

SECTION C. ENROLLMENT INFORMATION

1. Requested Effective Date:(mmddyyyy) 2. Employer's Contribution will be _____ of the single employee premium, and _____ of the dependent coverage premium.

3. What is the Probationary Period for New Hires?
 Salaried Employees: 1st of the month following _____ day(s) of employment.
 Hourly Employees: 1st of the month following _____ day(s) of employment.

4. Employer groups must select whether continuation or COBRA benefits will be available to employees who lose eligibility under the group policy. Please select one of the following options:
 COBRA 12 Months of continuation (this option only for groups not eligible for COBRA)

5. Has this Employer ever been covered by an Optima Plan before? Yes No
 If yes, dates of coverage: (mmddyyyy)

6. Total number of active full and part-time employees as defined in Section E:

7. Total number of eligible employees as defined in Section E:

8. Total number of eligible employees waiving group health insurance:

9. Total number of eligible employees applying for group health insurance:

10. Are any of the employees or dependents applying for group health insurance totally disabled? Yes No
 If yes, please explain:
 Name: _____ Age: _____ Date of Disability: (mmddyyyy)
 Name: _____ Age: _____ Date of Disability: (mmddyyyy)

11. Are all eligible employees covered by Worker's Compensation? Yes No

12. Who is your company currently insured by? No Current Carrier
 Years with this carrier:

13. Under the Medicare Secondary Payer rules, which one applies for your group?
 Medicare is primary (less than 20 full time and part time employees) Optima Health is primary (20 or more full time and part time employees)
 Optima Health is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

SECTION D. EMPLOYER AGENT BROKER DESIGNATION (IF APPLICABLE)

The Employer authorizes the following agent(s)/broker(s) or agency(s) to be the Employer's Agent of Record:

Name of Agent/Broker:	Telephone Number:
Name of Agency:	Telephone Number:
Address:	Fax Number:

I as the Agent of record represent that all information contained above is complete and wholly true to the best of my knowledge, and that I know nothing unfavorable about the firm or any individual proposed for insurance except as noted on their Enrollment Application. I have complied with all all applicable eligibility and enrollment rules and have explained in detail the coverages. Any exceptions are detailed here or are referenced to on an additional sheet.

SIGNATURE OF AGENT/BROKER	VENDOR NUMBER	DATE SIGNED (mmddyyyy)
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SECTION E. EMPLOYEE ELIGIBILITY	SECTION F. EMPLOYER ELIGIBILITY
<p>An eligible employee is one of the following persons who is determined to be eligible for coverage under this contract by the Employer, subject to acceptance by the plan:</p> <ol style="list-style-type: none"> 1. A Full-time employee (at least 17 years of age) of the Employer who works at least 25 hours per week as of the effective date and who works 50 weeks or more per year. 2. An employee who enters into full-time employment after the policy's effective date and who completes the required probationary (waiting) period for eligibility. 3. An employee who is employed and at the Employer's usual place of business. Full-time sales personnel with a primary source of income from the Employer are eligible. 4. An employee who receives a regular paycheck wherein the Employer deducts social security and/or state and federal income taxes. 5. Partners and owners are eligible only if they are bona fide employees of the organization whose main job is to conduct business for the Employer and they meet all other employee eligibility requirements. 	<p>The Employer certifies that the information on this form is correct to the best of his/her knowledge. The employer further agrees to submit to the following requirements with the application and as may be necessary in the future:</p> <ol style="list-style-type: none"> 1. The Employer is a corporation, partnership or proprietorship. 2. That the Employer is financially stable and has a minimum of two (2) participating employees. 3. That a payroll deduction system for employee contribution, if any, is in place. 4. That the Employer understands Optima Health requires a minimum contribution with groups of 51 or more total employees. 5. That no other group health policy shall be in force. 6. That the employer will permit any eligible employee (as defined in Section E) to enroll. 7. That the Employer's organization was not formed for the sole purpose of obtaining insurance coverage. 8. That the Employer will assist the plan in obtaining a signed statement from the employee or dependents indicating coverage by any other insurance company for coordination of benefits purposes only. 9. That the Employer will permit an audit by Optima to verify compliance with all policies, procedures and eligibility requirements as defined by the Plan.

SECTION G. FOR CLIENTS ENROLLING IN AN OPTIMA EQUITY HSA PLAN:

The Employer acknowledges that Optima Equity is an integrated product providing individual subscribers with the option to select Optima's partner Health Equity to administer a Health Savings Account (HSA) for them. As the sponsor of this benefit plan the Employer will do the following:

1. Enable employees who establish an HSA with Health Equity to make contributions to this account via payroll deduction.
2. Direct employer HSA contributions, if any are to be made, to employee accounts at Health Equity.

SECTION H. NON-PAYMENT OF PREMIUMS AND FUTURE COVERAGE

Your group coverage premiums must be paid in full on time in order for coverage to remain in effect. In accordance with the Plan's Grace Period provisions Your group plan will be cancelled for non-payment of premiums. If You later decide to apply for enrollment in another Optima plan, before the new coverage will start, we will require that you pay all past due premium owed to us for coverage during the twelve month period prior to the effective date of the new coverage. You will also have to pay any applicable initial binder payments for your new coverage.

SECTION I. EMPLOYER CERTIFICATION

I represent that all information noted on this Employer Group Application and all Employee Applications / Health Questionnaires is true and accurate to the best of my knowledge. I hereby confirm that all Employer and Employee eligibility guidelines have been met and will continue through the contract. I understand that non-payment of premiums may result in a termination of coverage for all parties. I also understand that the proposed insurance coverage shall not become effective until approved by the plan.

PLEASE PRINT NAME	TITLE
AUTHORIZED SIGNATURE	DATE SIGNED (mmdyyy)

To be completed by Primary Agent or Broker (if splitting commissions)		
Primary Agent: %	Secondary Agent Name:	2nd Agent: %

Primary Agent Signature:

Optima Health Alternative Language Options for Notices and other Written Information

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:

ማሳሰቢያ:

አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:

إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجاناً. اتصل بالرقم 1-855-687-6260.

Bengali/Bangla:

লক্ষ্য করবেন: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন- 1-855-687-6260।

Chinese (Mandarin):

注意: 如果您讲中文普通话, 可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:

ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:

ધ્યાન આપો : જો તમે ગુજરાતી બોલી છે તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કોલ કરો.

Hindi:

ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:

CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:

GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:

重要: 日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:

주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.

Kru/Bassa:

YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha l nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນຳໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:

កំណត់សំគាល់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:

SHOOH: Diné Bizaad bee yáníłti'go doo báááh ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'á. Kojí' hólne' 1-855-687-6260.

Persian/Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:

ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:

ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:

ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:

DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 numaralı telefonu arayın.

Urdu:

توجه دیں: اگر آپ اردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:

CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:

KÉÉRE:

Ti o bá ń sọ èdè Yorùbá, isẹ̀ ìrànlọ́wọ́ èdè wà fún ọ lófẹ̀ẹ́. Pe 1-855-687-6260