Stop loss coverage underwritten by
Rocky Mountain HealthCare Options, Inc. (RMHCO)

OE

Premier Advantage Self-Funded Employer Application For Groups with 5 to 50 Employees

Please complete all information on front and back using black ink only. We cannot process incomplete applications.

Section 1 – Company Information

Company Name				
Phone ( )	Fax ( )	E-Mail		
Physical Address	City	State	Zip	PO Box
Mailing Address	City	State	Zip	PO Box
Contact Person		Title		
President/CEO/Owner (Name)	Federal Tax ID Number (TIN / EIN)			
Proposed Effective Date	Industry or Type of Business	Industry Code (SIC)		

Does the company or owners applying for coverage share ownership in any other business(es)? ☐ Yes ☐ No

If yes, give:

Name of business(es):______________________________

Name of all owners:______________________________

Total number of all employees on payroll who work 24 hours per regular work week for all businesses: ______________________________

Eligible employees must have a regular work week of the required number of hours a week and must satisfy any applicable eligibility waiting period.

Section 2 – Employee Eligibility

1. Number of employees on payroll who work 24 hours or more per week: #	2. Number of employees eligible for health benefits coverage: #
3. Number of employees in Colorado: #_________ Number of employees outside of Colorado: #_________	4. Total number of eligible employees enrolling in group plan: #_________ Total number of eligible employees waiving: #__________
5. Number of full-time or part-time employees who were employed for 20 weeks or more this year or last year: # _________	6. Number of full-time or part-time employees who worked at least 50% of your working days in the preceding calendar year: # _________
7. Are your employees leased from a leasing company or a professional employer organization? ☐ Yes ☐ No	8. Hours Worked Requirement:
9. Waiting Period for New Hires: ☐ Date of hire **OR** First of month following: ☐ Date of hire ☐ 1 Month ☐ 3 Months ☐ 6 Months ☐ 9 Months ☐ Other ______________________________ Does any class have a different waiting period? ☐ Yes ☐ No If yes, please describe:	10. Waiting Period Waived at Initial/ Open Enrollment ☐ Yes ☐ No
11. Employer Contribution Medical (50% minimum of employee) Employee ______________% Family_______________%	12. Classes Excluded (If applicable, please describe.)
13. Number of employees, former employees, or employees' dependents currently covered by or eligible for a Colorado or COBRA continuation of coverage plan: # ______________________________	14. Does group administer its own COBRA? ☐ Yes ☐ No

15. Does your company's eligibility include anyone who is not a company employee; for example, a person who is an independent contractor? ☐ Yes ☐ No

16. Has your group been insured with health insurance during the past 90 days? ☐ Yes ☐ No
If yes, name of current medical carrier:

17. Was coverage through a MEWA? ☐ Yes ☐ No Self-Funded? ☐ Yes ☐ No

18. Will you be or are you offering another group plan in addition to this group plan? ☐ Yes ☐ No
If yes, please provide carrier and effective date:______________________________

Section 3 – Desired Coverage

Select your specific Stop Loss deductible
☐ $15,000 ☐ $20,000 ☐ $25,000

Medical Plan 1: Rx Plan: ☐ Brand ☐ Generic Only

Medical Plan 2: Rx Plan: ☐ Brand ☐ Generic Only

Medical Plan 3: Rx Plan: ☐ Brand ☐ Generic Only

Chiro Plan:

Medical and Rx Plan Options

☐ PA 1000 80/60	☐ $10 Generic only	☐ $10/$35/$50	☐ PA 1500 70/50	☐ $10 Generic only	☐ $10/$35/$50
☐ PA 1000 70/50	☐ $10 Generic only	☐ $10/$35/$50	☐ PA 2000 70/50	☐ $10 Generic only	☐ $10/$35/$50
☐ PA 1500 80/60	☐ $10 Generic only	☐ $10/$35/$50	☐ PA HSA 2650	☐ PA HSA 3250	

I understand that stop loss coverage will not be made effective until all enrollment information given here or is otherwise provided to or obtained by Rocky Mountain HealthCare Options, Inc. (RMHCO), is evaluated and approved by RMHCO. I understand RMHCO has the right to terminate coverage and deny benefits if any information on this enrollment application or as otherwise provided by the undersigned for enrollment purposes is knowingly false, incomplete, or misleading in any material respect.

Any misrepresentation or failure to notify RMHCO of any change in responses between the date of application and the effective date of coverage could result in termination of coverage. Rocky Mountain Health Plans has the right to verify information provided and request additional information if necessary.

