company_____