



# GROUP APPLICATION - LARGE EMPLOYER (51+)

UTAH

10421 South Jordan Gateway  
Suite 400  
South Jordan, Utah 84095

**Important: Please type or print all sections in ink.  
Employer or designee must complete and sign this application.**

## I - EMPLOYER INFORMATION

Employer's Legal Name: \_\_\_\_\_ e-mail address: \_\_\_\_\_  
 DBA: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
 Corporation  Partnership  Sole Proprietorship  Other: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Membership/Administrative Contact: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ e-mail: \_\_\_\_\_  
 Billing Contact: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ e-mail: \_\_\_\_\_  
 Contract Attention: \_\_\_\_\_ e-mail: \_\_\_\_\_  
 Subsidiary/Affiliate Location: \_\_\_\_\_  
 (For multiple locations please attach separate sheet with address, phone #, contact)

## II - BUSINESS INFORMATION

1. Proposed Effective Date: \_\_\_\_\_  
 2. Current anniversary date: \_\_\_\_\_  
 3. Nature of Business: \_\_\_\_\_  
 4. SIC Code: \_\_\_\_\_  
 5. Number of years in operation: \_\_\_\_\_  
 6. Total number of individuals employed by this company/division: \_\_\_\_\_  
 7. Are any of the individuals working at your company contracted to you by an employee leasing firm?  Yes  No

8. Total number of full-time employees working a minimum of 30 hours per week: \_\_\_\_\_  
 9. Total number of full-time employees working and residing:  
 a. within the Altius service area: \_\_\_\_\_  
 b. outside the Altius service area: \_\_\_\_\_  
 10. Total number of individuals on COBRA: \_\_\_\_\_  
 11. Has this business filed for bankruptcy within the last 12 months?  Yes  No

12. Employer Contributions  %  \$  
 Employee: \_\_\_\_\_  
 Dependent: \_\_\_\_\_  
*Minimum employer contribution is 100% of single premium or 50% of all premiums.*  
 13. Does your company offer continuing health insurance coverage to retirees?  Yes  No  
*If "Yes," please submit company eligibility and contribution policy.*

## III - CARRIER INFORMATION This plan is intended to replace the following coverage:

1. Medical insurance carrier: \_\_\_\_\_ Anticipated termination date: \_\_\_\_\_  
 2. Dental insurance carrier: \_\_\_\_\_ Anticipated termination date: \_\_\_\_\_  
 3. The following carrier supplies Employer Liability Coverage (i.e. Workers' Compensation): \_\_\_\_\_  
 4. Is any employee NOT covered by Employer Liability Coverage (i.e. Workers' Compensation)?  Yes  No  
 If yes, reason not covered: \_\_\_\_\_  
 5. Does your company offer any other supplemental health or accident products?  Yes  No  
 If yes, please provide policy details. \_\_\_\_\_

## IV - DESIRED BENEFITS

<p><b>MOUNTAIN</b></p> <input type="checkbox"/> Mountain (PCP required) Hospital Coinsurance: _____ OV Copay: _____ Rx Copay: _____ Mental Health: _____ Deductible Options: <input type="checkbox"/> \$0 <input type="checkbox"/> \$250/\$500 <input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> Other _____	<p><b>PEAK</b></p> <input type="checkbox"/> Peak <input type="checkbox"/> Peak Plus Hospital Coinsurance: _____ OV Copay: _____ Rx Copay: _____ Mental Health: _____ Deductible Options: <input type="checkbox"/> \$0 <input type="checkbox"/> \$250/\$500 <input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> \$Other _____	<p><b>PEAK ADVANTAGE</b></p> <input type="checkbox"/> PA702 <input type="checkbox"/> PA801 <input type="checkbox"/> PA802 <input type="checkbox"/> PA901 <input type="checkbox"/> PA902 OV Copay: _____ Rx Copay: _____ Mental Health: _____	<p><b>PEAK QHDHP</b></p> <input type="checkbox"/> HMO <input type="checkbox"/> Plus POS Coinsurance: <input type="checkbox"/> 80/20% <input type="checkbox"/> 80/20% 60/40% <input type="checkbox"/> 90/10% <input type="checkbox"/> 90/10% 70/30% <input type="checkbox"/> 100% <input type="checkbox"/> 100% 80/20% Single Deductible <input type="checkbox"/> \$1,050 <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> \$1,250 <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> \$2,000 <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> \$2,650 <input type="checkbox"/> \$5,250 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 Rx Copay: <input type="checkbox"/> \$10/\$25/\$50 <input type="checkbox"/> \$15/\$30/\$60 Preventive Care before deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health: _____
<p><b>DENTAL</b></p> <small>*75% of employees taking medical coverage must also take dental coverage.</small> <input type="checkbox"/> D1 <input type="checkbox"/> D2 <input type="checkbox"/> D3 <input type="checkbox"/> Ortho \$1,000 <input type="checkbox"/> Ortho \$1,500	<p><b>PEAK PLUS EXTENDED</b> (PHCS Network) Will mirror Peak Plus Plan</p> OV Copay: _____ Rx Copay: _____	<p><b>PEAK PLUS TRADITIONAL</b></p> <input type="checkbox"/> PPT70 <input type="checkbox"/> PPT80 Deductible Options: <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Rx Copay: _____ Mental Health: _____	<input type="checkbox"/> EAP <input type="checkbox"/> My ePHIT

