



WESTERN MUTUAL INSURANCE® COMPANY

P.O. Box 572450 Salt Lake City, Utah 84157-2450
(801) 263-8000 (800) 748-5340 Fax: (801) 263-1247

EMPLOYER APPLICATION

Please complete this application for group health insurance, including any optional plan benefits, provided by Western Mutual Insurance Company. Before signing in the appropriate space, check each section. Signature applies to all sections.

Section I: General Information

Date

Company Name Federal EIN Contact Person

Address City State ZIP

Phone Fax E-mail address

Does the company currently have group health insurance with another company? Yes No

Present Insurer Date Coverage to Terminate

Please attach a copy of current group health plan information (plan summary, schedule of benefits, etc.).

Section II: Employee Classification Information

The following employee classifications are eligible to participate in the company's group health plan:

Waiting Period for New Employees: 30 days 60 days 90 days 120 days Other

Employees are required to work a minimum of hours per to be eligible for group insurance. (Cannot be less than 20 hours per week (30 hours per week or another amount determined by the employer in Arizona)

Total number of employees of all related companies: Full-time: Part-time: Seasonal:

Total number of employees eligible to participate in the company's group health insurance plan:

Total number of employees participating in the company's group health insurance plan:

Total number of eligible employees NOT participating in the company's group health insurance plan:

Reason(s) for waiving coverage:

Please attach a current copy of company payroll (FICA or Workers' Compensation).

Section III: Premium Contribution Information

The Employer pays % of employee health insurance premium.

The Employer pays % of dependent health insurance premium.

Will the Employer reimburse employees and/or their dependents for amounts paid toward the satisfaction of the policy deductible? Yes No If yes, how much and/or at what percentage?

**Section IV: Benefit Information**

Medical:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Plan Selected: _____
Dental:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
Vision:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Requested effective date: _____
Life (“VGL”):	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
Disability:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	WPMA membership: Yes _____ Pending _____
Other	_____		

Does employer currently carry workers’ compensation insurance? Yes\_\_\_\_ No\_\_\_ If owners and partners are not covered under workers’ comp, do they want normal plan coverage while on the job for additional premiums? Yes\_\_\_\_\_ No\_\_\_\_\_

Is anyone currently on COBRA? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list those participating: \_\_\_\_\_

Please list any information on any claims over \$10,000 in the past 12 months: \_\_\_\_\_

**Section V: Group Benefit Eligibility Criteria**

The undersigned employer hereby certifies that the company employees are required to work a minimum of \_\_\_\_\_ hours per week in order to qualify to participate in the company’s group benefit program(s) through Western Mutual Insurance Company, and that the forgoing policy and criteria is applicable to all employees and has been conveyed to all employees.

**Section VI: Terms and Conditions**

The undersigned employer hereby requests group insurance with the Western Mutual Insurance Company. By signing this agreement, the employer agrees to adopt and subscribe to all terms and conditions of this document as well as those set forth in the insurance policy booklet. The employer understands and agrees that all insurance underwriting and participation requirements must be maintained during the insurance period. Insurance applied for hereunder will not be effective until this application has been approved in writing by Western Mutual Insurance Company. The employer agrees to notify Western Mutual Insurance Company within ten (10) days of any material change affecting the employer or which may render the employer ineligible for insurance with the company. The employer agrees that it is the administrator of the plan as that term is contemplated under the Employee Retirement Income Securities Act (“ERISA”) and that Western Mutual Insurance Company does not assume any obligations imposed by that law or any amendments thereto, including, but not limited to, the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) and the Health Insurance Portability and Accountability Act (“HIPAA”). The employer also agrees that Western Mutual Insurance Company may conduct periodic audits to ensure that eligibility, participation, and contribution requirements are being satisfied and that the employer will provide each insured employee and qualified beneficiary with not less than thirty (30) days prior written notification of termination.

**Section VII: Signature**

I hereby certify that the information provided herein is true and complete to the best of my knowledge. I have also read and understand the group enrollment requirements\* as explained in the benefit description booklet and the terms and conditions set forth herein.

By: \_\_\_\_\_  
Signature of Authorized Company Officer

Title: \_\_\_\_\_ Date \_\_\_\_\_

\* WMI requires that companies with 2-5 eligible employees enroll 100% of eligible employees; companies with 6-9 employees must enroll at least 80% of all eligible employees; and companies with 10+ employees must enroll at least 75% of all eligible employees. An eligible employee is one who works a minimum of 80 hours per month (120 hours per month or another minimum amount determined by the employer in Arizona), satisfies the employer’s eligibility criteria, and does not carry other major medical insurance coverage.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.**