



**Community First PPO Plans**  
*A Preferred Provider Benefit Product Sponsored by  
 Community First Group Hospital Service Corporation*

## GROUP APPLICATION

(If Applicant is issued coverage, this becomes part of the Group Agreement or Policy/Certificate)

To avoid processing delays:

1. Answer all questions completely and accurately.
2. Do not cancel your existing coverage until you receive written notification of approval.
3. Include a deposit check in the amount of the estimated first month's premium; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective

Section 1 (To be completed by Employer)						
COMPANY NAME						
TAX ID				REQUESTED EFFECTIVE DATE		
ADDRESS (Number, Street)						
CITY		STATE		ZIP	COUNTY	
PHONE #		EXT.		FAX #		
PRIMARY CONTACT/TITLE			PHONE/FAX		EMAIL ADDRESS	
MANAGEMENT CONTACT/TITLE			PHONE/FAX		EMAIL ADDRESS	
ASSOCIATED COMPANIES COVERED (Must file taxes under same Tax ID) <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, list names and addresses. Attach additional sheets if necessary)						
Name of Current Medical Carrier _____ Begin Date _____ End Date _____ Please attach your most recent billing statement and plan design from your current carrier <input type="checkbox"/> Medical coverage not currently offered						
Does the Applicant offer other coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please attach a list of the carriers and type of coverage offered and premium for each option)						
Are all employees eligible for this plan covered by Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO (If no, please attach explanation) Do you maintain an IRS Section 125 Texas Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you currently have COBRA Enrollees? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please attach list of names and effective dates)						
TYPE OF ORGANIZATION: (CHECK ALL APPLICABLE) <input type="checkbox"/> Non-Profit <input type="checkbox"/> Association <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Union <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> Trust Fund <input type="checkbox"/> Political Subdivision <input type="checkbox"/> Other :						
Number of employees _____ Full Time*    Part Time *30 Hours or more a week		Number of eligible employees	Number of employees to be enrolled	Number of employees outside service area	Years in business	Industry Code _____ Nature of Business:



Section 4 (To be completed by Employer)

EMPLOYER STATEMENT OF UNDERSTANDING

SELECTED ELIGIBILITY REQUIREMENTS

A bona-fide employee/employer relationship is required to be maintained, that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g., FICA, FUI, SUI and Workers' Compensation) normally associated with a bona-fide employee relationship. Generally, employees must be Actively At Work before coverage commences. Any other eligibility arrangements require prior Community First approval.

PREMIUMS

Premiums are due on the first of each month for which coverage is provided. Delinquent premiums shall be subject to late charges. If payment is not received from the employer, coverage for all enrollees will be terminated on the last day of the month for which premiums were received. Any other payment arrangements require prior approval by Community First.

EMPLOYER CONTRIBUTION

- Employee Only \$ \_\_\_\_\_ or \_\_\_\_\_% of Community First premium (certain minimums apply for Small Employers).
- Dependents \$ \_\_\_\_\_ or \_\_\_\_\_% of Community First premium.

MINIMUM PARTICIPATION REQUIREMENTS

\_\_\_\_\_ Employees must enroll during initial enrollment period and must be maintained thereafter by the group (certain minimums apply for Small Employers).

This application shall be the basis for the issuance of coverage under the group agreement and shall become a part thereof. Community First reserves the right to terminate group coverage or the coverage for an individual member for up to two years from the date hereof if the contract holder or individual member has made any intentional misrepresentation of material fact. Coverage may be terminated at any time in the event of a fraudulent misstatement contained herein.

Section 5 (To be completed by Employer)

EMPLOYER STATEMENT

I certify that I am authorized to sign this application and to agree to the following on behalf of the Employer identified on Page 1 of this Application.

I certify that all the information contained in this application is correct to the best of my knowledge and all participation requirements have been met.

I certify that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to eligible employees.

I understand that if this application is accepted, it becomes part of the Group Contract.

I understand that the optional riders offered in this Application are being offered to the Employer Group that I represent. I have reviewed the riders and related information. For riders checked "NO" I hereby waive the Employer Group's option to purchase these riders.

I understand that the employer will be responsible for collecting employee contributions to premium, submitting the entire premium to Community First in a timely manner in accordance with the Group Contract, and for otherwise complying with the Group Contract.

I understand that the Employer should not cancel its current coverage until notified in writing by Community First Group Hospital Service Corporation that it agrees to cover the Group.

Dated at \_\_\_\_\_ a.m. / p.m., this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Broker/Agent Signature

Section 6 (To be completed by Broker/Agent)		
<b>BROKER INFORMATION</b>  <input type="checkbox"/> NEW BROKER  <input type="checkbox"/> EXISTING BROKER	NAME	PHONE NUMBER
	ADDRESS (CITY, STATE, ZIP)	TAX ID
	COMMISSION <input type="checkbox"/> STANDARD _____% <input type="checkbox"/> SPLIT (LIST 2 <sup>ND</sup> BROKER _____) <input type="checkbox"/> OTHER (APPROVAL SIGNATURE REQUIRED _____ TITLE _____)	

**Section 7 (To be completed by Community First Account Executive)**

I certify that all the information contained in this application is correct to the best of my knowledge. I certify that the applicant is a bona-fide business establishment. I certify all participation requirements have been met. I certify that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

Dated at \_\_\_\_\_ a.m. / p.m., this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_

Account Executive Signature

\_\_\_\_\_

Print Name

**APPROVAL**

Director of Sales & Marketing \_\_\_\_\_ Date \_\_\_\_\_

Underwriting \_\_\_\_\_ Date \_\_\_\_\_

Contract Prepared By \_\_\_\_\_ Date \_\_\_\_\_