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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 health insurance for employee NEW HIRES. **CHOOSE ONE**

The following eligibility language applies to: _____ (Please identify any segmentation that may apply).

- First of the month following _____ days* Date of full-time employment
 First of the month following the date of hire Date following completion of _____ days
 Other: _____

*For purposes of this section February = 30 days.

2. Effective date of termination: Date of termination End of the month following date of termination

3. Effective date for status change (marriage, divorce): **Date of status change**

4. Effective date for return to work (leave, strike, layoff): _____

5. Effective date for part-time employees moving to full-time: _____

6. Dependent Eligibility: 27 DOB (P+ standard) OTHER _____

7. 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)

- _____ days/weeks of approved leave.
 Other _____

C. EMPLOYEE ELIGIBILITY: Physicians Plus reserves the right to verify all eligible employees were offered insurance (on any size group) in compliance with WI State St. 632.746(10).

1. Please use your most recent wage & tax or Contribution Report (UCT 101) filed with the State of Wisconsin to report the following.

_____ Number of TOTAL employees (active, permanent on payroll (one part time = one employee)	_____ Number of employees who are seasonal
_____ Number of permanent employees ELIGIBLE for health insurance (does not include temporary)	_____ Number of employees who are temporary
_____ Number of permanent employees NOT eligible for health insurance (i.e. less than 30 hours/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 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 questions:

- 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 Choice:							
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).

E. 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.

1. 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
2. Has anyone been advised to have surgery in the next six months or anticipate hospitalization for any other reason? Yes No
3. Are there any employee, spouse and/or dependent confined in a hospital or treatment facility? Yes No
4. 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

F. BILLING AND SERVICE INFORMATION

1. Group contact _____
2. Billing Address _____
3. Other Information or Billing Instructions: _____
4. Administrative Manual Distribution: Employer Agent

G. 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 Coverage?			
Coverage Type:	_____ HMO	_____ POS/PPO	_____ OTHER (specify)	_____	_____	_____	_____
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	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Calendar Year:	_____	Policy Year:	_____				
Current Rates	Single	ES	EC	Family	Medicare Eligible 1	Medicare Eligible 2	OTHER
	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Monthly Premium	\$ _____						
Renewal Increase		% _____					

H. 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. I further certify that I have offered insurance coverage to all eligible employees and their eligible dependents.

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)

I. 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)

J. 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 named agency _____

Listed agent's name (printed) _____

Signature of listed agent named above _____
 (Date)

Agent License # _____ Date of Listing _____