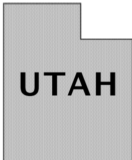
10421 South Jordan Gateway, Suite 400
South Jordan, Utah 84095

GROUP APPLICATION
SMALL EMPLOYER (2-50)



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:__________ DBA:__________

Address:__________ City:__________ State:____ Zip:______

Phone: (____) ________ Fax: (____) ________ e-mail: __________

Billing Address:__________ City:__________ State:____ Zip:______

❑ Corporation ❑ Partnership ❑ Sole Proprietorship ❑ Other:________ Tax ID#:________

Membership/Administrative Contact:__________ Title:________ Phone: (___) ______

Billing Contact:__________ Title:__________ Phone: (___) ______

Contract Attention: __________ Subsidiary/Affiliate Location: __________
(for multiple locations please attach separate sheet with address, phone #, contact)

II. BUSINESS INFORMATION

1. Proposed Effective Date:________ 2. Nature of Business:__________
3. SIC Code:__________ 4. Number of years in operation:__________
5. Total number of individuals employed by this company/division:________
6. Total number of full-time employees working a minimum of 30 hours per week:________
7. Total number of full-time employees working and residing:

   WITHIN the Altius service area: ______ OUTSIDE the Altius service area: ______
8. Is this business currently in Chapter 11, or has this business filed for bankruptcy within the last 12 months?
   ❑ Yes ❑ No
9. Employer Contribution toward premium: (*Minimum employer contribution is 50% of single premium; 50% of Peak High single premium for Health Suite*)

   ______% of Employee premium ______% of Dependent premium
10. Are all employees covered by an Employer Liability Plan? (i.e. Workers' Compensation)

    ❑ Yes ❑ No — If "No," please explain: __________

    If "No," list names/titles: __________

    ____

III. CARRIER INFORMATION — *This plan is intended to replace the following coverage:*

1. Current Medical insurance carrier:________ Start date:______ Anticipated termination date:______
2. Current Dental insurance carrier:________ Start date:______ Anticipated termination date:______
3. Reason for changing:__________

If less than three years with current carrier:

4. Prior Medical insurance carrier:________ Start date:______ Termination date:______
5. Prior Dental insurance carrier:________ Start date:______ Termination date:______
6. Reason for changing:__________

IV. DESIRED BENEFITS

Plan	Coinsurance Options	Deductible Options	Office Visit Options	Rx Options Preferred Generic/ Preferred Name Brand/ Non-Preferred
☐ Peak (In network only)	☐ 70% ☐ 80% ☐ 90%	☐ $0 ☐ $250 ☐ $500 ☐ $1000 ☐ $2000 ☐ $3000 ☐ $4000 ☐ $5000	☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $35 ☐ $40	☐ $10/$25/$50 ☐ $15/$30/$60
☐ Peak Plus (In & out of network)	☐ 80/60% ☐ 90/70%	☐ $0 ☐ $250 ☐ $500 ☐ $1000 ☐ $2000 ☐ $3000 ☐ $4000 ☐ $5000	☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $35 ☐ $40	☐ $10/$25/$50 ☐ $15/$30/$60
☐ Peak Traditional (In network only)	☐ 70% ☐ 80%	☐ $0 ☐ $250 ☐ $500 ☐ $1000 ☐ $2000 ☐ $3000 ☐ $4000 ☐ $5000	☐ $10 AD ☐ $15 AD ☐ $20 AD ☐ $25 AD ☐ $30 AD ☐ $35 AD ☐ $40 AD (AD = After Deductible)	**Peak Traditional –** Fixed Benefit $15/$30/50% w/ $60 minimum copay for non-preferred medications
☐ Peak Advantage 4 Level (In & out of network with tiered benefits)	☐ 70% ☐ 80%	☐ $0/$250/$500/$1000 ☐ $250/$500/$1000/$2000 ☐ $500/$1000/$2000/$4000	☐ $10/$20/$30 ☐ $15/$25/$35 ☐ $20/$30/$40 ☐ $25/$35/$45 ☐ $30/$40/$50 ☐ $35/$45/$50 ☐ $40/$50/$60	☐ $10/$25/$50 ☐ $15/$30/$60
☐ Peak Advantage 3 Level (In network only with tiered benefits)	☐ 70% ☐ 80%	☐ $0/$250/$500 ☐ $250/$500/$1000 ☐ $500/$1000/$2000	☐ $10/$20/$30 ☐ $15/$25/$35 ☐ $20/$30/$40 ☐ $25/$35/$45 ☐ $30/$40/$50 ☐ $35/$45/$50 ☐ $40/$50/$60	☐ $10/$25/$50 ☐ $15/$30/$60
Peak (In network only) ☐ QHDHP	☐ 80% ☐ 90%	☐ $1050 Single/$3150 Family ☐ $2000 Single/$6000 Family	Coinsurance After Deductible Preventive: ☐ Before Deductible ☐ After Deductible	☐ $10/$25/$50 ☐ $15/$30/$60
Peak Plus (In & out of network) ☐ QHDHP	☐ 80%/60% ☐ 90%/70%	☐ $1050 Single/$3150 Family ☐ $2000 Single/$6000 Family	Coinsurance After Deductible Preventive: ☐ Before Deductible ☐ After Deductible	☐ $10/$25/$50 ☐ $15/$30/$60
Health Suite	**Coinsurance Options**	**Deductible Options**	**Office Visit Options**	**Rx Options**
☐ 4 Standard Plans May not be offered alongside other plans Peak Plus . . . . Peak - High . . . . . Peak - Low . . . . . Peak Traditional. .	Coinsurance is pre-determined for each plan: 90% Par/70% Non-Par 80% 70% 70%	☐ $250 ☐ $3000 ☐ $500 ☐ $4000 ☐ $1000 ☐ $5000 ☐ $2000	**Peak Plus** ☐$10 ☐$15 ☐$20 **Peak - High** $20 $25 $30 **Peak - Low** $30 $35 $40 **Peak Traditional:** $20 PCP/$30 Other	*Option selected applies to Peak Plus, Peak High & Peak Low* ☐ $10/$25/$50 ☐ $15/$30/$60

