MEDICAL ASSOCIATES

1605 Associates Dr.
Dubuque, IA 52004

Group Application

Section A. General Group Information - Please Print

The following is provided by the Group as requested for: ☐ A new application for group benefits ☐ A revised application for group benefits

Group Name	Group No.

Street Address (Mailing Address)	City	State	Zip

Phone No. ( )	County

Business Type	SIC
☐ Association ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other	

Nature of Business	Subsidiaries Included ☐ Yes ☐ No (If yes, give legal name and address)
	Name
Administrative Contact Person/Title	Subsidiaries Address
Federal ID No.	

Requested Effective Date:_____ *We request that you do not cancel you existing group coverage until we notify you of acceptance and effective date.*

Requested plan:

- ☐ Tri-States MA Health Plans
- ☐ Tri-States Community Health Plan
- ☐ MercyOne North Iowa Health Plans
- ☐ Quad Cities Community Health Plans
- ☐ MercyOne Cedar Valley Health Plans
- ☐ Mercy Iowa City Health Plans
- ☐ MercyOne Clinton Community Health Plans
- ☐ Mercy Cedar Rapids Health Plans
- ☐ MercyOne Siouxland Health Plans

Are you replacing existing Group Coverage? ☐ Yes ☐ No If yes, furnish a copy of your policy and your most recent billing statement.

Name of current group insurance company:_____ Effective Date of Current Group Plan:_____

Section B. Eligibility

Persons to Be Covered			Waiting Period for New Hires
# Full-time Employees	# Eligible for Coverage	# of Covered Employees	Waiting Period Waived for Present Employees ☐ Yes ☐ No

A. The persons to be covered are:

☐ All active employees working 30 or more hours per week.

☐ Other_____

Note: A person must meet an Active Work Requirement to become covered under the group insurance policy.

B. Special Requests: Will any of the following be covered? (If permitted under state law.)

☐ Partners ☐ Directors, other than full-time employees ☐ Employees working between 20 and 30 hours per week

☐ Sole Proprietor ☐ Consultants, other than full-time employees

C. Exclusions: Will any class of persons not be covered? ☐ Yes ☐ No (If yes, please define classes to be excluded, such as hourly union, non-union, etc.)_____

D. Attach a listing of COBRA individuals, with qualifying event and termination date.

Section C. Employers Statement / Sales Representative Statement

The undersigned Group hereby makes application for the coverage described above. This application is subject to acceptance by Medical Associates Health Plans at their offices in Dubuque, Iowa. This Application is subject to the Terms and Conditions stated above.

Binder Check Amount $_____ Check # _____ Dated _____ on the _____ day of _____, 20_____

_____ /	_____ /
Employer Representative's Signature Date	MAHP Representative's Signature Date
_____	_____ /
Employer Representative's Printed Name/Title	Agent of Record Signature Date

Terms and Conditions

1. **The provisions of this Application shall be subject to the terms and conditions of the contract(s) and amendments, if any, in effect for the group.**

2. **The Group shall allow all Eligible Employees to enroll in accord with and within the Group's rules regarding classes eligible for coverage. Coverage hereunder may be subject to a minimum enrollment requirement which, if applicable, shall be conveyed to the Group prior to the effective date of coverage. An Eligible Employee other than a partner must have on file with the Group a completed W-4 form for reporting income tax deductions to the Federal Government.**

   a. **The group will offer each new employee the opportunity to apply for coverage at the time of hire and during his/her probationary period.**

3. **The Group will permit Eligible Employees to pay their portion, if any, of the cost of coverage by means of payroll deductions.**

4. **The money submitted with the Application by the Group is accepted by the Insurer(s) as applicable toward the first month premium, if this application is accepted by the Health Plan.**

5. **The contract(s) applied for is issued for a term of one month. It may be renewed for additional terms by paying premium therefore before the end of the grace period. Payment of more than one month's premium at that time will not extend the term of the contract(s).**

   a. **Premium for each month's coverage will be due at the offices of the insurer(s) on the 10th of each month. If premium is not paid before the end of the grace period, that is, within 31 days of the first day of the coverage month, the contract(s) will terminate. The group will be responsible for paying premium due for the coverage provided during the grace period.**

   b. **The group shall notify all employees and other insured persons who cease to be eligible for coverage under its contract(s) of their right, if any, to continue group coverage and their right, if any, to apply to the Health Plan for an individual conversion policy. The group shall provide such employees and other insured persons with the forms and applications necessary to continue group coverage or to apply for such conversion policy as may then be available.**

By signing this Application, the Group represents that (a) it has read the foregoing terms and; (b) it is a bona fide business which has a true employer-employee relationship with the persons it has designated or will in the future designate as eligible for coverage under the contract(s) applied for. If the Health Plan issues the contract(s) applied for, it reserves the right to verify the eligibility of such persons as often as it deems necessary.

6. **This Application, when approved, and any endorsement, amendment, or rider hereto will be made part of the contract(s) applied for.**