

There are eligibility requirements to participate in the CHAMBER ALLIANCE PROGRAM, including, but not limited to, being a member of a participating Chamber of Commerce. Please confirm your participation below and the Chamber of Commerce to which your organization belongs. A List of CAP Participating Chambers is available at qualchoice.com.

Are you currently a member of a participating chamber YES NO

If YES, what chamber? _____

PLEASE PRINT. All sections must be completed.

SECTION I: GROUP INFORMATION			
PLAN SPONSOR/GROUP NAME		EFFECTIVE DATE (MM/DD/YYYY)	
ADMINISTRATIVE CONTACT NAME		EMAIL ADDRESS	
PHONE NUMBER	CELL NUMBER	FAX NUMBER	
EXECUTIVE CONTACT NAME		EMAIL ADDRESS	
PHONE NUMBER	CELL NUMBER	FAX NUMBER	
MAILING ADDRESS		CITY	STATE ZIP CODE
PHYSICAL ADDRESS (IF SAME AS ABOVE, MARK 'SAME')		CITY	STATE ZIP CODE
IS THIS A MULTI-LOCATION GROUP? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST CITY AND STATE OF OTHER LOCATIONS			
IS THE PLAN SPONSOR SUBJECT TO THE FEDERAL CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1985? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Questions? Please consult your broker or attorney.			
IS THE PLAN SPONSOR ELECTING COBRA/HIPAA ADMINISTRATION SERVICES THROUGH COMPLIANCE CONSULTING COMPANY (CCC)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, SUBMIT THE PRODUCT SELECTION & SOLD RATES FORM AND THE SIGNED CCC CONTRACT.			

SECTION II: BILLING INFORMATION		
FEDERAL TAX ID NUMBER	SIC CODE	NATURE OF BUSINESS
BANK DRAFT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE ATTACH THE AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS FORM		

SECTION III: BROKER INFORMATION			
AGENCY NAME		BROKER NAME	EMAIL ADDRESS
PHONE NUMBER	CELL NUMBER	FAX NUMBER	
MAILING ADDRESS		CITY	STATE ZIP CODE

SECTION IV: PRIOR CARRIER INFORMATION		
IF ACCEPTED FOR COVERAGE WITH QUALCHOICE, WILL THIS COVERAGE REPLACE AN EXISTING GROUP HEALTH INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF CURRENT CARRIER	DATE COVERAGE ENDS (MM/DD/YYYY)
ARE ALL EMPLOYEES COVERED BY WORKERS' COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF WORKERS' COMPENSATION CARRIER	

SECTION V: CONTRIBUTIONS NOTE: Changes to contributions could affect the grandfathered status of the health plan(s)

EMPLOYER CONTRIBUTION FOR EMPLOYEE ONLY HEALTH COVERAGE (Cannot be less than 50%) _____%	EMPLOYER CONTRIBUTION FOR DEPENDENT HEALTH COVERAGE _____%
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SECTION VI: ENROLLMENT RULES

NEW HIRE(S): WAITING PERIOD: _____ WAITING PERIOD: _____ ARE YOU WAIVING THE INITIAL WAITING PERIOD? YES NO	OPEN ENROLLMENT: 30 DAYS PRIOR TO THE RENEWAL DATE OTHER (PLEASE EXPLAIN)* _____ *NOTE: Will be subject to underwriting approval.
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SECTION VII: ELIGIBILITY INFORMATION

ELIGIBILITY CLASSES OF EMPLOYEES FOR HEALTH COVERAGE

FULL-TIME ACTIVE EMPLOYEES* NUMBER OF REQUIRED HOURS PER WEEK: _____

CONTRACT EMPLOYEES

RETIREES (only available to employer groups of 100 employees or more)

Please explain _____

OTHER _____

	IN STATE	OUT OF STATE	TOTAL
FULL-TIME EMPLOYEES ENROLLING (include those satisfying their waiting period within 3 months after the effective date)			
FULL-TIME EMPLOYEES WAIVING COVERAGE (include those satisfying their waiting period within 3 months after the effective date)			
FEDERAL COBRA OR STATE CONTINUATION COVERAGE CONTINUEES ENROLLING			
TOTAL ENROLLING AND WAIVING			
NEW FULL TIME EMPLOYEES WHO WILL NOT SATISFY THE WAITING PERIOD WITHIN 3 MONTHS AFTER THE EFFECTIVE DATE			
PART TIME/SEASONAL/TEMPORARY EMPLOYEES			
TOTAL NUMBER OF EMPLOYEES			

