Paradigm HEALTH PLANS

Group Name:

EMPLOYER APPLICATION

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:
CEO Name:		Phone:	Email:
Main Contact Name:	Title:	Phone:	Email:
Billing/Administration Contact Name:	Title:	Phone:	Email:
Privacy Officer Name:	Title:	Phone:	Email:

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

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

List current/prior insurance carrier(s) or TPA(s) during previous two (2) years:

Current group health plan: ☐ Fully insured ☐Self-funded	Current Plan Year End Date:	Fiscal Year End Date:

Does current health insurer/TPA extend coverage/benefits for disabilities after termination date? ☐ Yes ☐ No
If yes, please provide copy of policy, employee certificate and/or SPD.
☐ Medical leave of absence ☐ Personal leave of absence ☐ Disability

Will any other health plan cover employee out-of-pocket expenses while this plan is in force? ☐ Yes ☐ No
If Yes, please explain the other health plan's levels and provide a copy of the plan of benefits.

Financial Information:
(a) Has your firm ever been denied credit? ☐ Yes ☐ No
(b) Has your firm ever filed bankruptcy or now in the process or considering filing for bankruptcy? ☐ Yes ☐ No
If (a) or (b) is yes, please explain: _____

Do you currently have an ERISA Fidelity Bond in effect?
☐ Yes; plan number reported to the IRS on the Form 5500 for the plan (501, 502, 503, etc.) = _____
☐ No; if no, you are required to get an ERISA Fidelity Bond at actual cost.

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.
(Note: Any COBRA applications received after approval of this application may result in a rate adjustment or declination).

Are there any employees currently not at work due to Total, Permanent or Temporary Disability at this time? ☐ Yes: Total #_____ ☐ No
If yes, attach a list indicating: Full Name, Nature of Disability, Date of Disability and Date Expected to Return to Work.

Are there any employees that the Employer considers full-time employees that are not shown on the Employer's most recent Quarterly Wage Report (for example: owners, new hires, approved leave of absence, temporary layoff, indefinite layoff, part-time, or seasonal)? ☐ Yes: Total #_____ ☐ No
If yes, attach a list indicating Full Name and reason(s) employer considers them full-time employees.

Workers' compensation carrier: _____ Policy Number: _____
You must have workers' compensation insurance for all employees & partners/owners as the Plan does not provide coverage for work related illnesses/injuries.

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Employee Information

Hours per week required for Full-Time: _____
(ACA mandates maximum of 30 hours per week)

Total number of Full-Time Employees: _____

Number of Full-Time Employees Expected to Enroll:_____

Covering Part-Time Employees? ☐ Yes ☐ No

If Yes, indicate minimum hours per week required :_____

Total number of Part-Time Employees: _____

Number of Employees Expected to Enroll: _____

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.

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

Indicate any other Waiting period for different classes: _____

Employee Coverage Termination: ☐ Immediate (Day of) ☐ End of month after termination
Note: Dependents reaching age 26 must be termed the end of their birthday month

If absent from work due to disability, Employee coverage to end: ☐ Day of Disability ☐ After_____weeks

Allow for Domestic Partners: ☐ Yes ☐ No
If yes, Paradigm will request proof of status to confirm enrollment.
Allow for Same-Sex Marriage: ☐ Yes ☐ No
Note: Paradigm Health Plans will request birth certificates for Dependent children with different last names.

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

Reinstatement Provision:
☐ Yes, Immediate ☐ No, Must Satisfy Waiting Period
☐ Medical leave of absence ☐ Personal leave of absence ☐ Disability ☐ Layoff

Are you establishing a retiree class for medical? ☐ Yes ☐ No
If yes, attained age: Years of Service: _____

Any excluded classes of employees? ☐ Yes ☐ No
If yes, give description/reason: _____

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

Does the group require SBCs and/or plan documents in that language? ☐ Yes ☐ No

If, yes, what language? _____

Organizational Structure/Key Executive Contact Info:

Name:	Title	Work Phone	Email	Permission for Health Plan to Email
				Yes_____ No _____
				Yes_____ No _____
				Yes_____ No _____
				Yes_____ No _____
				Yes_____ No _____
				Yes_____ No _____
				Yes_____ No _____
				Yes_____ No _____

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Plan Information

Funding Type: ☐ Level Funded (Fixed and Claims costs will be debited on the first business day of the month)
☐ Self-Funded Claims (Fixed costs will be debited each month and claims costs will be debited weekly)

