GROUP APPLICATION

Employer Information

Group Name: _____ Tax ID: ____-_____

Address: _____ City, State Zip : _____

Previous Carrier: _____ Eligible Employees: #_____ Phone: #_____

Key Contact
(To Receive Welcome Email & Submit Eligibility)

Name: _____

Email: _____

Billing Contact
(To Receive Invoices)

Name: _____

Email: _____

Plan Information

Effective Date: _____ / 01 /_____ Waiting Period: 1st of the month following ☐ 0 ☐ 30 ☐ 60 days

Payroll Cycle: ☐ W (48) ☐ W (52) ☐ BW (26) ☐ SM (24) ☐ M (12)

Employer Contribution: ☐ None ☐ Set Amount $_____ ☐ Set Percentage _____%

Plan Options

MEC Plans

☐ BASIC ☐ ULTRA ☐ ULTIMATE ☐ OTHER

MDay Limit Health Plan

☐ BASIC ☐ Plus ☐ Premier

Dental

☐ PREVENTIVE ☐ COMPREHENSIVE

Vision

☐ VSP VISION

Unlimited Health Plan

☐ Ultimate ☐

IF OTHER: _____

** MEC Required to Offer Benefits*

Employer Acknowledgement

Employer acknowledges the above information is accurate and will be utilized for the purpose of implementation and associated plan documentation. Policy terminations must be sent to Options Plus on company letterhead, signed by the group administrator and submitted prior to the effective date of termination.

Authorized Name: _____ Title: _____

Signature: _____ Date: _____

Group Enrollment Materials

☐ Group Application (this form) ☐ Automatic Payment Form ☐ Enrollment Census

To begin group implementation, email all enrollment materials to: updates@optionsplusplan.com

Enrollment Kits Available by Request