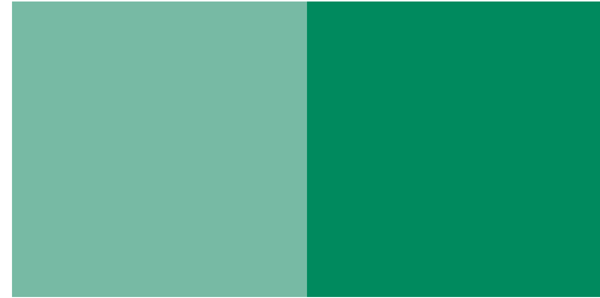
2-50



PriorityHMO℠
PriorityPOS℠
PriorityPPO℠

New Group Application

1-50 Eligible Employees

PriorityHealth®

This comprehensive health care plan is available to small businesses. Key advantages include:

- **No Medical Underwriting.** Coverage is guaranteed issue.
- **No Pre-Existing Condition Limitations.** Employees are covered even if they currently have health concerns or conditions.
- **Flexible Benefit Designs.** Variety of plans with various office visit and prescription copayments designed to meet the needs of you and your employees.
- **Access to Priority Health's Large Network of Qualified Providers.** Employees can access primary and specialty care providers near home or work.
- **Quality Health Care Plan.** Priority Health has received full accreditation from the National Committee for Quality Assurance (NCQA)
- **Valuable Online Resources.** Once registered, employees and their dependents can access claims data and other healthy living resource tools. In addition, employers can access billing and enrollment tools.

All of the information you need to apply for this plan is right here.

Use this checklist to expedite the processing of your submission.

- ☐ New Group Application 2-50 – All pages
- ☐ Enrollment Form for all enrolling employees
- ☐ Copy of Class Schedule for any dependent age 19-25
- ☐ Employee Waiver Form 2-50 for all eligible employees waiving coverage
- ☐ Check for 1st Month's Premium
- ☐ Required Proof Documentation as outlined on Page 3 of New Group Application
- ☐ Proof of member COBRA eligibility if COBRA enrollment
- ☐ Copy of Sold Proposal and Census from Rate Generator; Please make sure that census and enrollment forms match.
- ☐ Mail all materials to Priority Health by the 1st of the month before you would like your coverage to start.

  Priority Health
  PO Box 269
  MS 1380
  Grand Rapids, MI 49501-0269
- ☐ New Group Exception Letter if completed application submitted after 10th of month preceding effective date.

Priority Health will send an acceptance letter to the group and agent upon approval. Rates are based on final enrollment.

It's that easy.

If you have questions or need additional information, please call your independent insurance agent or the Priority Health Small Business Department at 616 942-1820 or 800 471-2504.

Group Eligibility Requirements

Group Size (check one)	Participation Requirements
☐ 2-10 eligible employees	1. 100% of eligible employees seeking coverage must enroll with Priority Health. 2. Retirees are eligible if they make up less than 20% of employees seeking coverage with Priority Health. *Those eligible for Medicare must enroll in Medicare Parts A & B.
☐ 11-25 eligible employees	1. 75% of eligible employees seeking coverage must enroll with Priority Health. 2. Retirees are eligible if they make up less than 20% of employees seeking coverage with Priority Health. *Those eligible for Medicare must enroll in Medicare Parts A & B.
☐ 26-50 eligible employees	1. 50% of eligible employees seeking coverage must enroll with Priority Health. 2. Retirees are eligible if they make up less than 20% of employees seeking coverage with Priority Health. *Those eligible for Medicare must enroll in Medicare Parts A & B. 3. Group can offer more than one health plan, unless they select **Priority**POS or **Priority**PPO. **Priority**HMO high/low option may be offered. Minimum requirement of 10 enrolled contracts in each benefit level unless one of the plans is an HSA. There is a minimum requirement of 2 enrolled contracts in an HSA. At renewal, segments may be terminated if participation requirements are not met. *Prescription drugs must be offered to all segments, or prescription drugs must be excluded from all segments.
☐ Available to all groups of 2-50 eligible employees	■ **Priority**POS ☐ May only be sold as a total replacement. ☐ No more than 10% of enrolled employees can reside and work out of the service area. ■ **Priority**PPO ☐ May only be sold as a total replacement if offered for both out-of-area and in-area. ☐ At least 50% of the enrolled employees must reside in the Priority Health service area. ☐ Groups with two - 50 eligible employees seeking coverage may offer the PPO product for out-of-area employees along side a Priority Health HMO or POS product for in-area employees. The in-area and out-of-area benefits should match closely. ☐ Only one Priority Health PPO option can be offered to groups having two - 50 eligible employees seeking coverage.