Note: ER copays for Peak, Peak Plus and Peak Traditional are linked to the participating office visit copay chosen.
ER copays for Peak Advantage Plans are based on the Level 1 office visit copay.
Office visits of $10 or $15 will have ER copays of $75 participating/$150 non-participating.
Office visits of $20 or more will have ER copays of $100 participating/$200 non-participating.

Rx Deductible Options

Option selected applies to all plans offered except Peak QHDHP and Peak Plus QHDHP

☐ None

☐ **Per person:** ☐ $50 ☐ $100 ☐ $250

OR

☐ **Per contract:** ☐ $250 ☐ $500

Health Suite:

Rx deductibles are standard:

Peak Plus	None
Peak - High	None
Peak - Low	$50 per person
Peak Traditional	$250 per person

Ancillary Products

Mental Health ☐ None ☐ 50/50 ☐ Catastrophic

Mental Health EAP ☐ Yes ☐ No

My ePHIT ☐ No ☐ Yes (check one below)

☐ Employee Only ☐ Employee/Spouse

Dental ☐ D-1 (DMO) ☐ D-1 (DMO) with Ortho $1000 LTM

☐ D-3 (POS) ☐ D-3 (POS) with Ortho $1000 LTM

Dental Participation Requirements:

2-14 Eligible Employees – 100% of those enrolling in medical must take dental.

15-50 Eligible Employees – 75% of those enrolling in medical must take dental.

Ortho may be offered in groups of 20+ eligible employees; minimum enrollment of 20 subscribers or 75% of those taking medical, whichever is greater.

V. RATES APPLIED FOR

The rates shown on the attached copy of the rate proposal are preliminary rates. The employer's signature on the application authorizes Altius to proceed with processing this group application. Any deviation from the proposed rates will be communicated separately on an underwriting final rate review form that will require the employer's signature before the group will be enrolled.

VI. COBRA - STATE CONTINUATION

Which are you required to offer: ☐ COBRA ☐ State Continuation of Benefits (less than 20 EEs)

Names and Expiration Dates of current COBRA / State Continuation participants:

Name:______________________________ COBRA / State Continuation Expiration Date:__________

Name:______________________________ COBRA / State Continuation Expiration Date:__________

Name:______________________________ COBRA / State Continuation Expiration Date:__________

Name:______________________________ COBRA / State Continuation Expiration Date:__________

Name:______________________________ COBRA / State Continuation Expiration Date:__________

VII. ELIGIBILITY/BILLING OPTIONS

ELIGIBILITY DATE FOR NEW EMPLOYEES *(check one)*
1st of the month coinciding with or next following: ☐ 30 ☐ 60 ☐ 90 or ☐ _________ days of employment.
(Employer pays entire month's premium for coverage. Coverage extends through the month in which employment terminates.)

REHIRE POLICY: ☐ Yes ☐ No *If yes, policy will be administered as follows: Employees rehired within 6 months of termination date will be re-enrolled on chosen coverage effective the first of the month following rehire date.*

VIII. PAYMENT OPTIONS

For your convenience, Altius Health Plans has two ways you can pay your premium. Please select the one right for you:

☐ Automatic payment withdrawal *(Please complete an auto payment form)* ☐ Please bill me

IX. 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:_________________________

IXa. 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

X. STATEMENT OF UNDERSTANDING

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.