2019 Employer Application

Please complete the below form in its entirety in order to ensure the most efficient implementation of your group with Lifestyle Health Plans. Any missing information may delay group implementation and processing.

Requested Effective Date (Must be 1st of the Month): _____ / 01 / 2019

SECTION 1: COMPANY INFO / KEY CONTACTS			
Company Legal Name			
Street Address	City	State	Zip
Mailing Address ☐ Check if same as Street Address	City	State	Zip
Phone Number	Fax Number		
Key Contact Name	Title		
Key Contact's Email Address			
Federal Tax ID#	Nature of Business		

SECTION 2: EMPLOYEE STATUS	
Total Number of ALL Employees (Full-time, Part-time, COBRA, FMLA, Disability and Other)	
How many are Full-time (FT)?	☐ Check if N/A
How many are Part-time (PT)?	☐ Check if N/A
How many are COBRA?	☐ Check if N/A

How many are on or have been on disability or FMLA over the last 12 months? _____

(Please complete below for all employees who qualify for COBRA, FMLA, or Disability and check appropriate status)
Please use additional pages as necessary

First Name	Last Name	COBRA	FMLA	Disability	Other (please specify)

SECTION 3: MEDICAL COVERAGE COUNT AND ELIGIBILITY			
MEDICAL PLANS SOLD: ☐ HealthyEssentials MEC ☐ Lifestyle Major Medical Plans ☐ Lifestyle Custom Plan			
If electing MEC coverage, please list selected MEC plan name:			☐ Check if N/A
How many Full-time employees have qualified waivers? ☐ Check if N/A	How many Full-time employees are enrolling in medical? ☐ Check if N/A		
Waiting/Affiliation Period to reflect 1st of the month following:	☐ 0 days	☐ 30 days	☐ 60 days
Eligibility (number of hours worked per week to be eligible for benefits)			
Will any of the plans have an HRA? ☐ Yes ☐ No	If yes, will Medova administer?	☐ Yes	☐ No
COBRA Administration is available for groups with 20 or more full-time employees. Will Medova administer COBRA?	☐ Yes	☐ No	

SECTION 4: PPO NETWORK AND BILLING INFORMATION			
PPO Network:	**Wrap Network:** ☐ **PHCS**	☐ **First Health**	
Billing Method: ☐ **e-mail** ☐ **mail**	**Pre-tax:** ☐ **Yes**	☐ **No**	
Divisional Billing by Location? (If yes, please attach list of locations to this form) ☐ **Yes** ☐ **No**			
Billing Contact (Group or PEO)	**E-mail**		
Billing Address	**City**	**State**	**Zip**

SECTION 5: DENTAL AND VISION COVERAGE		
DENTAL PLANS SOLD:	☐ **DentalCare 1000**	☐ **DentalCare 1500**
How many employees are electing dental coverage (Minimum of 3 Enrolled Employees)		
In order to be eligible for Orthodontia Coverage, employer must provide proof of 1-year prior dental coverage*		
Coverage Type: ☐ **Dental** ☐ **Orthodontia** **Name of current carrier**		**Policy No**
***Please attach recent dental invoice / billing statement from prior carrier to detail individuals covered on prior dental plan**		
VISION PLANS SOLD:	☐ **VSP VisionCare 120**	☐ **VSP VisionCare 150**
How many employees are electing vision coverage (Minimum of 3 Enrolled Employees)		

SECTION 6: ENROLLMENT & ADMINISTRATION OPTIONS (INITIAL & ONGOING ENROLLMENT)			
Enrollment Type:	☐ **Online Enrollment (Min of 25 Enrolled)**	☐ **Census Enrollment**	☐ **Paper Enrollment**
Benefit Setup:	☐ **Plan Year**	☐ **Calendar Year**	

SECTION 7: SIGNATURE AND AUTHORIZATION

As a part of the group submission process, we hereby attest to the accuracy of the information provided above. We recognize and assume all legal responsibility in the event that the information provided above is not correct and a member's benefits are denied or incorrectly administered by Medova Healthcare based on the information disclosed in this Employer Application Form.

Print Name of Employer: _____ **Title:** _____

Signature of Employer: _____ **Date:**_____

Print Name of Agent: _____

Signature of Agent: _____ **Date:**_____

Print Name of Agency: _____