*See Enrollment Requirements for additional information on Medicare eligibility.

Business Proof Requirements

All groups

- Most recently filed quarterly wage detail report (MESC 1017)
- Employee waiver forms where applicable

Groups with only 2 eligible employees
Required proof documentation

☐ **Partnership**	1. Copy of Schedule 1065 and 2. Copy of Federal Tax I.D. and the IRS Verification Form, or Partnership Papers
☐ **Corporation**	1. Copy of Schedule 1120 (Sub S - Schedule 1120s) and 2. Copy of any federal document with Federal I.D. number, or Articles of Incorporation
☐ **Farmer**	Copy of Schedule F
☐ **Limited liability company**	1. Copy of Schedule 1065 and 2. Copy of Articles of Organization
☐ **Non-profit corporation**	1. If Sole Proprietor - Schedule C and State License or Certification 2. Non Sole Proprietor - Copy of Federal Tax I.D. including the IRS Verification Form and State License or Certification and copy of applicable tax filing for entity

Enrollment Requirements

1. The group must be of a permanent nature and financially stable.
2. The group must have been formed for a purpose other than to secure group insurance.
3. Eligible employees shall include ALL active employees who work a minimum of 17.5 hours per week.
4. Seasonal employees (those working less than 36 weeks per year), are not eligible. Directors, corporate officers, trustees, corporate lawyers, elected officials, and owners or partners are not eligible unless they are full-time employees.
5. The group must carry Worker's Compensation coverage unless not required by law.
6. The group must be a member of an organization recognized by Priority Health or any Chamber of Commerce in the Priority Health service area (See Group Application, page 5).
7. Priority Health will not co-exist with an employer sponsored individual plan if it violates Group Eligibility Requirements outlined above.
8. Members who are eligible for Medicare (or any governmental benefits), will be treated as if they are enrolled in Medicare parts A & B when Priority Health benefits are applied whether or not they are actually enrolled.
9. Group must meet Premium Contribution Guidelines as outlined on Page 10 for all actively enrolled employees or those in a Retiree or Early Retiree Classification.

Application

P.O.Box 269
MS 1380
Grand Rapids, MI 49501-0269

Small Business Dept: 616 942-1820
800 471-2504
Fax: 616 957-2529

What month would you like this health coverage to start? (effective date) ____________________

Employer Information (please print)

Employer (legal name): ____________________

Mailing address: ____________________ Billing address: ____________________

____________________ ____________________

Phone: ____________________ Fax: ____________________

Email (required) ____________________

Administrative contact/title ____________________

Billing contact/title ____________________

Chief Executive Officer or decision maker ____________________

Business Information

Priority Health reserves the right to request additional information for verification from the group regarding business activities and proper SIC code placement. Final SIC code determinations will be made by Priority Health. Priority Health reserves the right to re-rate at any time if discrepancies are found.

SIC Code: ____________________

Type of business: ____________________

Insurance Information

Has your business ever had coverage with Priority Health? ____________________

☐ Yes - If yes, date of coverage and group number: ____________________ ☐ No

Who is your most recent health insurer? ____________________

Workers' compensation carrier: ____________________

Policy number: ____________________ Federal Tax ID number: ____________________

Organizations recognized by Priority Health

At this time Priority Health does not require employer groups to select Chamber/Association affiliations. In the future this will be a requirement. More information to come in the future regarding Chamber/Association affiliations.

Benefit Design: 2-50 Eligible Employees

If electing consumer engaged products (CEH) — HSA, HRA or HealthbyChoice Incentives — skip to Section 5.

1. Choose your base plan.

PriorityHMO:	**Priority**POS:	**Priority**PPO:	Select PPO Network:
□ 100%	□ 100/70%	□ 100/70%	□ **Priority**PPO
□ 80/20%	□ 80/60%	□ 80/60%	□ Other: ______________________

Choose your deductible.

