VIVA HEALTH

EMPLOYER GROUP APPLICATION

COMPANY INFORMATION					
Company's Full Legal Name:		Contact Name:	Telephone Number: ( )		Fax Number: ( )
Address:		City:	State:	Zip Code:	County:
Nature of Business:	# of Years in Business:	Type of Business: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other			
EIN:	Effective Date:	Email Address:			

ELIGIBILITY INFORMATION

1. Have you ever applied for VIVA HEALTH Coverage? ☐ Yes ☐ No
2. Do you currently have other group health coverage? ☐ Yes ☐ No
   Name of Current Health Carrier: _____ Effective Date of Policy: _____
3. Employer will contribute _____% of the cost of the employees' insurance and _____% of the cost of their dependents.
4. Waiting Period: New employees are covered on the first of the month coincident with or following how many days of work?
   ☐ 0 days ☐ 30 days ☐ 60 days
5. a. What is the total number of full- employees (30+ hours a week)? _____ *(Required: Quarterly Wage & Tax statement or a payroll report)*
   b. Total number of employees covered under other coverage (i.e. spouse's plan, Medicare, individual policy)? _____
   c. Total number of full-time employees that do not have other health coverage (a-b)? _____
   d. Of the employees in "c" above, how many will participate in the health coverage? _____
6. Are there any employees who will become eligible after the effective date of the policy that are serving a new-hire waiting period? ☐ Yes ☐ No If yes, how many? _____ (These individuals must complete an employee enrollment form)
7. Are there any former employees who have elected or are covered under COBRA or state continuation? *(Groups with 20 or more employees only)* ☐ Yes ☐ No *(These individuals must complete an employee enrollment form)*
   If yes, please list these individuals and the COBRA/state continuation expiration dates:
   _____
   _____
8. Are all eligible employees covered by workers' compensation insurance? ☐ Yes ☐ No
   Name of workers compensation carrier: _____
9. What is the requested coverage effective date? _____

TERMS AND CONDITIONS

The employer certifies that the information provided above is complete and accurate. The employer shall notify VIVA HEALTH, Inc. promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees, dependents or COBRA and FMLA participants prior to the effective date of the group. VIVA HEALTH, Inc. shall be entitled to rely on the most current information available regarding eligibility of employees or their dependents in providing coverage under this policy. When/if the employer and VIVA HEALTH, Inc. come to an agreement on an effective date to activate the selected plan(s); the employer agrees to follow the terms and conditions outlined in VIVA HEALTH, Inc.'s Group Policy. Upon receipt of the employer's signed application and payment of the required Group Policy charges, the Group Policy is deemed executed. Pediatric dental coverage is a required essential health benefit mandated by the Affordable Care Act. By signing this application for medical coverage from VIVA Health, you are also agreeing to purchase pediatric (children up to age 19) dental coverage. VIVA Health has entered into an agreement with Delta Dental Insurance Company to provide the required coverage under the Delta Dental Plan 70 for Children. Although this is a separate policy, monthly dental premiums are included in your VIVA Health rates and will be remitted by VIVA Health on your behalf to Delta Dental as part of your monthly premiums to VIVA Health.

AUTHORIZED SIGNATURE: _____ **DATE:** _____

EMPLOYER NAME (PRINT): _____

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FOR OFFICE USE ONLY

☐ **New Group** – Benefit Plan: _____	☐ **Renewal** – Benefit Plan to renew on: _____
☐ **Change**	☐ **Other:** _____

Group Name: _____ **Group Number:** _____

Rep Name: _____ **Effective Date:** From ____/____/____ through ____/____/____

Agent Name: _____ **Agent #:** _____

Initial Enrollment Period: From ____/____/____ through ____/____/____

Eligibility: **Total Number of Employees:** _____ **County Code:** _____
Dependent Age Limit: To age 26
Full-Time Employees: 30 hours per week
Waiting Period: 1st of the month following _____ days/months/date of hire

Mailing Address: _____
_____
_____

Billing Address: _____
_____
_____

RATES		
Tier	**Code**	**Rate**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

APPROVALS

Sales Representative: _____ **Date:** _____

Sales Manager: _____ **Date:** _____

Underwriting: _____ **Date:** _____