



411 N. Chelan Ave.,  
Suite A  
Wenatchee, WA 98801

Phone: (877) 649-1314  
Fax: (217) 902-9704

# SMALL GROUP EMPLOYER APPLICATION

(for 1–50 total employees)

Group Name as shown on Tax and Wage Statement:		
Employer Federal Tax ID Number (TIN):		
Group Contact:		
Industry Type:		
Email Address:		
Physical Address:		
Billing Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

## SECTION 1: ADDITIONAL GROUP INFORMATION

1. Total number of employees including full-time, part-time, seasonal, owners, etc.?
2. Requested Health Alliance Northwest effective date:
3. Name of current carrier:
4. Is Health Alliance Northwest the sole source of health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, identify other carriers:
5. Date business started:
6. Is your organization a: <input type="checkbox"/> State Government <input type="checkbox"/> Local Government <input type="checkbox"/> Publicly Traded Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Controlled Group <input type="checkbox"/> Privately Held Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Church Group <input type="checkbox"/> Other
7. Is your organization subject to ERISA? <input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION 2: MEDICARE SERVICES

**Please contact your Insurance Producer and/or Client Consultant for plan options, rates and details.**

1. Are you interested in a Medicare Advantage plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Which plan option?:
2. Effective date of Medicare plan: <i>(please note applications for Medicare Services cannot be retroactive)</i>
3. Approximately how many Medicare-Eligible (primary) employees does your group have?:
4. Approximately how many Medicare-Eligible retirees does your group have?:
5. Medicare billing type: <i>(choose one)</i> <input type="checkbox"/> Group Level <input type="checkbox"/> Individual
6. Medicare plan contact information. Medicare Group Contact: _____ Email Address: _____ Physical Address: _____ City: _____ State: _____ Zip Code: _____ Billing Address: _____ Phone Number: _____ FaxNumber: _____
7. Sponsor type: <input type="checkbox"/> Employer <input type="checkbox"/> Union <input type="checkbox"/> Trustees of a Fund
8. Who will the plan(s) be offered to? <input type="checkbox"/> Future Retirees <input type="checkbox"/> Past Retirees <input type="checkbox"/> Both <input type="checkbox"/> Active-Medicare Eligible
9. Will the plan be offered to spouses/domestic partners? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Can retirees leave the plan and come back? <input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION 3: THIRD PARTY ADMINISTRATIVE SERVICES

1. Do you have a Health Savings Account (HSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have an HRA? <input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 4: INSURANCE PRODUCER INFORMATION (IF APPLICABLE)**

I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application and the eligibility and enrollment information is accepted. I understand I have no right to bind this coverage, to alter terms of the Coverage Contract or Application in any manner or to adjust any claim for benefits under the Coverage Contract.

Print Insurance Producer Full Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree that the typed name above shall be treated as a valid signature for all purposes of this form.

**SECTION 5: GROUP INFORMATION**

I have read this application and attest to the accuracy of the above information.

I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud. If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

Group Contact: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree that the typed name above shall be treated as a valid signature for all purposes of this form.