□ None	□ $250 individual/$500 family	□ $500 individual/$1,000 family
□ $1,000 individual/$2,000 family	□ $2,000 individual/$4,000 family	□ $3,000 individual/$6,000 family

2. Choose your standard office visit copay.

□ $15 Copay □ $20 Copay □ $30 Copay

□ Copay Alignment Benefits (check one below)

PCP	Specialist	Urgent care	ER	Advanced Diagnostic imaging
□ $15 Copay	$30 Copay	$45 Copay	$100 Copay	$150 Copay
□ $20 Copay	$35 Copay	$50 Copay	$100 Copay	$150 Copay
□ $30 Copay	$45 Copay	$60 Copay	$100 Copay	$150 Copay

3. Choose your ER copay.

□ $50 copay □ $100 copay (required for Copay Alignment plans)

4. Choose your ambulance copay.

□ $50 copay □ $100 copay

5. Choose your prescription drug copay and prescription deductible.

Prescription drug copay	□ No outpatient prescription drug benefit (Groups opting not to carry prescription drug coverage must wait 24 months prior to offering drug benefits to their employees.)		
	□ $15 copay	□ $20 copay	□ $25 copay
	□ $15 generic only	□ $10 generic/$30 brand name	□ $10 generic/$40 brand name
	□ $15 generic/$25 brand name	□ $15 generic/50% brand name (up to $1,000 per contract year)	□ $15 generic/$50 brand name
Rx deductible	□ No Rx deductible	□ $100 individual/$200 family	□ $200 individual/$400 family
Contraceptive medications	□ Yes	□ No	

HealthbyChoice Incentives[SM]

The following are guidelines for fully funded **Health**byChoice (HbC) groups with 2-50 eligible employees. The fully funded HbC product follows all other guidelines including these additional requirements:

- HbC is offered as a total replacement product. Priority Health will not co-exist with another Priority Health plan or any other carrier.
- This product can not be wrapped with any third party administrator (TPA).
- Only one Priority Health HbC option can be offered to groups with 2-50 eligible employees seeking coverage.
- If contraceptive medication is offered, it must be offered on both choice and standard benefit designs or neither design.
- Medicare retirees will be offered the Priority Health MAPD program only.

For more information, please contact the Small Business Department at 616 942-1820 or 800 471-2504.

PriorityCEH[SM] Products: 2-50 Eligible Employees

Product	Item	Options
☐ **Health**byChoice Incentives		Includes $10 generic/$40 brand name prescription copay
	Plan type (choose one)	☐ **Health**byChoice Incentives HMO #1 ☐ **Health**byChoice Incentives HMO #2 ☐ **Health**byChoice Incentives HMO #3 ☐ **Health**byChoice Incentives HMO #4 ☐ **Health**byChoice Incentives PPO #1 ☐ **Health**byChoice Incentives PPO #2 ☐ **Health**byChoice Incentives PPO #3 ☐ **Health**byChoice Incentives PPO #4
	Contraceptives	☐ Yes ☐ No
☐ **Priority**HSA		Bank Name: ______________________ *If using Mellon Bank, please complete Discovery document.
	Plan type (choose one)	**Priority**HMO ☐ 100% ☐ 80% **Priority**POS ☐ 100/70% ☐ 80/60% **Priority**PPO ☐ 100/70% ☐ 80/60%
	Deductible	☐ $1,100 individual/$2,200 family ☐ $3,000 individual/$6,000 family ☐ $2,000 individual/$4,000 family
	Prescription coverage	☐ No prescription coverage ☐ $10 generic/$40 brand name after deductible
	Contraceptives	☐ Yes ☐ No
☐ **Priority**HRA		The employer group must complete an HRA application in addition to the new group application.
	Plan type (choose one)	**Priority**HMO ☐ 80% **Priority**POS ☐ 80/60% **Priority**PPO ☐ 100/70% ☐ 80/60%
	Office visit	Standard office visit copay ☐ $15 copay ☐ $20 copay ☐ $30 copay Copay Alignment benefits (check one) — see table below
	Deductible	☐ $1,000 individual/$2,000 family ☐ $3,000 individual/$6,000 family ☐ $2,000 individual/$4,000 family
	ER copay	☐ $50 copay ☐ $100 copay (required for Copay Alignment plans)
	Ambulance	☐ $50 copay ☐ $100 copay
	Prescription coverage	☐ No outpatient prescription drug benefit (Groups opting not to carry prescription drug coverage must wait 24 months prior to offering drug benefits to their employees.) ☐ $15 copay ☐ $20 copay ☐ $25 copay ☐ $15 generic only ☐ $10 generic/$30 brand name ☐ $10 generic/$40 brand name ☐ $15 generic/$25 brand name ☐ $15 generic /$50 brand name ☐ $15 generic/50% brand name (up to $1,000 per contract year)
	Contraceptives	☐ Yes ☐ No
	Rx deductible	☐ None ☐ $100 individual/$200 family ☐ $200 individual/$400 family