**V - RISK EVALUATION**

Altius requires the Employer to answer the questions below. This form should be filled out by the person responsible for operation of the current benefit plan. Please answer each question to the best of your knowledge with respect to all employees and dependents who are eligible for coverage under Altius' plan, including those who will be on continuation of benefits under COBRA, or state continuation insurance.

1. Are you aware of any employee or dependent having been diagnosed with or treated for any of the following conditions in the past 5 years?

- |                      |                         |                                |                           |                              |                             |
|----------------------|-------------------------|--------------------------------|---------------------------|------------------------------|-----------------------------|
| a. Cardiac disorder  | d. Kidney disorder      | g. AIDS/Immune system disorder | j. Neuromuscular disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Cancer (any form) | e. Respiratory disorder | h. Alcohol/Drug abuse          | k. Transplant candidate   |                              |                             |
| c. Diabetes          | f. Liver disorder       | i. Psychological disorder      |                           |                              |                             |

2. Are you aware of any employee or dependent who is currently disabled or receiving ongoing care for a medical disability?  Yes  No

5. Has any employee or dependent accumulated claims in excess of \$5,000 in the past 12 months?  Yes  No

3. Are you aware of any employee or dependent who is currently hospitalized or who is anticipating hospitalization or surgery within the next 60 days?  Yes  No

6. Are you aware of any employee or dependent who is currently pregnant?  Yes  No

4. Are you aware of any employee who has missed more than 10 consecutive days of work in the past 12 months due to illness or injury?  Yes  No

7. Number of employees or dependents currently pregnant.  
 Employees: \_\_\_\_\_ Dependents: \_\_\_\_\_  
 Due Dates: \_\_\_\_\_

If you answered "Yes" to any questions above, please provide the additional information requested below for each individual. Attach a separate sheet if necessary.

Employee or Dependent	Nature of Illness	Date of Onset	Amount of Claim	Length of Disability	Current Health Status
		/ /			
		/ /			
		/ /			
		/ /			

8. Which are you required to offer?  COBRA  State Continuation of Benefits

**Names and Expiration Dates of current COBRA/State Continuation Participants**

Name	COBRA/State Continuation Expiration Date	Name	COBRA/State Continuation Expiration Date
	/ /		/ /
	/ /		/ /
	/ /		/ /

**VI - ELIGIBILITY/BILLING OPTIONS**

A. Eligibility Date for New Employees:

- Date of Hire

An employee who becomes effective on or before the 15th of the month will be billed an entire month's premium. Nothing is billed for the first partial month for an employee who becomes effective on or after the 16th of the month. Coverage ends on the termination date. When an employee's coverage terminates on or before the 15th of the month, no premium is due; if the coverage terminates on or after the 16th of the month, an entire month's premium is due.

B. Eligibility Date for New Employees:

- 1st of the month coinciding with or next following \_\_\_\_\_ days of employment.
- 1st of the month coinciding with or next following date of hire.

Employer pays entire month's premium for coverage. Coverage extends through the month in which employment terminates.

