Please use fillable PDF format.
Handwritten applications will not be accepted.
All fields must be filled in; form must be signed.

EMPLOYER APPLICATION
For Achieve Plans

Paradigm Health Plans® Self-Funded Products

Employer Information

Full Legal Business Name of Employer/Plan Sponsor:		Effective Date:	
Street Address:	City:	State:	Zip:
Mailing Address (if different):	City:	State:	Zip:
Nature of Business:	Date Business Started:	SIC Code:	Fed. Tax I.D:
Name of Person for Service of Legal Process:	Phone:	Email:	
Group CEO Name:	Phone:	Email:	
Group Billing/Administration Contact Name: / Title:	Phone	Email:	
Group Privacy Officer Name: / Title:	Phone	Email:	

Is this group a government agency or church group? ☐ Yes ☐ No
Is your company Tax Exempt? ☐ Yes ☐ No

Is the PLAN subject to collective bargaining? ☐ Yes ☐ No
If yes, Union name and Expiration Date:

Has your firm ever filed bankruptcy or now in the process or considering filing for bankruptcy? ☐ Yes ☐ No
If is yes, please explain: _____

Is anyone in your group currently under COBRA, state continuation plan, or within their election period? ☐ Yes Total #_____ ☐ No
If yes, attach list indicating Employee/Dependent Name, Qualifying Event, Event Start Date and Event End Date.

Workers' compensation carrier: _____ Policy Number: _____
You must have workers' compensation insurance for all employees, Paradigm does not provide coverage for work related illnesses/injuries.

Employee Information

Minimum hours per week required for Full Time: _____ Total Full-Time Active employees: _____
(ACA mandates maximum of 30 hours per week)

Covering Part-Time Employees? ☐ Yes ☐ No
If Yes, indicate minimum hours per week required :_____ Total Part-Time Active employees (if covered): _____

Approximate number of employees by state residence/location:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Employer contribution for Single Employee is _____
Minimum Required Employer contribution for Single Employee is 50% of Premium or Balance after 9.5% Employee Contribution; whichever is compliant.

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Employee waiting period: ☐ Date of hire ☐ First of the month after date of hire ☐ First of the month after 30 days ☐ First of the month after 60 days
Employee & Dependent Coverage Termination will be Immediate (Day of). Re-hired Employees must satisfy waiting period.

Is there a working spouse/spousal carve-out provision? ☐ Yes ☐ No

The Employer terminates employment after an employee has not worked for the Employer for_____work days (e.g. 3, 5, 10 working days). If labor laws such as FMLA or any other terms, conditions or contract of employment require that the Employer continues to employ an employee for a longer period of time, the Employer will give written notice to Paradigm when the Employer terminates employment for that employee.

Allow for Domestic Partners: ☐ Yes ☐ No ☐ Same-sex Marriage
If yes, Paradigm will request proof of status to confirm enrollment

Does the term "Child" cover include foster children and/or grandchildren? ☐ Yes ☐ No

Number of non-English speaking employees: _____ Language spoken:_____
_____ Language spoken:_____
_____ Language spoken:_____

Plan Information

Initial Eligibility Submission: ☐ Forms ☐ Excel Spreadsheet

Confirm Plan Sold: Medical Network = PHCS / Pharmacy Network = ServeYou Rx

☐ Achieve Value:	$99 Employee / $226 Emp & Spouse / $226 Emp & Child / $329 Family	Expected Enrollment_____
☐ Achieve Select:	$129 Employee / $295 Emp & Spouse / $295 Emp & Child / $429 Family	Expected Enrollment_____
☐ Achieve Preferred:	$159 Employee / $363 Emp & Spouse / $363 Emp &Child / $529 Family	Expected Enrollment_____

Division or Location Names for Billing/Reporting:

Initial First Shipment of ID Cards:
☐ Standard: all cards shipped to Employer's Main Contact ☐ Cards shipped to Employee; $4.00 per Employee charge on the first month's invoice

PHI Access

HIPAA requires that only those employees or classes of employees or other persons under the control of the Plan sponsor, and as described in your Plan document, will be given access to Protected Health Information (PHI).