Copay Alignment benefits (check one)

PCP	Specialist	Urgent	ER	Advanced Diagnostic imaging
☐ $15 Copay	$30 Copay	$45 Copay	$100 Copay	$150 Copay
☐ $20 Copay	$35 Copay	$50 Copay	$100 Copay	$150 Copay
☐ $30 Copay	$45 Copay	$60 Copay	$100 Copay	$150 Copay

Group Roster: Other Coverage Information

Is Priority Health the sole carrier? ☐ Yes ☐ No

If no, please provide the name of the other carrier: ______________________________

Is the employer self-funding (reimbursing the member for) any or all of the medical or Rx deductible? ☐ Yes ☐ No

List of all employees (for group size 26+, please attach additional roster)

Employee Name	Average hours worked per week	Eligible for health benefits?	Waiving all employer-sponsored coverage?	Enrolling with Priority Health?	Enrolling with another carrier?
1. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
16. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
17. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
18. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
19. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
20. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
21. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
22. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
23. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
24. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
25. ____________	________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Total number of employees: ____________ Total number of eligible employees: ____________

Total number of eligible employees outside Priority Health's network area: ____________

Total number of eligible employees enrolling with Priority Health: ____________

Total number of eligible employees enrolling with another carrier: ____________

Total number of eligible employees waiving all employer offered coverage (please attach waiver forms): ____________

GROUP NAME | EMPLOYER SIGNATURE | DATE

Employee Information: Eligibility

How many hours must employees work to be considered eligible for health benefits?

☐ 40 hours per week ☐ Other:____ hours (cannot be less than 17.5)

All employers who had 20 or more employees on 50% of its typical business days during the preceding calendar year must comply with COBRA. Qualified beneficiaries, as defined by COBRA, are eligible for coverage unless in an excluded class, i.e. retiree, part-time and temporary employees.

Is your company eligible for COBRA? ☐ Yes ☐ No

Would you like an Infinisource packet? ☐ Yes ☐ No

*Retirees are eligible if they make up less than 20% of employees seeking coverage with Priority Health.

Are retirees over age 65 covered? (members must have Medicare Parts A and B) ☐ Yes ☐ No

Are retirees under age 65 covered? ☐ Yes ☐ No

1. Newly hired employee waiting period

Please select from one of the following two options.

☐ Date of Hire	☐ 30 days		☐ First of the month following_____ days
☐ 60 days	☐ 90 days	**or**	
☐ Other:_____ days			

2. Terminated Employee Policy

Employees whose employment has been terminated will be covered until:

☐ Date of termination

☐ End of month in which employment terminatees

3. Extension of coverage after Layoff Policy*

☐ Last day of employment ☐ End of month ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 months

4. Disabled Employee Policy

☐ Last day of employment ☐ End of month ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 months

*Group may offer an extension of coverage for employee(s) on temporary lay off or short-term disability provided said extension of coverage is documented in the Group's written employee handbook and applies uniformly to all employees. If Layoff or Disability policy is not indicated, the default provision will be based on the Terminated Employee Policy.

Employer Contribution Levels (percentage or dollar amount)

The employer must contribute at least 75% of the single rate **or** at least 50% of the total premium.

	Single	Double	Family
Employer pays	________	________	________
Employee pays	________	________	________

Check calculation. Final rates are based on final enrollment.