C.  Other: \_\_\_\_\_

**VII - TERMINATION OF COVERAGE**

- On termination date (with Option A only – see section VI - ELIGIBILITY/BILLING OPTIONS)
- Last day of month after termination (with Option B only – see section VI - ELIGIBILITY/BILLING OPTIONS)
- Other: \_\_\_\_\_

**VIII - PRODUCER/AGENCY APPOINTMENT**

As a representative of the Employer, I appoint the following individual as Producer of Record and authorize that person to act on our behalf regarding the benefits being applied for:

Producer Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: ( \_\_\_\_ ) \_\_\_\_\_  
 e-mail: \_\_\_\_\_

**VIIIa. PAYEE INFORMATION**

Payee:  Producer  Agency Payee's SS#/Tax ID: \_\_\_\_\_  
 Payee's Producer Code: \_\_\_\_\_ Payee's Utah License #: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_ Currently appointed with Altius?:  Yes  No

**IX - SIGNATURE**

I understand and do hereby certify that the information contained in this Group Application is complete and accurate to the best of my knowledge. I further certify that I hold a position with the employer that permits me to have the information necessary to complete this Group Application on behalf of the employer, or I have conferred with and confirmed my answers with person(s) that hold such position(s) with the employer. It is further understood that Altius Health Plans (Altius) reserves the right to reform or rescind coverage if any supplied information is materially inaccurate or incomplete. This application will form a part of any contract issued by Altius.

I understand that Altius may contact employees and dependents to obtain additional follow-up information. I agree to inform employees that Altius may contact them in order to obtain additional information or to discuss information provided on this form. Employer agrees to indemnify Altius for any liability or damages resulting from any breach of representation made in this form and for claims brought by employees and their dependents regarding the use of the information disclosed by the employer.

The effective date will be determined by Altius and will be the latest of: (a) the date this application is given written approval by Altius; (b) the requested effective date, if not prior to the date the employer signs this application, provided Altius approves the application; or (c) the date Altius establishes for coverage to begin, in the event this application is not accompanied by all information needed to underwrite the coverage. A full first month's payment must be received and Altius must approve the application in writing before coverage will become effective.

No Altius producer has the authority to: (a) modify this form; (b) waive the answer to any question; (c) bind Altius in any way by giving or receiving data that is not written on this form; or (d) bind Altius by making any promise or representation.

Employer Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I have read the above statements. The answers to all questions are complete and accurate, to the best of my knowledge.

Producer Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Received from this employer, a one month deposit of \$ \_\_\_\_\_. Altius will hold the deposit without obligation until Altius either accepts or denies the application. If accepted, the deposit will be applied to the first premium due and payable for the coverage. If denied, coverage will not become effective and the deposit will be refunded.

**PLEASE SUBMIT THE FOLLOWING:**

- Deposit Check
- Completed Employer Group Application
- Current Billing Statement(s)
- Current Benefit Booklet(s)
- Copy of Final Rate Acceptance Sheet
- Statements of Health on those individuals identified in the Risk Evaluation Section of this application
- Applications/Waiver Forms, # submitted \_\_\_\_\_
- Statements of Health, # submitted \_\_\_\_\_ (if required)
- Quarterly Wage & Contribution Report (if requested)

*Altius Health Plans reserves the right to request additional information as necessary to complete the underwriting process.*

**OFFICE USE ONLY**

Approved Effective Date

**Final Rate Acceptance** Date: \_\_\_\_\_

Date Received

Received from UW

Date Submitted to UW

Submitted to Group

Returned from Group

Final Submission to UW

Positioning

Carrier Replaced

Reason:  Cost  Network

Dual Option

Sole Source


Benefits

Funding

Service

Other

If dual option, list Competitors, Plans, and Payroll Deductions.

Competitor	Plan Description	Single	Two-Party	Family

Enrollment Summary		# of Subscribers	Rate	Total Premium	Members
Mountain	Single				
	Two-Party				
	Echild				
	Family				
Peak	Single				
	Two-Party				
	Echild				
	Family				
Peak Advantage	Single				
	Two-Party				
	Echild				
	Family				
Peak Plus Extended	Single				
	Two-Party				
	Echild				
	Family				
<input type="checkbox"/> Peak Traditional	Single				
	Two-Party				
<input type="checkbox"/> Peak Plus Traditional	Echild				
	Family				
<input type="checkbox"/> Peak QHDHP	Single				
	Two-Party				
<input type="checkbox"/> Peak Plus QHDHP	Echild				
	Family				

**Ancillary Products Placed**

	Effective Date	Vendor	Plan	# Enrolled
Dental				
EAP				
My ePHIT				