

LARGE GROUP APPLICATION



MotivHealth Insurance Company
PO Box 709718
Sandy, UT 84070-9718

HSA Health Plan: Group Application

Group Name: _____

Effective Date: _____ Length of Contract (months): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Employer Tax ID #: _____

Company Type (LLC, C Corp, S Corp, etc.): _____

List all DBAs or other names used:

of employees: _____ # of enrollees waiving due to other group coverage: _____
of eligible employees: _____ # of enrollees waiving without other group coverage: _____
of ineligible employees: _____ # of enrollees currently in a new hire waiting period: _____
of employees outside UT: _____ # of enrollees on COBRA: _____
of enrollees are retired: _____

Health Savings Account:

Are you currently a full replace HSA Group? Yes No

If so, are your employees HSAs currently administered by HealthEquity? Yes No

Group Contact Information:

Contact 1

Name: _____ Title: _____

Phone Number: _____ Email: _____

Contact 2

Name: _____ Title: _____

Phone Number: _____ Email: _____

Product Selection

Product 1

Deductible Individual: _____

Deductible Family: _____

Deductible embedded? _____

Individual Maximum Out of Pocket: _____

Family Maximum Out Of Pocket: _____

Maximum Out Of Pocket embedded? _____

Coinsurance Copayments: _____

Rx Cost Sharing: _____

Monthly Premiums for this product: _____

Single \$: _____

Employee + Spouse \$: _____

Employee + Child \$: _____

Employee + Children \$: _____

Family \$: _____

Product 2

Deductible Individual: _____

Deductible Family: _____

Deductible embedded? _____

Individual Maximum Out of Pocket: _____

Family Maximum Out Of Pocket: _____

Maximum Out Of Pocket embedded? _____

Coinsurance Copayments: _____

Rx Cost Sharing: _____

Monthly Premiums for this product: _____

Single \$: _____

Employee + Spouse \$: _____

Employee + Child \$: _____

Employee + Children \$: _____

Family \$: _____

Other plan/product details including any alternative funding details:

Employer HSA Contributions: Please explain any employer HSA contributions:

Eligible Employees

To be eligible, employees must work at least _____ hours per week.

Are domestic partners covered? Yes No

Newly Eligible Employees

The Employer Waiting Period is _____ days, and the effective date is _____

(Note that the waiting period cannot exceed 90 days.)

If multiple classes, please explain below.

Employer Monthly Contribution

Employer must contribute an amount equivalent to at least _____ % of the single coverage premium and/or _____ % of all rating tiers.

Dependent Age Limitations

Dependent children are eligible for coverage up to age 26, unless they meet the criteria for disabled children as specified in the Certificate of Coverage.

Termination of Coverage

Employee and Dependent(s) coverage will terminate as of the end of the month in which termination of eligibility occurs.

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. If minimum employee participation and employer contribution requirements are satisfied, the Master Group Policy and its terms shall commence on the effective date for a term of 12 months. In addition to any other applicable premium, insured employees shall pay the cost sharing amounts as described in the Outline of Coverage. "Not Covered" on the Outline of Coverage indicates that the service is not covered regardless of any other statement of coverage. Coverage is made on the basis of information provided to MotivHealth 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 it is relied upon in making decisions about coverage and payment. Employee applications must be submitted to and approved by MotivHealth 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: _____

