

Patriot Health Insurance Company, Inc.
Employer Application & Agreement for Group Insurance



Section 1 -- FOR INTERNAL USE

Group No.	Active Div. No.	Plan No.	COBRA Div. No.
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Section 2 -- TO BE COMPLETED BY BROKER OR EMPLOYER

<input type="checkbox"/> New Group <input type="checkbox"/> Rate Change <input type="checkbox"/> Renewing Group <input type="checkbox"/> Benefit Change	<table style="width:100%;"> <tr> <td><input type="checkbox"/> Signature Plus Plan</td> <td><input type="checkbox"/> 1200/2400</td> <td><input type="checkbox"/> 2500/5000</td> <td><input type="checkbox"/> 5000/10,000</td> </tr> <tr> <td><input type="checkbox"/> Signature Plan</td> <td><input type="checkbox"/> 1200/2400</td> <td><input type="checkbox"/> 2500/5000</td> <td><input type="checkbox"/> 5000/10,000</td> </tr> <tr> <td><input type="checkbox"/> Traditional Plan</td> <td><input type="checkbox"/> 250/500</td> <td><input type="checkbox"/> 500/1000</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Standard Plan</td> <td><input type="checkbox"/> 500/1000</td> <td><input type="checkbox"/> 1000/2000</td> <td></td> </tr> </table>	<input type="checkbox"/> Signature Plus Plan	<input type="checkbox"/> 1200/2400	<input type="checkbox"/> 2500/5000	<input type="checkbox"/> 5000/10,000	<input type="checkbox"/> Signature Plan	<input type="checkbox"/> 1200/2400	<input type="checkbox"/> 2500/5000	<input type="checkbox"/> 5000/10,000	<input type="checkbox"/> Traditional Plan	<input type="checkbox"/> 250/500	<input type="checkbox"/> 500/1000		<input type="checkbox"/> Standard Plan	<input type="checkbox"/> 500/1000	<input type="checkbox"/> 1000/2000	
<input type="checkbox"/> Signature Plus Plan	<input type="checkbox"/> 1200/2400	<input type="checkbox"/> 2500/5000	<input type="checkbox"/> 5000/10,000														
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<input type="checkbox"/> Standard Plan	<input type="checkbox"/> 500/1000	<input type="checkbox"/> 1000/2000															

For groups with effective dates of 10/1 or 11/1:
 4th quarter carry-over option?

Employer Name	Effective Date / /	Renewal Month
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Street Address (Mailing Address)	City	State	Zip Code
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Phone Number	Fax Number	Tax ID Number	Date Business Established / /
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Employer Contact (Name & Title)	Contact Phone No. () -	Contact e-mail address:
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SIC	Nature of Business
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Is your company, or are any of your employees covered by a collective bargaining agreement? Yes No

Is your company a: sole proprietor partnership or LLC corporation

Are you a Subsidiary of a Larger Company? Yes No

If you are a Subsidiary, Which Company? _____

Does your company have additional Subsidiaries not included for the purposes of this Application? Yes No

If you have additional Subsidiaries, please list: _____

New Hire Policy (probationary period): 1 Month 2 Months 3 Months Other (describe below): _____

Rehire Policy:	Do you plan to offer coverage to domestic partners? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please select applicable eligibility type <input type="checkbox"/> Same Sex <input type="checkbox"/> Opposite Sex
Termination Policy: 1st day of the month after date of termination		

Employer Contribution Towards Health Premium:	Employee	Dependent(s)
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Workers Compensation Carrier

Billing Level Group Division Plan

Proposal Offering Scenario: Total Replacement

Offered with another Carrier Name of Other Carrier: _____

Other Products Offered along side Patriot Healthcare: _____

Please indicate the number of employees in your group in each of the following classifications as of today's date:

	Total # of employees	Benefit Eligible	Enrolled on Current Plan	Enrolled on Spouse's Plan	Not Eligible	Refused Coverage	COBRA Participants	TOTAL
Permanent Full Time (over 30 hours)								
Permanent Part Time (15 to 30 hours)								
Permanent Part Time (less than 15 hours)								
Temporary or Seasonal								
Retired								
Other (eg: State or Federal Contractors)								
TOTAL								

Monthly Premium Rates for the period beginning _____		through _____			
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family	
<input type="checkbox"/> Signature I*	\$	\$	\$	\$	
<input type="checkbox"/> Signature II*					
<input type="checkbox"/> Signature III*					
<input type="checkbox"/> Traditional I	\$	\$	\$	\$	
<input type="checkbox"/> Traditional II					

These rates are effective for the period described above.

Is Your Company Subject to COBRA? Yes No

COBRA administration is provided by Employee Benefit Plan Administration (EBPA) as a service to Patriot customers. If you **do not** want EBPA to provide COBRA administration services, please indicate your decision below. If you are not subject to COBRA, EBPA will administer the 39 week extension.

I DO want EBPA to provide COBRA administration services

I DO NOT want EBPA to provide COBRA administration services

Section 3 -- TO BE COMPLETED FOR GROUPS USING BROKER

Agency Name and Address	Agency Phone	Agency Fax
Broker Name	Broker Number:	

Section 4 - TERMS AND CONDITIONS

Coverage Provided: Patriot will provide group health coverage to eligible Members under the terms and conditions set out in the Member Certificate.

Premium: Monthly premium is due in advance from the Employer no later than the first of the month. The amount invoiced by Patriot shall reflect Membership as of the first day of the month the invoice is sent. The Employer shall pay the invoiced amount even if Membership changes have occurred. Each month, premium shall be adjusted to reflect membership changes that occurred in the preceding month.

Premium shall be paid by automatic electronic funds transfer unless another arrangement is agreed to in advance by Patriot. If payment is not received prior to the first of the month, claims will be pended for up to 31 days beginning on the first of the month. On the 10th day of the month, Patriot will provide written notice of cancellation to Members effective on the 31st day following the first of the month. If payment is not received prior to the 31st day, coverage will be terminated retroactively effective back to the first day of the month. If payment is received prior to the 31st day, Patriot will notify Members of the reinstatement of coverage.

The rates quoted by Patriot shall remain in effect until the Anniversary Date, except that such rates may be increased by Patriot with at least 30 days notice to the Employer in the following cases: (i) the Employer and Patriot agree to a benefit change; (ii) there is a change in the law effecting Patriot's cost of providing coverage, including, but not limited to the addition of mandatory benefits or the imposition of a new tax or surcharge effective prior to the Employer's Anniversary Date.

Patriot shall provide Employer with a premium quote at least 30 days prior to the Anniversary date.

Employer's Termination Right: Employer has the right to terminate coverage under this Agreement with 30 days prior written notice to Patriot.

Employer's Participation in Member Education: The Employer agrees to participate in Patriot's member education by permitting employees to attend meetings and/or access Patriot's website from work at reasonable times as agreed in advance by Patriot and the Employer.

I represent that all information contained in this application for group insurance is complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

I acknowledge that the broker named above is the company's Broker of Record.

Section 5 - SIGNATURE

Employer Signature _____	Patriot Healthcare _____
Print Name _____	Print Name _____
Title _____	Title _____
Date _____	Date _____

*Same health rates apply to Signature Plus plans **Please complete and sign the attached Delta Dental contract if applicable**