HSA healthplan

HSA Health Insurance Company
PO Box 709718
Sandy, UT 84070-9718
www.hsahealthplan.com

HSA Health Plan: Group Application

Group Legal Name____

Effective Date: ________________ Length of contract ______ months

Mailing Address ____

City____ State: __________ Zip:_____________

Employer Tax ID#_______________________

Company Type (LLC, C Corp, S Corp, etc.) ______________________

List all DBAs or other names used: ______________________________________

Total # employees: __________

# of retired employees: ________

# of employees enrolling: _______

# of employees waiving due to other coverage: _____

# of eligible employees: _______

# of employees waiving without other coverage: _____

# of ineligible employees: _______

# of employees currently in a new hire waiting period: _____

# of employees on COBRA: ________

Previous Insurance

Insurance Carrier Name: ____

Other Insurance

Dental Carrier Name:________________________________ Phone Number: ____________________

Vision Carrier Name:________________________________ Phone Number: ____________________

Health Savings Account

Who is administering your Health Savings Account? _____________________________________

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Group Contact Information

Contact 1
Name: ______________________________________ Title: ___________________________

Phone Number: ________________________ Email: ____________________________________

Contact 2
Name: ______________________________________ Title: ___________________________

Phone Number: ________________________ Email: ____________________________________

Employer HSA Contributions: Please explain any employer HSA contributions:

____

____

Benefit Year

❒ Plan Year ❒ Calendar Year

Eligible Employees
To be eligible, employees must work at least _____ hours per week. (Must not exceed 30 hours per week.)

Is your company currently enrolling Domestic Partners?_________________
Does your company want to change the eligibility for these individuals?____

Newly Eligible Employees
The Employer Waiting Period is:

❒ First of the month following: ❒ 30 days ❒ 60 days ❒ Date of hire
❒ Date of hire
❒ Other (please explain):______________________
(Note that waiting period cannot be such that it can exceed 90 days)

Employer Monthly Contribution
Employer must contribute an amount equivalent to at least 50% of the single coverage premium.

Single	$__________	or	________%
Employee + Spouse	$__________	or	________%
Employee + Child	$__________	or	________%
Employee + Children	$__________	or	________%
Family	$__________	or	________%

Leave of Absence
Eligible employees are granted a leave of absence by the Employer for up to 60 days. Leave time can only be accrued and used by the employee using the leave time. Leave Banks, where employees share or purchase leave time from other employees, are not allowed.

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Additional Terms

Coverage is made on the basis of information provided to HSA Health Insurance Company by the Employer and its employees and is subject to the above criteria as well as properly completed employee applications. Employer understands that this application is relied upon in making decisions about coverage and payment. Employee applications must be submitted to and approved by HSA Health Insurance Company before the proposed effective date.

This Group Application, as part of the Master Group Policy, must be signed by Employer and received by HSA Health Insurance Company before the Contract can be finalized.

Employer understands and agrees that any coverage provided will be limited according to the terms of this Group Application, and the Master Group Policy including the Outline(s) of Coverage.

This Group Application is attached to and made a part of the Master Group Policy. It cancels and replaces all other applications, if any, attached to the Master Group Policy. This Application will be void if not signed and returned to the Company prior to the effective date.

Company Name: ____

Company representative: ____

Signature:____Date: ___________________

Phone Number:____Email: ___________________

Broker Contact Information

Name:_____________________________________ Agency:___________________________

Phone Number: _________________________ Email: __________________________________