Total Health Care USA, Inc.
Group Administration Form

❑ GRANDFATHERED PLAN
❑ NON-GRANDFATHERED PLAN

GROUP NUMBER_____

Company Name (to be listed on GOA):_____ Industry:_____

Contact Person:_____ Title:_____

Company Address:_____ P.O. Box:_____

City:_____ State:_____ County:_____ Zip Code:_____

Email Address: _____

Employer Tax ID Number:_____ Requested Effective Date of Coverage:_____

Phone Number:_____ FAX Number:_____

BILLING CONTACT NAME AND ADDRESS (If different from above)	ELIGIBILITY AND PARTICIPATION	EMPLOYER CONTRIBUTION TOWARD MONTHLY PREMIUM (Employer contribution must be 50% or more of the single rate)	
_____	1. Number of total employees on your payroll_____	Tier	Contribution
_____	2. Number of full-time employees _____	Single	0.00%
_____	3. Number of employees applying to THC_____	Double	0.00%
_____	4. Number of employees with other coverage _____	Family	0.00%
_____	5. Number of employees waiving health coverage _____	Sponsored Dependant	0.00%

Do you currently offer Group Medical Coverage? ❑ Yes ❑ No (If yes, provide copy of most recent bill.)

BENEFIT OPTIONS FOR SMALL COMPANIES

PRODUCT: ❑ HMO ❑ POS

BENEFIT PLAN: _____

❑ Domestic Partner

BENEFIT OPTIONS FOR LARGE COMPANIES

PRODUCT: ❑ HMO ❑ POS ❑ PPN

BENEFIT PLAN: _____ **TIER:** _____

❑ Vision ❑ Hearing ❑ SNF

❑ Domestic Partner ❑ Rx_____ ❑ Abortion

	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	TOTAL	AVERAGE
Average Employee Count (for previous calendar year):													0.0	0.0

ENROLLMENT AND ELIGIBILITY CRITERIA

Effective date for New Hires: 1st of the month following
❑ Date of Hire ❑ 30 day waiting period ❑ 60 day waiting period

Effective date of Subscriber Termination:
❑ EOM following term date

Effective date for Return to Employment (i.e., Layoff, Leave, Strike): 1st of the month following
❑ Date of return ❑ 30 day waiting period ❑ 60 day waiting period

Effective date for Status Change (i.e., Part-time, Full-time): 1st of the month following
❑ Date of change ❑ 30 day waiting period ❑ 60 day waiting period

Former Total Health Care Coverage: ❑ Yes ❑ No ❑ Cancellation Date:_____

Workers Compensation Carrier:_____ Policy #:_____ Effective Date:_____

ORGANIZATION AND AFFILIATION

Union: ❑ Yes ❑ No National/International Name:_____ Number of Union Employees:_____

Local #:_____ Local Rep:_____ Contract Expiration Date:_____

AUTHORIZATION

*By signing this I do hereby certify that all statements made by me in this application are true and accurate to the best of my knowledge.

Name of person who will sign the agreement (GOA):_____ Title:_____

Agent of Record:_____ Agency:_____

_____ _____ _____
(Person completing form – printed) (Signature) (Date)

_____ _____ _____
(Total Health Care Representative – printed) (Signature) (Date)