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(608) 282-8900
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EMPLOYER GROUP APPLICATION

Application is hereby made to **PHYSICIANS PLUS INSURANCE CORPORATION** by:

(Official name of Group) _____

of (Street Address) _____

(City) _____ (State) _____ (Zip) _____ (Phone #) _____ (Fax #) _____

Federal Tax ID# _____ Website _____ Email _____

for health insurance to cover present and future eligible employees and their dependents of the Employer and/or of such of the Employer's subsidiary affiliated or allied corporations, firms or individuals as listed: _____

Type of Business _____ Years in Business _____ Employee Turnover Rate _____

Workers Compensation Carrier: _____

List names of ALL OWNERS & PERCENTAGE of Ownership _____

This group is a: Corporation Partnership
 Proprietorship Other _____
 Union Non-Union

A. EFFECTIVE DATE The group effective date is based on request and Physicians Plus underwriting approval.

The requested effective date is _____. ***The effective date cannot precede the date of application.***
The Employer understands and agrees that this application is subject to acceptance by PHYSICIANS PLUS INSURANCE CORPORATION, as evidenced by issuance of appropriate contract documents.

B. EFFECTIVE DATES OF COVERAGE and DEPENDENT ELIGIBILITY

1. Effective date of employee insurance (new hire):
2. First of the month following _____ days Date of full-time employment
3. First of the month following the date of hire Date following completion of _____ days
4. Other: _____
5. Effective date of termination: Date of termination End of the month following date of termination
6. Effective date for status change (marriage, divorce): Date of status change
7. Effective date for return to work (leave, strike, layoff): _____
8. Effective date for part-time employees moving to full-time: _____
9. Dependent Eligibility: 18/27 DOB (P+ standard) OTHER _____
10. Effective date of termination of insurance for employees on an approved leave of absence is the end of the month following (Please attach written company policy):
 _____ Weeks of approved leave
 Other _____

C. EMPLOYEE ELIGIBILITY

1. Please use the number of employees reported on your most recent calendar year Contribution Report (UCT 101) filed with the state of Wisconsin.

- _____ Number of **TOTAL** employees (active, permanent and payroll (One PT= One EE))
- _____ Number of employees who are seasonal
- _____ Number of permanent employees **ELIGIBLE** for health insurance (does not include temporary)
- _____ Number of employee who are temporary
- _____ Number of permanent employees **NOT** eligible for health insurance (i.e. part time)
- _____ Number of employees waiving P+ health insurance due to other creditable coverage

OTHER: _____

2. Minimum hours per week an employee must work to be eligible for health insurance: _____ hours. (An Eligible Employee means an employee who works on a permanent basis and has a normal work week of 30 or more hours; as defined by Wis. State St. 632.745).

- a. Participants on (State/Federal) continuation _____ (Do not count these people in totals above).
- b. Total number of retirees applying for coverage: _____

NOTE: Retiree coverage requires P+ approval: Please answer the following:

- Please indicate the earliest age retirement is available _____
- Number of years of service required _____
- Number of retirees currently meeting retiree criteria _____

c. In the past 12 months, have you, any employee or dependent been totally disabled? Yes No

If yes, give the names, ages, and dates of disability, description of disability, insurance carrier's name, and state whether (1) Disability continues and (2) Benefits are being received:

D. BENEFITS AND PREMIUM CONTRIBUTION

The benefits applied for will be as close to the following:

Plan Choices:							
Type of Coverage:	_____ HMO		_____ POS/PPO		_____ OTHER (specify)		
Dental (Yes/No):	_____ Domestic Partner (Yes/No)						
Deductible:	\$ _____	In Network	\$ _____	Out of Network	\$ _____		
Coinsurance	_____ %	In Network	_____ %	Out of Network	_____ %		
Office Visit Copay	\$ _____	In Network	\$ _____	Out of Network	\$ _____		
Employee MOOP	\$ _____	In Network	\$ _____	Out of Network	\$ _____		
RX Employee Out of Pocket cost	\$ _____	<Generic	\$ _____	<Brand	\$ _____	<Non-Formulary	\$/%

Insurance will be:

- On the Non-Contributory basis (Employer assumes the entire cost of the plan).
- On the Contributory basis (employer must contribute at least 50% of the single rate per quote).

