Health Alliance™

3310 Fields South Drive
Champaign, IL 61822

IL LARGE GROUP EMPLOYER APPLICATION
(for 51+ full-time-equivalent 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 effective date:
3. Name of current carrier:
4. Is Health Alliance the sole source of health insurance? ❑ Yes ❑ No If No, identify other carriers:
5. Date business started:
6. Is your organization a: ❑ State Government ❑ Local Government ❑ Publicly Traded Corporation ❑ Non-Profit ❑ Controlled Group ❑ Privately Held Corporation ❑ Sole Proprietorship ❑ Partnership ❑ Church Group ❑ Other
7. Is the group subject to ERISA? ❑ Yes ❑ No
8. SIC Code:

SECTION 2: CREDITS

Deductible and Out-of-Pocket Credit is defined as the amount Health Alliance will credit for payments made toward the in-network deductible under the previous health insurance. If the new deductible is higher than the previous deductible, the additional amount needs to be met before benefits will be paid. Explanation of Benefits and/or a Deductible/Out-of-Pocket Credit Report from your previous carrier must be submitted for credit to be applicable.

SECTION 3: MEDICARE SERVICES

Please contact your Broker and/or Sales Account Executive for plan options, rates and details.

1. Please check the plan(s) that interest you: ❑ Medicare Advantage ❑ Medicare Supplement ❑ Medicare Stand-Alone PDP
   Which plan(s)?:
2. Effective date of Medicare plan:
   (please note applications for Medicare Services cannot be retroactive)
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: *(choose one)* ❑ Group Level ❑ Individual
6. Medicare plan contact information.

Medicare Group Contact:	Email Address:	
Physical Address:		
City:	State:	Zip Code:
Billing Address:		
Phone Number:	Fax Number:	

7. Sponsor type: ❑ Employer ❑ Union ❑ Trustees of a Fund
8. Who will the plan(s) be offered to? ❑ Future Retirees ❑ Past Retirees ❑ Both
9. Will the plan be offered to spouses? ❑ Yes ❑ No
10. Will the group allow non-Medicare eligible spouses to stay on the active plan if the spouse moves to the group Medicare plan? ❑ Yes ❑ No
    Same for dependents? ❑ Yes ❑ No
11. Can retirees leave the plan and come back? ❑ Yes ❑ No

SECTION 4: THIRD PARTY ADMINISTRATIVE SERVICES

1. Do you have a Health Savings Account (HSA)? ❑ Yes ❑ No

2. Do you have an HRA? ❑ Yes ❑ No

3. Are you currently using a TPA to administer third party services such as COBRA, HRA, FLEX or HSA?: ❑ Yes ❑ No
   If Yes, please list name of TPA and services:

SECTION 5: BROKER 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 Broker 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 6: GROUP INFORMATION

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

Group Contact: _____

Signature: _____ Date: _____

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