



REQUEST FOR GROUP INSURANCE



Please type or print in ink. This application will be returned if all sections are not completed.

EMPLOYER INFORMATION

Employer: _____

Federal I.D. Number: _____

Full Legal Name of Business (as it is to be shown in your policy): _____

Business Street Address: _____

City: _____ Zip Code: _____ County: _____

Billing Address (if different than above): _____

City: _____ State: _____ Zip Code: _____

Phone No: (____) _____ Fax No: (____) _____

Contact Name: _____ E-Mail Address: _____

Inception Date of Business: _____ SIC Code: _____

Names and Addresses of Affiliates to be Insured: _____

Association Affiliation: ABC OHBA Other _____

If OHBA, Name of Local Chapter _____

POLICY EFFECTIVE DATE

The requested effective date for the policy is _____, 20____ (must be 1st or 15th of month)

EMPLOYER CONTRIBUTION

Small employers must contribute at least 50% of single employee premium. Large employees 75% of single employee premium.

Employer contribution toward employee premium (percent): Medical: _____ Dental: _____

Employer contribution toward dependent premium (percent): Medical: _____ Dental: _____

REQUESTED BENEFITS

Please indicate requested benefits by checking the plan name(s). Groups with fewer than 50 enrolling employees do not have a dual choice option and may only select one plan from each product line.

Medical-Preferred: Value 500+35/80 Value 500+35/70 Value 1000+45/80 Value 1000+45/70
Value 2000+35/80 Value 2500+45/70 Value 5000+45/70 50/3750 HSA 80+3000*

All medical plans include a \$2 million maximum benefit. HSA eligible plans include pharmacy subject to the medical deductible.

Pharmacy: Tiered Rx \$10/50/75 PDL/MacB Tiered Rx\$15/30/45 PDL/MacB Value Rx\$15/\$2500 PDL/MacB None

AltCare: Alternative Care and Chiropractic 10/1000 Alternative Care and Chiropractic 1000 (HSA) None

Vision: Standard Option High Option None

Dental: Advantage Premier 1000 Advantage Premier 1500 Preventive Only Dental None

Ortho: Orthodontia 1500 None (Ortho available to groups of 26+ with Dental Plan 1000 or Plan 1500 only)

*If electing an HSA eligible plan will you use this plan with an HSA? _____ Name of bank used for HSA: _____

GROUP DOCUMENTS

Language: Do you need Spanish plan materials? Yes No Quantity: _____