Under the Medicare Secondary Rules, it is the employer's responsibility to annually inform QualChoice of proper employee counts for the purpose of determining payment priority between Medicare and QualChoice. QualChoice is required to furnish these counts to the Centers of Medicare and Medicaid Services (CMS).
***FULL TIME MEANS AN ACTIVE EMPLOYEE WITH A MINIMUM OF 30 HRS/WEEK AND 48 WKS/YR.**

SECTION VIII: ID CARDS

ID CARDS DELIVERED TO: GROUP ALWAYS GROUP (Initially) INDIVIDUAL

SECTION IX: COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE FOR NEW HIRES

EFFECTIVE DATE IS DATE OF HIRE

EFFECTIVE DATE IS FIRST OF THE MONTH FOLLOWING COMPLETION OF THE WAITING PERIOD

OTHER (Please define) _____

EFFECTIVE DATE FOR RE-HIRES

NO REHIRE POLICY. EMPLOYEE HAS TO COMPLETE THE WAITING PERIOD AGAIN AS NEW HIRE.

EFFECTIVE DATE IS FIRST OF THE MONTH FOLLOWING THE REHIRE DATE (NOTE: REHIRE DATE CANNOT EXCEED 12 MONTHS FROM TERMINATION DATE)

_____ MONTHS 3 MONTHS 6 MONTHS 9 MONTHS 12 MONTHS

TERMINATION DATE FOR EMPLOYEES

ON THE DATE OF TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY

END OF THE MONTH

OTHER (Please define) _____

TERMINATION DATE FOR DEPENDENTS

ON THE DATE OF LOSS OF ELIGIBILITY

END OF THE MONTH

OTHER (Please define) _____

SECTION X: ONLINE AUTHORIZATION (eENROLL)	
Our eEnroll web-based tool streamlines and automates the process of enrolling new health plan members, resulting in fewer errors, quicker turnaround time, and seamless administration. To create an online account which allows access to the eEnroll feature, please indicate below all parties who should be granted access and their email address.	
<input type="checkbox"/> EMPLOYER ONLY <input type="checkbox"/> BROKER ONLY <input type="checkbox"/> EMPLOYER AND BROKER	
EMPLOYER EMAIL	BROKER EMAIL
SECTION XI: MISCELLANEOUS	
HAS THE PLAN SPONSOR (OR ANY AFFILIATED ENTITY) FILED FOR PROTECTION OR OPERATED UNDER FEDERAL/STATE BANKRUPTCY LAWS (CHAPTER 7 OR CHAPTER 11) WITHIN THE LAST 36 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS ANY CREDITOR FILED OR THREATENED TO FILE A PETITION REQUESTING THE PLAN SPONSOR (OR ANY AFFILIATED ENTITY) BE PLACED VOLUNTARILY INTO BANKRUPTCY WITHIN THE LAST 36 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO
IS THE PLAN SPONSOR A MEMBER OF A "CONTROLLED GROUP OF CORPORATIONS" AS THAT TERM IS DEFINED BY U.S. SECTION 414(B) INTERNAL REVENUE CODE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, PLEASE GIVE THE LEGAL NAMES OF ALL OTHER BUSINESS ENTITIES WITHIN THE CONTROL GROUP AND THE NUMBER OF EMPLOYEES THAT ARE EMPLOYED BY EACH. INCLUDE ADDITIONAL SHEETS IF NEEDED.	
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HAS THE PLAN SPONSOR HAD 20 OR MORE EMPLOYEES, ON AT LEAST 50% OF THE PLAN SPONSOR'S WORKING DAYS, IN THE PRECEDING CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SECTION XII: AUTHORIZED SIGNATURES	
<p>The undersigned certifies on behalf of the Plan Sponsor that the information entered on this Group Application for Coverage is correct and complete. The undersigned agrees submission of a Group Application for Coverage containing a false statement, material misrepresentation, or omission constitutes insurance fraud and may result in termination of coverage. 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.</p> <p>In making this application, the Plan Sponsor agrees to the terms of the Group Master Contract provided by QualChoice and further agrees that the Group Application for Coverage will be part of the Agreement between the Plan Sponsor and QualChoice.</p> <p>Consistent with the requirements of the Genetic Information Nondiscrimination Act of 2008, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. The undersigned acknowledges that as part of the application process QualChoice requested that it not be provided with any plan participant's family medical history or any plan participant's information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which the participant believes she/he may be at risk.</p>	
PLAN SPONSOR/GROUP NAME	
PRINT NAME	TITLE
SIGNATURE	DATE
APPROVED BY QUALCHOICE REPRESENTATIVE (PRINT NAME)	TITLE
SIGNATURE	DATE
SECTION XIII: INSTRUCTIONS	
PLEASE FAX OR MAIL TO:	
<p>QualChoice ATTN: Marketing Department 12615 Chenal Pkwy, Ste 300 . Little Rock, AR 72211 FAX: 501.219.5121</p>	