What Coverage Tier? ☐ 2-Tier (Single/Family) ☐ 3-Tier (Single/Couple/Family) ☐ 4-Tier (Single/Couple/Parent & Children/Family)

Lifestyle-for-Life® Health option: ☐ Lifestyle-for-Life® Program
☐ Lifestyle-for-Life® Program w/ Program Manager (Health Management Program)

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

HRA Administration? ☐ Yes ☐ No If yes, rollover: ☐ Yes ☐ No Proration: ☐ Yes ☐ No

If Medical is being sold with separate Dental or Vision plan:
Is Split Coverage Allowed (Ex: Single on Medical, Family on Dental) ☐ Yes ☐ No
Can Coverage be "unbundled" (Medical/Dental/Vision etc. elected separately)? ☐ Yes ☐ No

If prior plan was self-funded; will Run-in Claims be included? ☐ Yes ☐ No ☐ Not Applicable

Deductible Carry-Over Quoted? ☐ Yes ☐ No
If Yes, how will it be provided? ☐ Deductible Report ☐ Members providing last EOB

COBRA Administration? ☐ Yes ☐ No

Initial Eligibility Submission: ☐ Forms ☐ Spreadsheet ☐ EDI (requires 45 day set-up)

Confirm Plans Selected: Medical Network: CIGNA PPO

Plan Name	Additional Title Requested (i.e. High/Low)	Expected Enrollment

Names of Divisions or Locations Required for Billing/Reporting:

Name	Address	# of EEs	Shift Work	H.R. Contact	Email	Work Phone

Paradigm HEALTH PLANS

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). PHI either identifies the person or reasonably can be used to identify the person; is created or received by the health care provider, health plan, employer, or health care clearinghouse; is maintained or transmitted by a covered entity orally, in writing, or electronically; and relates to the past, present, or future physical or mental health/condition of a person or relates to the provision of health care to a person, OR relates to the payment for the provision of health care to a person. Please note that all employees who have access to PHI should undergo training on your Plan's HIPAA Policies & Procedures

Group Contact	Access Type		
	Enrollment Portal:	☐Enrollment Processing	☐View Only
	Health Portal:	☐Eligibility Only	☐Eligibility & Claims
Name: ______	**Secure Mailbox:**	☐Monthly Fixed Cost Invoice ☐COBRA Report ☐High Dollar Claim Alerts	☐Weekly Claim Funding ☐Enrollment Issues ☐Stop Loss Report
Title: ______ Email: ______	**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
	Enrollment Portal:	☐Enrollment Processing	☐View Only
	Health Portal:	☐Eligibility Only	☐Eligibility & Claims
Name: ______	**Secure Mailbox:**	☐Monthly Fixed Cost Invoice ☐COBRA Report ☐High Dollar Claim Alerts	☐Weekly Claim Funding ☐Enrollment Issues ☐Stop Loss Report
Title: ______ Email: ______	**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
	Enrollment Portal:	☐Enrollment Processing	☐View Only
	Health Portal:	☐Eligibility Only	☐Eligibility & Claims
Name: ______	**Secure Mailbox:**	☐Monthly Fixed Cost Invoice ☐COBRA Report ☐High Dollar Claim Alerts	☐Weekly Claim Funding ☐Enrollment Issues ☐Stop Loss Report
Title: ______ Email: ______	**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

Broker Authorization	Access Type		
	Enrollment Portal:	☐Enrollment Processing	☐View Only
	Health Portal:	☐Eligibility Only	☐Eligibility & Claims
Name: ______	**Secure Mailbox:**	☐Monthly Fixed Cost Invoice ☐COBRA Report ☐High Dollar Claim Alerts	☐Weekly Claim Funding ☐Enrollment Issues ☐Stop Loss Report
Title: ______ Email: ______	**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

Main Contact Signature: ______________________ Date: ______________

Broker(s) of Record

Name of Brokerage:			
Street Address:	City:	State:	Zip:
Licensed Broker First and Last Name:	Phone:	Email:	
Name of Brokerage 2:			
Street Address:	City:	State:	Zip:
Licensed Broker 2 First and Last Name:	Phone:	Email:	

Employer Applicant Agreement

The agent has explained the details of the coverage(s)/benefits and I, the undersigned, acknowledge reading the entire application. The answers I have provided are true and complete. I understand that the terms and conditions herein binds the applicant when the applicant receives written approval**.**

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.