2018 EMPLOYER APPLICATION

Please complete the below form in its entirety in order to ensure the most efficient implementation of your group with Lifestyle Health, Dental and Vision Plans. Any missing information may delay group implementation and processing.

Requested Effective Date (Must be 1st of the Month): _____ / 01 / 2018

Section 1: Company Info / Key Contacts

1. **Company Legal Name:** ____
2. **Street Address:** ______________________ **City:** __________ **State:** _____ **Zip:** _________
3. **Mailing Address:** ______________________ **City:** __________ **State:** _____ **Zip:** _________
4. **Phone Number:** ____________________ **Fax Number:** ____________________
5. **Key Contact Name:** ______________________________ **Title:** ________________
6. **Key Contact's E-mail Address:** ____________________________________
7. **Federal Tax ID#:** ______________________ **Nature of Business:** ________________

Section 2: Employee Status

8. **Total Number of ALL Employees** __________ **(Full-time, Part-time, COBRA, FMLA, Disability and Other)**
9. **How many are Full-time (FT)?** __________ ☐ **Check if N/A**
10. **How many are Part-time (PT)?** __________ ☐ **Check if N/A**
11. **How many are on COBRA?** __________ ☐ **Check if N/A**
12. **How many are or have been on disability or FMLA over the past 12 months?** __________

(Please complete below for all employees who qualify for COBRA, FMLA, or Disability and check appropriate status.)

First Name	Last Name	COBRA	FMLA	Disability	Other (please specify)

Please Use Additional Pages As Necessary

Section 3: Medical Coverage Count and Eligibility

MEDICAL PLANS SOLD: ☐ HealthyEssentials MEC ☐ Lifestyle Major Medical Plans ☐ Lifestyle Custom Plan

13. How many employees are electing coverage? ________________

    If electing MEC coverage, please list selected MEC plan name: ______________________________ ☐ Check if N/A

14. How many FT employees have qualified waivers? ______________________ ☐ Check if N/A

15. Waiting/Affiliation Period to reflect 1st of the month following: ☐ 0 days ☐ 30 days ☐ 60 days

16. Eligibility (number of hours worked per week to be eligible for benefits): ______________________________

17. Will any of the plans selected have an HRA? ☐ yes ☐ no If yes, will Medova administer? ☐ yes ☐ no

18. COBRA Administration (Available for 20 or more full-time equivalent employees) ☐ yes ☐ no

Section 4: PPO Network and Billing Information

19. PPO Network: ______________________________________

20. Billing Method: ☐ email ☐ mail Pre-tax: ☐ yes ☐ no

21. Divisional Billing by Location? ☐ yes ☐ no (If yes, please attach list of locations to this form.)

22. Billing Contact (Group or PEO): ____________________________________ E-mail: ______________________________

23. Billing Address: _______________________________________City: __________________State: _____ Zip:_________

24. Plan Summary: ☐ electronic (PDF) ☐ paper

Section 5: Dental and Vision Coverage

DENTAL PLANS SOLD: ☐ Lifestyle Dental Plans

25. How many employees are electing dental coverage? ________________ (Minimum 3 Enrolled Employees)

26. In order to be eligible for Orthodontia Coverage, employer must provide proof of 1-year prior dental coverage. *

    Coverage Type: ☐ Dental ☐ Orthodontia Name of Current Carrier: ____________________ Policy No:___________

    ** Please attach recent dental invoice / billing statement from prior carrier to detail individuals covered on prior dental plan.*

VISION PLANS SOLD: ☐ Lifestyle Vision Plans

27. How many employees are electing vision coverage? ________________ (Minimum 3 Enrolled Employees)

Section 6: Enrollment & Administration Options (Initial & Ongoing Enrollment)

28. Enrollment Type: ☐ Online Enrollment (Minimum of 25 Enrolled) ☐ Census Enrollment ☐ Paper Enrollment Forms

29. Benefits Setup: ☐ Plan Year
☐ Calendar Year

30. Products to Enroll: ☐ Lifestyle Health Plans ☐ Lifestyle Dental Plan ☐ Lifestyle Vision Plan

- COMPLETE QUESTIONS 31 - 37 FOR ONLINE ENROLLMENT ONLY -

31. Payroll Frequency: ☐ Bi-weekly (26) ☐ Semi-Monthly (24)

32. Employee Medical Rate Summary:

Lifestyle Medical Plans	EE Rate (Total Premium, 100% Rate)	ES Rate (Total Premium, 100% Rate)	EC Rate (Total Premium, 100% Rate)	Family Rate (Total Premium, 100% Rate)
Plan 1:				
Plan 2:				
Plan 3:				
Plan 4:				

33. Employer Medical Contribution:

☐ **Percentage (0-100%):** **EE ________% ES _________% EC _________% F_________%**

☐ **Defined Contribution ($$$):** **EE $________ ES $_________ EC $_________ F $_________**

34. Employee Dental Rate Summary:

Lifestyle Dental Plans	EE Rates (Total Premium, 100% Rate) Standard / LHP Participating	ES Rates (Total Premium, 100% Rate) Standard / LHP Participating	EC Rates (Total Premium, 100% Rate) Standard / LHP Participating	Family Rates (Total Premium, 100% Rate) Standard / LHP Participating
Plan Name:	/	/	/	/

35. Employer Dental Contribution:

☐ **Percentage (0-100%):** **EE ________% ES _________% EC _________% F_________%**

☐ **Defined Contribution ($$$):** **EE $________ ES $_________ EC $_________ F $_________**

36. Employee Vision Rate Summary:

Lifestyle Vision Plans	EE Rates (Total Premium, 100% Rate) Standard / LHP Participating	ES Rates (Total Premium, 100% Rate) Standard / LHP Participating	EC Rates (Total Premium, 100% Rate) Standard / LHP Participating	Family Rates (Total Premium, 100% Rate) Standard / LHP Participating
Plan Name:	/	/	/	/

37. Employer Vision Contribution:

☐ **Percentage (0-100%):** **EE ________% ES _________% EC _________% F_________%**

☐ **Defined Contribution ($$$):** **EE $________ ES $_________ EC $_________ F $_________**

Section 7: Signature and Authorization

As a part of the group submission process, we hereby attest to the accuracy of the information provided above. We recognize and assume all legal responsibility in the event that the information provided above is not correct and a member's benefits are denied or incorrectly administered by Medova Healthcare based on the information disclosed in this employer application form.

Print Name of Employer: ____ **Title:** ____________________

Signature of Employer: ____ **Date:** ____________________

Print Name of Agent: ____

Signature of Agent: ____ **Date:** ____________________

Print Name of Agency: ____