	Monthly rate		Number of covered employees		
Single	__________	X	__________	=	$ ________
Double	__________	X	__________	=	$ ________
Family	__________	X	__________	=	$ ________
				Total	$ ________

Agent Information

Agent name: ____________________

Contact name: ____________________

Agency name: ____________________

Mailing address: ____________________

____

Phone: ____________________ Fax: ____________________

Federal Tax I.D. number: ____________________ Email: ____________________

Group Certification

- I hereby certify that all information completed on this Small Group Application and Agreement is true and complete to the best of my knowledge and that Priority Health will rely on these statements and this information as a basis for approving this application and administering benefits according to the Certificate of Coverage.
- I understand my Independent Agent has no right to bind coverage, alter terms of the contracts or application in any manner, or to adjust any claim for benefits under the contracts.
- I understand that mid-year benefit changes are not permitted.
- We will not cancel our current health coverage until Priority Health has advised that coverage applied for has been approved.
- Final rates will be based on final enrollment as of the effective date of coverage.
- If this application is approved, I agree to be bound by all terms and conditions of the documents I submit in connection herewith, as well as the agreement between Priority Health and my Sponsor Organization.
- I understand that I must maintain membership to one of the recognized organizations or any Chamber of Commerce in the Priority Health service area to maintain eligibility for this plan.
- Priority Health reserves the right to change SIC code designations for your account. Any changes in SIC code designations that result in premium adjustments will be initiated within 30 days notice to the group. No retroactive changes will be issued as either positive or negative rate credits.
- I understand that the group may terminate this Agreement, without cause, at the end of any month by giving Health Plan 30 days advance written notice of termination.

____
SIGNATURE OF COMPANY OFFICER TITLE DATE

____
SIGNATURE OF AGENT TITLE DATE

____
PRIORITY HEALTH REPRESENTATIVE TITLE DATE

Automatic Bill Payment Plan

Groups with only one eligible employee must sign up for electronic funds transfer for monthly premiums.

Priority Health has an electronic fund transfer process for collecting monthly health insurance premiums. On the first day of every month, the checking or savings account that you designate below will be automatically debited for the amount on your billing statement. You will receive your premium billing statement each month approximately 10 days prior to the deduction occurring from your account.

Priority Health must be notified of any changes to your designated account at least 5 business days prior to the last day of the month.

You will receive a letter in the mail confirming your request for automatic monthly deductions from the account you specified. This letter will also notify you in advance of the first date that your premium payment deduction will occur.

If you have additional questions on the automatic bill payment plan, please call Small Business at 800 471-2504.

Group Automatic Bill Payment Plan Enrollment Form

I authorize Priority Health to deduct the premium payment from the checking or savings account listed below. I understand the deduction will occur on the 1st of every month, and if at any time I decide to discontinue this payment service, I will notify Priority Health in writing 30 days before discontinuing.

Company name: ______________________________

Group I.D. number: ______________________________

Billing address: ______________________________

____

Mailing address (if different): ______________________________

____

Contact person: ______________________________ Phone: ______________

To ensure the correct account number is used for this electronic payment and to obtain the ABA/routing number, please contact your financial institution.

Name of financial institution: ______________________________

ABA/routing number (Nine digits on bottom of check): __ __ __ __ - __ __ __ __ - __

Checking or savings account number: ______________________________

There will be a $50 charge for any transferes returned insufficient. Please attach a voided check for the account from which you would like premiums automatically deducted. **Insured party must be on account.** If the premium withdrawal is from a savings account, you must attach a letter from your financial institution verifying account information. **Deposit slips are not accepted.**

Authorized signature*: ______________________ Date: ______________

*I understand I must be authorized by the company to sign this form on its behalf.

Print name: ______________________________

For Internal Use Only

Group name: ______________________________

Effective date: ______________________________

Group number: ____________________ Industry class ____________________

Subgroup number: ____________________ Commission Arrangement I.D.: ____________________

Binder Check: ____________________ ☐ Jackson: ☐ New group ☐ Renewal

☐ Main class ☐ Detroit: ☐ New group

☐ Hourly class

☐ Retiree class

☐ COBRA class

☐ Salary class

☐ Early retiree class

Finance:

1. ____________________

2. ____________________

☐ PPO: network* = ____________________ (*required information)

Group services: ____________________ Date ____________________

Billing: ____________________ Date ____________________

Finance: ____________________ Date ____________________

Copyright © Priority Health