SIHO INSURANCE SERVICES

ASSOCIATION HEALTH INSURANCE APPLICATION
MEMBER ORGANIZATION
LARGE GROUP (51+) APPLICATION FORM

GROUP #: _____

417 Washington Street
Columbus, IN 47201

Association Name: _____

Entity Information

Legal name of Member Organization: _____

Billing/Mailing address: _____

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

Domicile/Principal Place of Business: _____

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

Phone: _____ Fax: _____ Date joined Association (MM/YY): _____

Administrative Contact Name: _____ Title: _____ Phone: _____

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

Type of Business and SIC (Standard Industry Code): _____ Tax ID/FEIN: _____

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

_____

Total number of employees: _____ Total number of ELIGIBLE employees working 30+ hrs./week: _____
Total COBRA participants, if any: _____ Total number of working owners working 20+ hrs./week or 80 hrs./month: _____

List all working owners and COBRA participants: _____

COBRA: **COBRA**: Under federal law, Associations with 20+ employees (as determined by all of its Member Organizations' collective payrolls 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. SIHO administers COBRA on behalf of the Association, Member Organizations will be charge a monthly admin fee of $2.50/AHP subscriber for the provision of those administrative services on behalf of the Association. AHPs may require COBRA continuation of coverage due to its classification as a large employer regardless of the size of individual Member Organizations. Each COBRA participant will be charged 102% of premium if they elect COBRA.

Medicare: Under federal law, AHPs with 20+ employees (as determined by all of its Member Organizations during 20 or more calendar weeks in the preceding calendar year), are primary and Medicare is secondary. These statements do not set forth all rules governing COBRA and group level Medicare status. The Association 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 Association's responsibility to accurately determine COBRA and Medicare status.

Other Notices and Related Question regarding eligibility and coverage limitations:
- Coverage is not available to early retirees (under age 65)
- Coverage is not available to contract employees or independent contractors (paid by 1099), unless qualify as working owner
- ERISA does apply to your Plan

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

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 and working owners. Eligible subscribers must be working owners and full-time employees who work 30+ hrs./week, must be actively at work, must have satisfied any applicable eligibility waiting period.

Do you have more than one business location? Yes o No o 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: _____ Date joined Association (MM/YY): _____

Administrative Contact Name: _____ Title: _____

Phone: _____

1si ONE SOUTHERN INDIANA Insurance Under ONE

Plan Selection

Please circle the option(s) to be offered to your employees:

Products	Networks	Deductible Amounts		
• Choice	• SIHO Norton/Clark	• $2,000	• $3,000	• $5,000
• HSA	• SIHO Baptist Health	• $2,500	• $3,300	• $6,500
	• SIHO Norton/Clark & Baptist	• $2,700	• $4,000	

Waiting Period for Employees

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

☐ **Option 2:** On ☐ 0 ☐ 30 ☐ 60 days from date of hire

Member Organization Contribution

Individual Member Organizations must declare their respective contribution amounts toward their eligible employees' (including working owners) 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: _____

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

Agreement

As an authorized representative of the above Member Organization, I affirm and declare that the Member Organization participates in the above-indicated Association and that at all times that its employees and their dependents participate in the AHP that it agrees to follow all laws, regulations, and rules applicable to MEWAs and AHPs and any relevant rules, policies, procedures, or guidelines imposed by the Association, MEWA, AHP, and/or SIHO as relevant under the circumstances. The failure to follow the above may impact the availability of coverage and could result in termination from the plan to the extent permitted by State and Federal law. I further acknowledge that policies issued by SIHO do not cover occupational injuries for both employees and working owners and affirm that only confirmed working owners or full-time 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 the AHP.

Additionally, I acknowledge and declare that I am aware of the requirements for Member Organizations regarding the above total replacement coverage including that each Member Organization must make a continuous, minimum contribution/premium payment and impose a continuous, minimum eligible employee participation requirement for each Member Organization to be considered an eligible subgroup. 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 to an individual Member Organization if less than 50% of all eligible employees working at least 30 hours do not elect to participate.

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 the related application, 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 Member Organization 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.

Employee's Position with Company: _____

Employer's Signature: _____ Date: _____

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

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