Employer Application For Small Groups Colorado

For Internal Use Only	Group No.	SE:
Benefit & Premium Modification Date:		

Consult the Evidence of Coverage for complete coverage terms and conditions

Application Type

☐ New Enrollment ☐ Change(s)	Rating Type: ☐ Age-Based rates ☐ Composite rates	Requested Effective Date:

General Information - Please type or print clearly in black ink

Employer Group's Legal Name		Employer Tax ID No. (Required)		
Doing Business As (DBA if applicable)				
Street Address	City	County	State	ZIP code
Billing Address (If Different From Above)		City	State	ZIP code
Administrator Name / Title	Telephone:	Email Address:		
Type of Business (Be Specific)	Date Business Established	# of Locations if Applicable (Attach List of Addresses)		
Organization type: (C-Corp, S-Corp, LLC, LLP, Partnership, Proprietorship, etc.)	Names of Owners/Partners not covered by Workman's Compensation			

Eligibility

Waiting Period for New Hires (Check one)

☐ 1st of the month following date of hire ☐ 1st of the month following 30 days ☐ 1st of the month following 60 days

Waiting Period waived for initial enrollees? ☐ Yes ☐ No

Classes Excluded:

☐ None ☐ Union ☐ Hourly ☐ Salary ☐ Non-Management

Hours per week to be eligible to enroll (Must be at least 24 hours and not more than 40 hours):

Employer Contribution (Contribution required for employees only. Must be consistent for all classes of employees)

☐ Employer will contribute _____% of Employee premium (must be at least 50% of lowest cost plan) and _____% of Dependent premium per month

☐ Employer will contribute $_____ towards Employee premium (minimum of $125 per month) and $_____ of Dependent premium per month

Deductible

Plan Year Deductible (Recommended) ☐ Calendar Year Deductible ☐

Plan Selection

Bronze	Silver	Gold	Platinum
☐ Friday SG Bronze	☐ Friday SG Silver	☐ Friday SG Gold	☐ Friday SG Platinum
☐ Friday SG Bronze Rx Copay	☐ Friday SG Silver Rx Copay	☐ Friday SG Gold Rx Copay	
☐ Friday SG Bronze Plus Copay	☐ Friday SG Silver Copay	☐ Friday SG Gold Copay	
☐ Friday SG Bronze HSA	☐ Friday SG Silver HSA		

☐ I wish to offer all plans in my Employer Group

Optional Benefits - VSP Vision

Exam Plus is included on all plans at no additional cost

☐ Exam Plus with $75 material allowance

☐ Exam Plus with $100 material allowance

Authorized Agent/Broker of Record

Agency Name:	NPN #:	Producer Name:	NPN #:
Phone:	Email:	Federal Tax ID#:	
Street Adress:	City:	State:	ZIP Code:

I acknowledge that to the best of my knowledge and belief, all information represented in this application is complete and accurate, and I represent and will service the Employer Group as an independent contractor and not as an employee of Friday Health Plans. I have presented the benefits and limitations of coverage to my client and have advised them to not terminate any existing coverage until receiving written notice that the coverage being applied for with Friday Health Plans has been approved. I understand that I have no right to bind this coverage, or to alter the terms of the insurance.

Signature:	Date: (MM/DD/YYYY)	General Agency:

General Terms and Agreements

This Agreement, consisting of the Evidence of Coverage (EOC), Benefit Schedule(s) and other related documents, as supplemented by this Employer Application and attachments, has been entered into between Friday Health Plans, Inc. and the Employer Group, in order to provide eligible Employees and eligible Dependents electing to enroll hereunder with healthcare benefits as specified. This Agreement may be amended pursuant to the Benefit Schedule(s) and related documents of at any time by mutual written consent between the Employer Group and Friday Health Plans.

The undersigned employer and or authorized representative(s) hereby request(s) that it be approved for insurance coverage underwritten by Friday Health Plans. Employer Group understands and represents, by way of it's authorized representatitives, that to the best knowledge and belief the entire application for Group Insurance has been reviewed and all answers contained herein are true and complete, and agrees:

1. To comply with all terms and provisions specified in the Evidence of Coverage
2. To offer coverage to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees
3. To provide timely applications/change forms for newly eligible employees or terminations/COBRA or Continuation elections
4. To pay the premium by the due date to maintain coverage, which is prior to the month of coverage
5. I understand the eligibility rules applicable to employee enrollment
6. I authorize the above listed broker of record to represent my company

Authorized Signature

Authorized Signature:	Printed Name:	Title:	Date: (MM/DD/YYYY)