The employer is contributing the following: Single _____ (% or \$ amount) Family _____ (% or \$ amount).

D. MEDICAL Questions: Answer the following questions to the best of your knowledge for the persons to be insured (proprietors, partners, eligible employees, spouses and dependent children). Give details to questions answered 'YES' on the back of this form.

- a. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past twelve months which has resulted in claims exceeding \$5000? Yes No
- b. Has anyone been advised to have surgery in the next six months or anticipate hospitalization for any other reason? Yes No
- c. Are there any employee, spouse and/or dependent confined in a hospital or treatment facility? Yes No
- d. Are there any employee, spouse and/or dependent who are disabled or on an approved leave, not actively working or performing his/her duties full time due to illness or injury? Yes No

E. BILLING AND SERVICE INFORMATION

- a. Group contact _____
- b. Billing Address _____
- c. Other Information or Billing Instructions: _____
- d. Administrative Manual Distribution: Employer Agent BOTH

F. PRIOR GROUP COVERAGE: Is this replacement of prior group coverage? Yes No

If Yes, you must furnish a copy of prior policy, last premium billing statement, a copy of the most recent Wage and Tax Form (always required), UC-7823 and/or UC-101A and complete the following:

Previous Carrier?	Original effective date of Previous Carrier coverage?						
Coverage Type:	<u> </u> HMO	<u> </u> POS/PPO	<u> </u> OTHER (specify)				
Deductible:	\$ <u> </u> In Network	\$ <u> </u> Out of Network	\$ <u> </u>				
Coinsurance	% <u> </u> In Network	% <u> </u> Out of Network	% <u> </u>				
Copay	\$ <u> </u> In Network	\$ <u> </u> Out of Network	\$ <u> </u>				
Employee MOOP	\$ <u> </u> In Network	\$ <u> </u> Out of Network	\$ <u> </u>				
RX Out of Pocket cost	\$ <u> </u> <Generic	\$ <u> </u> <Brand	\$ <u> </u> <Non-Formulary				
Calendar Year:	Contract Year:						
Current Rates	<u> </u> Single	<u> </u> ES	<u> </u> EC	<u> </u> Family	<u> </u> Medicare Eligible 1	<u> </u> Medicare Eligible 2	<u> </u> OTHER
Monthly Premium	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
	Renewal Increase %						

G. EMPLOYERS SIGNATURE

The undersigned hereby certifies that the participating employer indicated below employs _____ full-time (defined by Wis. State St. 632.745; eligible employee means an employee who works on a permanent basis and has a normal work week of 30 or more hours) employees. All statements are true and complete, and I understand that PHYSICIANS PLUS INSURANCE CORPORATION will rely upon these statements and this information as the basis for approving this application. I further understand that no insurance will become effective without the approval of PHYSICIANS PLUS INSURANCE CORPORATION.

Signed at _____ Wisconsin, this _____ day of _____ 20_____

Employer _____

By _____
 (Signature) (Date) (Print or Type Name)

H. PHYSICIANS PLUS INSURANCE CORPORATION WITNESS

I certify that I have witnessed the Employer’s Signature, and I have actively participated in the solicitation, negotiation, or placement of this insurance.

Account Executive _____
 (Signature) (Date) (Print or Type Name)

I. AGENT’S CERTIFICATION

I certify that I have participated in the solicitation, negotiation, or placement of this insurance and have witnessed the Employer’s Signature.

Group’s NAMES Agency _____

Listed Agent’s NAME _____
 (Print) (Date)

Agent Signature & License # _____