Group Contact	Access Type		
Name: _____ Title: _____ Email: _____	**Enrollment Portal:**	☐Enrollment Processing	☐View Only
	Health Portal:	☐Eligibility Only	☐Eligibility & Claims
	Secure Mailbox:	☐Monthly Fixed Cost Invoice ☐COBRA Report ☐High Dollar Claim Alerts	☐Weekly Claim Funding ☐Enrollment Issues ☐Stop Loss Report
	Reporting:	☐Consolidated Enrollment ☐Check Register ☐Claims Analysis ☐Lifestyle-for-Life Report ☐Provider Ledger ☐AdHoc Report Query	☐Enrollment by Age ☐Claim Ledger ☐Claim Matrix/Lag ☐Top Providers ☐Report Package
Name: _____ Title: _____ Email: _____	**Enrollment Portal:**	☐Enrollment Processing	☐View Only
	Health Portal:	☐Eligibility Only	☐Eligibility & Claims
	Secure Mailbox:	☐Monthly Fixed Cost Invoice ☐COBRA Report ☐High Dollar Claim Alerts	☐Weekly Claim Funding ☐Enrollment Issues ☐Stop Loss Report
	Reporting:	☐Consolidated Enrollment ☐Check Register ☐Claims Analysis ☐Lifestyle-for-Life Report ☐Provider Ledger ☐AdHoc Report Query	☐Enrollment by Age ☐Claim Ledger ☐Claim Matrix/Lag ☐Top Providers ☐Report Package

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Name: _____ Title: _____ Email: _____	**Enrollment Portal:** ☐Enrollment Processing ☐View Only **Health Portal:** ☐Eligibility Only ☐Eligibility & Claims **Secure Mailbox:** ☐Monthly Fixed Cost Invoice ☐Weekly Claim Funding ☐COBRA Report ☐Enrollment Issues ☐High Dollar Claim Alerts ☐Stop Loss Report **Reporting**: ☐Consolidated Enrollment ☐Enrollment by Age ☐Check Register ☐Claim Ledger ☐Claims Analysis ☐Claim Matrix/Lag ☐Lifestyle-for-Life Report ☐Top Providers ☐Provider Ledger ☐Report Package ☐AdHoc Report Query

Broker Authorization	Access Type
Name: _____ Title: _____ Email: _____	**Enrollment Portal:** ☐Enrollment Processing ☐View Only **Health Portal:** ☐Eligibility Only ☐Eligibility & Claims **Secure Mailbox:** ☐Monthly Fixed Cost Invoice ☐Weekly Claim Funding ☐COBRA Report ☐Enrollment Issues ☐High Dollar Claim Alerts ☐Stop Loss Report **Reporting**: ☐Consolidated Enrollment ☐Enrollment by Age ☐Check Register ☐Claim Ledger ☐Claims Analysis ☐Claim Matrix/Lag ☐Lifestyle-for-Life Report ☐Top Providers ☐Provider Ledger ☐Report Package ☐AdHoc Report Query

Main Contact Signature: _____ Date: _____

Broker(s) of Record

Name of Brokerage:			
Street Address:	City:	State:	Zip:
Licensed Broker First and Last Name:	Phone:	Email:	

Employer Applicant Agreement

The answers I have provided are true and complete. I understand that the terms and conditions herein bind the Employer and Paradigm Health Plans, LLC only when the Employer receives written approval from Paradigm Health Plans**.**

Dated at (City & State): _____ Dated on (Month, Date, and Year): _____

Full Legal Business Name: _____

Signature **X**: _____ (Must be signed by a person authorized to purchase benefits for this firm)

Print Name: _____ Title: _____

Paradigm Health Plans will at times initiate communications regarding plan updates and changes via email. Please let your account manager know if you do not wish to be emailed by Paradigm Health Plans.