1 Sundial Ave, Manchester, NH 03103
Phone: 857-263-8242
Fax: 857-263-8951
Minutemanhealth.org

EMPLOYER GROUP APPLICATION

DIRECTIONS: *Please return the following information to:*
Sales Department, Minuteman Health, 1 Sundial Ave Ste 512. Manchester, NH 03103

Please include:
☐ Employer Group Application ☐ Confirmation of Sold Rates ☐ Enrollment Forms ☐ Employer Agreement
☐ Evidence of employment, WR-1. *(Please contact the Sales Department to discuss alternatives.)*

EMPLOYER ACCOUNT INFORMATION

COMPANY NAME	NATURE OF BUSINESS	SIC CODE: TAX ID#:

STREET ADDRESS		BILLING ADDRESS (IF DIFFERENT)	
PO BOX		BILLING CONTACT	
CITY, STATE	ZIP	CITY, STATE	ZIP
EXECUTIVE CONTACT		BENEFITS ADMINISTRATOR	
PHONE ( ) -	FAX ( ) -	PHONE ( ) -	FAX ( ) -
EMAIL ADDRESS		EMAIL ADDRESS	
COMPANY WEBSITE			
SUBSIDIARIES OR AFFILIATES TO BE COVERED AND LOCATIONS			

# OF ELIGIBLE EMPLOYEES	# OF FULL TIME EQUIVALENT (FTE) EMPLOYEES	# OF EMPLOYEES ENROLLING	RETIREES (AGE 65+ WITH MED A&B)	# OF COBRA ENROLLING

REPORTING INFORMATION *(ADDITIONAL SPACE NEEDED, ATTACH SEPARATE SHEET)*

TOTAL NUMBER OF EMPLOYEES (INCLUDE ALL FULL- AND PART-TIME EXEMPT EMPLOYEES SUBJECT TO FICA TAXES) *

**THIS INFORMATION IS NECESSARY IN ORDER TO CLASSIFY YOUR COMPANY CORRECTLY FOR FEDERAL MEDICARE SECONDARY PAYER (MSP) REQUIREMENTS*.

***PLEASE USE THE CALCULATOR FROM healthcare.gov TO DETERMINE THE NUMBER OF FULL TIME EQUIVALENT EMPLOYEES (FTE) IN YOUR GROUP. LOCATED AT https://www.healthcare.gov/shop-calculators-fte/ .*

PRIOR CARRIER NAME	RATES

EMPLOYER CONTRIBUTION (FIXED DOLLAR OR %)
EMPLOYEE ONLY ______ EMPLOYEE + SPOUSE ______ EMPLOYEE + CHILD(REN) ______ FAMILY ______

WILL YOUR GROUP ALSO OFFER COVERAGE THROUGH ANOTHER GROUP HEALTH PLAN? YES_____ NO____
IF YES, NAME THE OTHER CARRIER(S):

MHI-NH-LG-APPForm-08012016

MEDICAL INFORMATION *(ADDITIONAL SPACE NEEDED, ATTACH SEPARATE SHEET)*

ARE YOU AWARE OF ANY EMPLOYEES AND/OR DEPENDENTS WHO HAVE INCURRED A CLAIM OF MORE THAN $25,000 IN THE PAST YEAR?
YES_____ NO___ IF YES, PLEASE PROVIDE DETAILS:

ARE YOU AWARE OF ANY EMPLOYEES WHO ARE NOT ACTIVELY AT WORK, DISABLED, OR MEDICALLY CONFINED DUE TO INJURY OR ILLNESS? YES___ NO___ IF YES, PLEASE EXPLAIN THE CONDITION, TREATMENT, AND EXPECTED RETURN TO WORK DATE.

ARE YOU AWARE OF ANY DEPENDENTS WHO ARE DISABLED, OR MEDICALLY CONFINED DUE TO INJURY OR ILLNESS? YES___ NO___
IF YES, PLEASE PROVIDE DETAILS:

MHI PLAN INFORMATION

REQUESTED EFFECTIVE DATE	ANNIVERSARY DATE	NEW HIRE WAITING PERIOD

PLAN NAME:	
☐ MyDoc HMO Premier Basic w/Child dental	☐ MyDoc POS Premier Basic w/Child dental
☐ MyDoc HMO Basic 1000 w/Child dental	☐ MyDoc POS Basic 1000 w/Child dental
☐ MyDoc HMO Premier 2000 w/Child dental	☐ MyDoc POS Premier 2000 w/Child dental
☐ MyDoc HMO Value 2500 w/Child dental	☐ MyDoc POS Value 2500 w/Child dental
☐ MyDoc HMO HSA 3000 w/Child dental	☐ MyDoc POS HSA 3000 w/Child dental
☐ MyDoc HMO HSA 4000 w/Child dental	☐ MyDoc POS HSA 4000 w/Child dental
☐ MyDoc HMO Value 5000 w/Child dental	☐ MyDoc POS Value 5000 w/Child dental
☐ MyDoc HMO HSA 6000 w/Child dental	☐ MyDoc POS HSA 6000 w/Child dental

POLICY TYPE:	RATING TIER:	DOMESTIC PARTNER COVERAGE:
☐ CALENDAR YEAR ☐ PLAN YEAR	☐ 2 TIER ☐ 3 TIER ☐ 4 TIER	☐ YES ☐ NO

EMPLOYER GROUP CERTIFICATION

To the best of my knowledge and belief, the foregoing statements are (1) true and correct and (2) made to induce the issuance of health coverage by Minuteman Health. The group understands that if it has committed fraud or made a misrepresentation of any material fact in conjunction with this application, Minuteman may cancel coverage. I understand and agree that any coverage issued shall be subject to the terms of the Minuteman Employer Agreement. I acknowledge that I have received a copy of the Employer Agreement. I also acknowledge that coverage is not effective until approved by Minuteman, and that the requested effective date may be deferred if the information submitted is incomplete. No alteration of any written application for insurance, by erasure, insertion or otherwise, shall be made by any person other than me without my written consent, and the making of any such alteration without my consent shall be a misdemeanor.

SIGNATURE OF COMPANY OFFICIAL | TITLE | DATE

BROKER OF RECORD ASSIGNMENT

<table>
<tr><td colspan="3">The group designates the broker named below as Broker of Record to obtain and receive information from MHI on the group's behalf and to receive commissions which may become payable upon acceptance of this application by MHI.</td></tr>
<tr><td colspan="2">BROKER NAME</td><td>COMPANY</td></tr>
<tr><td>ADDRESS</td><td>CITY, STATE</td><td>ZIP</td></tr>
</table>

New Business Sales Rep.