



# VIVA HEALTH

1222 14<sup>th</sup> Avenue South  
Birmingham, AL 35205  
(205) 558-7474

EMPLOYER GROUP  
APPLICATION  
51-99 EMPLOYEES

### COMPANY INFORMATION

Company's Full Legal Name		Contact Name	Telephone Number ( ) ( )	Fax Number ( ) ( )
Address		City	State	Zip Code County
Nature of Business	# of years in business	Type of Business : <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other _____		
Employer Identification Number (EIN):				

### ELIGIBILITY INFORMATION

- In the past 36 months has the company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)  Yes  No
- In the past 36 months has any creditor filed or threatened to file a petition requesting the company or any affiliate entity be placed into bankruptcy?  Yes  No
- Have you ever applied for VIVA Health coverage?  Yes  No
- Do you currently have other group health coverage?  Yes  No *If yes, please attach a copy of the last billing statement.*  
Name of Current Health Carrier: \_\_\_\_\_ Effective Date of Policy: \_\_\_\_\_
- Employer will contribute \_\_\_\_\_% of the cost of the employees' insurance and \_\_\_\_\_% of the cost of their dependents.
- Waiting Period: New employees are covered on the first of the month coincident with or following how many days of work?  
 30 days  60 days  90 days  Other \_\_\_\_\_
- a. What is the total number of full-time (30+ hours/week) employees? \_\_\_\_\_ (Required: Quarterly Wage & Tax statement or a payroll report)  
b. Total number of employees covered under other coverage (i.e. spouse's plan, Medicare, individual policy)? \_\_\_\_\_  
c. Total number of full-time employees that do not have other health coverage (a-b)? \_\_\_\_\_  
d. Of the employees in "c" above, how many will participate in the health coverage? \_\_\_\_\_
- Are there any employees who will become eligible after the effective date of the policy that are serving a new-hire waiting period?  Yes  No *If yes, how many? \_\_\_\_\_ (These individuals must complete an employee enrollment form.)*
- Are there any former employees who have elected or are covered under COBRA or state continuation? (Groups with 20 or more employees only)  Yes  No *(These individuals must complete an employee enrollment form.)*  
*If yes, please list these individuals and the COBRA/state continuation expiration dates:*  
\_\_\_\_\_  
\_\_\_\_\_
- Are all eligible employees covered by workers' compensation insurance?  Yes  No  
Name of workers compensation carrier: \_\_\_\_\_
- What is the requested coverage effective date? \_\_\_\_\_

### TERMS AND CONDITIONS

The employer certifies that the information provided above is complete and accurate. The employer shall notify VIVA Health, Inc. promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees, dependents or COBRA participants prior to the effective date of the group. VIVA Health, Inc. shall be entitled to rely on the most current information available regarding eligibility of employees or their dependents in providing coverage under this policy. When/if the employer and VIVA Health, Inc. come to an agreement on an effective date to activate the selected plan(s), the employer agrees to follow the terms and conditions outlined in VIVA Health, Inc.'s Group Policy. Upon receipt of the employer's signed application and payment of the required Group Policy charges, the Group Policy is deemed executed.

AUTHORIZED SIGNATURE  X  \_\_\_\_\_ DATE  X  \_\_\_\_\_

EMPLOYER NAME (PRINT)  X  \_\_\_\_\_

**FOR OFFICE USE ONLY**

**NEW GROUP** – Benefit Plan \_\_\_\_\_  **RENEWAL** – Benefit Plan to renew on \_\_\_\_\_  
 **CHANGE**  **OTHER** \_\_\_\_\_

**GROUP NAME:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_  
**REP NAME:** \_\_\_\_\_ **EFFECTIVE DATE:** From \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_  
**AGENT NAME:** \_\_\_\_\_ **AGENT #:** \_\_\_\_\_ **INITIAL ENROLLMENT PERIOD:** \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_  
**ELIGIBILITY:** **NUMBER OF SINGLES:** \_\_\_\_\_ **NUMBER OF FAMILIES:** \_\_\_\_\_ **NUMBER OF MEMBERS:** \_\_\_\_\_  
**CLASS OF EMPLOYEES:**  **All**  **Management Only**  **Salaried Only**  **Other** \_\_\_\_\_  
**DEPENDENT AGE LIMIT:** To age 19 for non-students and age 23 for full-time students  
**FULL-TIME EMPLOYEES:** 30 hours per week  
**WAITING PERIOD:** 1<sup>st</sup> of the month following \_\_\_\_\_ days/months/date of hire

**MAILING ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**BILLING ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tier	RATES	
	Code	Rate
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**APPROVALS**

**SALES REPRESENTATIVE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**SALES MANAGER** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**UNDERWRITING** \_\_\_\_\_ **DATE** \_\_\_\_\_