The employer hereby applies for participation in the Premier Advantage program including stop loss coverage offered RMHCO and administrative services and network access provided by CNIC Health Solutions, Inc(CNIC). Employer agrees to be bound by all the terms and conditions of Premier Advantage program.

I hereby represent as the employer or the person acting with the authority of the employer, that the information provided in this application is complete and true to the best of my knowledge and belief. The employer fully understands that no coverage under Premier Advantage, including stop loss coverage provided by RMHCO to the employer, will become effective without the approval of RMHCO and that any material falsification or omission may nullify coverage for employees, dependents, and the employee welfare benefit plan (the Plan) itself that I sponsor. It is further understood that no agent has the authority to alter or amend any Premier Advantage agreements, the services and coverages provided under Premier Advantage, or the stop loss policy, to adjust any claim for benefits, or to bind RMHCO and/or CNIC by making any promise or representation.

The coverages applied for provide benefits for an employee welfare benefit plan established and maintained by the employer under the Employee Retirement Income Security Act (ERISA), unless the Plan is specifically exempt from the terms of ERISA. For purposes of this agreement, the employer acknowledges and accepts full and complete responsibility for the operation, administration, and maintenance of this Plan in a prudent and diligent manner in the interests of the Plan participants and beneficiaries, as those terms are defined in ERISA. Unless the Plan is specifically exempted, the employer also agrees to comply with the fiduciary, reporting, and filing requirements of ERISA and to act in accordance with the duties and obligations set forth under ERISA, this agreement and any other applicable state or federal laws or regulations. The employer agrees to be solely responsible for compliance with the laws, including the payment of any required benefits. The Plan is an employee welfare benefit plan established and maintained by the employer under the Employee.

It Is further understood and agreed that: (1) the services and coverages under the Premier Advantage program and the cost of providing those services and coverages may change; (2) rates after the first year will be based on several factors which will include, but will not be limited to, the projected future claims experience of the Plan, except where prohibited by law; (3) those Plan participants and beneficiaries subject to evidence of eligibility must receive prior approval by RMHCO before stop loss coverage becomes effective; (4) participation in the Premier Advantage program may be discontinued or terminated by the employer or by RMHCO under certain circumstances identified in the stop loss policy issued by RMHCO to the employer, the Summary Plan Description and any additional Premier Advantage agreements; (5) only eligible employees of employer and their dependents are allowed to enroll; (6) I agree to the participation rules of the Premier Advantage program and that coverage may be terminated if the percentage falls below the participation requirements; (7) RMHCO and CNIC reserve the right to request a state wage and tax statement or other documentation at any time to verify current and future participation and eligibility; (8) I also understand that the Maximum Claim Liability (as that term is defined in the Premier Advantage agreements) is subject to change until all of the following have occurred:(a) the employer stop loss coverage has been approved by RMHCO; (b) notice of effective date has been furnished by RMHCO; and (c) the first invoiced amount due for services and coverages provided under the Premier Advantage program is paid, (9) and I understand that the failure to pay the monthly invoiced amount in a timely manner will result in termination of Premier Advantage services and coverages. I understand that I must give notice to CNIC within 30 days of any participant employee who ceases working the established eligible hours as defined on this application, including, but not limited to those on paid or unpaid leave, disability, salary continuation or workers' compensation. I understand that a run-out period of 6 months will be offered at time of group termination.

All eligible full-time employees, including those in the new employee waiting/affiliation period, must submit an enrollment form along with completed Medical Information. If additional Employees are hired between the date this application is completed and the date coverage is issued, completed enrollment forms must be submitted within five days of date of hire.

I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish eligibility and participation are met at all times while services and coverages are provided by CNIC and RMHCO (i.e., wage and tax forms, payroll records, business licenses, etc.).

I understand that providing incomplete, inaccurate or untimely information may void or terminate any services or coverages provided under the Premier Advantage program.

By signing below, I certify that I have read the Employer Application, agree to all terms and conditions contained therein and that all information provided is true and accurate.

Agent certification

I certify that all of the information contained in the Employer Application and any attached papers is correct to the best of my knowledge. I know nothing contrary about this firm or any individual proposed for coverage. I have submitted this employer for services and coverages consistent with all of the underwriting rules of the Premier Advantage program and have explained the services and coverages fully.

Employer/Authorized Signature:	Title:	Date:
Broker Signature:	Name of Agency:	