Total Health Care USA, Inc.
Group Administration Form

(Attachment 'A' of Group Operating Agreement)

❑ 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:_____

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)	
_____ _____ _____ _____ _____ Email Address: _____	1. Number of total employees on your payroll _____ 2. Number of employees applying to THC _____ 3. Number of employees with other coverage _____ 4. Number of employees waiving health coverage _____	Tier	Contribution
		Single	
		Double	
		Family	
		Sponsored Dependant	

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

BENEFIT OPTIONS

PRODUCT: ❑ HMO ❑ POS ❑ PPN

BENEFIT PLAN:_____ **TIER:**_____

❑ Vision ❑ Hearing ❑ SNF

Rx:_____ OV:_____ UR:_____ ER:_____

	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	AVERAGE	TOTAL
Average Employee Count (for previous 12 months):													0.0	0

ENROLLMENT AND ELIGIBILITY CRITERIA

Effective date for New Hires: 1st of the month following
❑ 30 day waiting period ❑ 60 day waiting period ❑ 90 day waiting period ❑ Other (Total Health Care USA Approval)

Effective date of Subscriber Termination:
❑ EOM following term date ❑ Other (Total Health Care USA Approval)

Effective date for Return to Employment (i.e., Layoff, Leave, Strike): 1st of the month following
❑ Date of return ❑ _____day waiting period ❑ Other (Total Health Care USA Approval)

Effective date for Status Change (i.e., Part-time, Full-time): 1st of the month following
❑ Date of change ❑ _____day waiting period ❑ Other (Total Health Care USA Approval)

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:_____

PEO/ASO: ❑ Yes ❑ No Organization Name:_____ Contract Expiration Date: _____

AUTHORIZATION

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)