EVERGREEN
HEALTH PLAN, INC.

P. O. Box 790, Columbus, GA 31902-0790

EMPLOYER GROUP APPLICATION

1.Name of Firm _____
Legal Name Phone Number

2. Business Address_____
Street City State Zip

3. Billing Address_____
Street City State Zip

4. Type Organization: Sole proprietorship_____ Partnership _____ Corporation _____ Other _____ Year Started
5. Addresses of Subsidiaries/Affiliates: _____

6. Nature of Business_____

7. Will this replace an existing group plan? _____ Yes _____ No If yes, Termination Date
8. Have any employees not been actively at work for more than five (5) consecutive days during the last 60 days due to sickness or injury(including on the job accidents) ? _____ Yes _____No

9. A. Are any employees currently absent due to illness or injury receiving disability benefits? _____Yes _____No

B. Have any employees or dependents incurred medical expenses in excess of $5,000 during the last 12 months? _____Yes _____No

C. Are you aware of any employee/dependent with a life threatening illness or injury (i.e. cancer, heart disease, diabetes, AIDS, etc..)?
_____Yes _____No

D. Are any former employees on COBRA benefits extension? _____Yes _____No
If yes, list names and end of eligibility periods:
E. Number of full time employees (including owner) working 30 hour or more weekly:
Number of employees enrolling in medical:

F. Eligibility and Termination Periods: **(Select Option A or B)**

A) _____ Eligible employees will be effective on the first day of the month following a waiting period of: 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 ☐ days, and coverage will expire on the last day of the month.

B) _____ Eligible employees will be effective on the day following a waiting period of: 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 ☐ days, and coverage will expire on termination date of employment.

G. The waiting period will apply to : ____ Future employees _____Present and Future employees

10. Are all individuals covered by Workers' compensation? ____Yes, Name of carrier

If no, give names of persons not covered :

PLAN OPTIONS ELECTED FOR EMPLOYEES

Health Plan	Prescription Drugs
Preferred Plan ☐ Select Plan ☐ Comprehensive Plan ☐ Premium POS ☐ Advantage POS ☐ **LaGrange Premium POS** ☐ **LaGrange Advantage POS** ☐	$20Brand/$10Generic ☐

11. COBRA ADMINISTRATION: (**additional PEPM charge applies)** ____Yes ____No Coordination, notification and premium collection for your Cobra employees. Cobra premium will be 102% of current cobra medical premium. **Must have 20 or more employees insured under the Evergreen Health Plan for EHP to administer COBRA for your group.**

12. SECTION 125 PREMIUM ONLY PLAN : _____YES _____NO

13. The insurance being applied for _____ Replaces, _____ Is in addition to the following group or wholesale insurance:

Name of Insurer _____ Paid to Date

14. Amount Submitted with application $_____ Requested Effective Date

ATTACH A COPY OF THE FOLLOWING DOCUMENTS

- ☐ Completed enrollment forms, including waivers
- ☐ First months premium check (no personal checks accepted)
- ☐ Copy of last bill from prior insurance carrier
- ☐ Employer's most recent wage & tax report

- ☐ Copy of proposal submitted to client with sold rates (Agent)
- ☐ Copy of employer's current business license
- ☐ Copy of Workers Compensation coverage
- ☐ Certificate of Credible Coverage from prior carrier

PARTICIPATION AGREEMENT

Pursuant to the rights granted by said AGREEMENT, the subscribing Employer named below by its signature to this AGREEMENT, does hereby agree to be a group under Evergreen Medical Group. I hereby apply for the above referenced coverage and agree, that Evergreen Medical Group, L.L.C., d/b/a Evergreen Health Plan, Inc., subject to the terms and conditions of the policies applied for will take affect as of effective date requested. Provided that this application is approved by Evergreen Medical Group, L.L.C. and provided that the employees are to contribute to the cost of the insurance. Insurance shall not become effective unless 25% or the minimum required by the company have enrolled and will be maintained. If this application is not approved, no insurance shall become effective and any advance payment will be returned.

SUBSCRIBING EMPLOYER

By: _____

Name: _____

Title: _____

Federal ID #: _____

Signed this _____day of _____ , 20____

EVERGREEN MEDICAL GROUP, L.L.C.

By:

Name:

Title:

Federal ID #: 58-2244760

Signed this _____day of _____ , 20

TO BE COMPLETED BY AGENT

Agent Name _____ Agent Signature
Mailing Address: _____ Phone :
Insurance License#:

Social Security or ID #: