WMI® MUTUAL INSURANCE™ COMPANY

P.O. Box 572450 Salt Lake City, Utah 84157-2450
(801) 263-8000 (800) 748-5340 Fax: (801) 263-1247

EMPLOYER APPLICATION

Please complete this application for group health insurance, including any optional plan benefits, provided by WMI Mutual Insurance Company. Before signing in the appropriate space, check each section. Signature applies to all sections.

Section I: General Information **Date** ________________________________

Company Name __________________________ Federal EIN ______________________ Contact Person ______________________

Address ___________________________________ City ______________________ State _______ ZIP ____________________

Phone (_____) _______________ Fax (_____) _______________ E-mail address _______________________________________

Montana Employers Only: Will the employer treat the health benefit plan as part of a plan or program for the purposes of sections 106, 125 or 162 of the Internal Revenue Code? Yes __ No __ If yes, is any part of the plan or program funded by the employer? Yes __ No ___

Does the company currently have group health insurance with another company? Yes _____ No _____

Present Insurer ____ Date Coverage to Terminate ______________________________

~ Please attach a copy of current group health plan information (plan summary, schedule of benefits, etc.).

Section II: Employee Classification Information

The following employee classifications are eligible to participate in the company's group health plan: ________________________
____

Waiting Period for New Employees*: 0 days _____ 30 days _____ 60 days _____ 90 days _____ (maximum allowable)
*If a waiting period of 60 days or less is selected, coverage will be effective on the first day of the month following the satisfaction of the waiting period. If a 90-day waiting period is selected, coverage will be effective on the first day of the month preceding the satisfaction of the 90-day waiting period, coverage will be effective for the entire month, and premium will be due for the entire month.

Employees are required to work a minimum of _________ hours per ______________ to be eligible for group insurance. This provision is applicable to all employees and must be conveyed to all employees. (Cannot be less than 30 hours per week (or another amount determined by an employer in Arizona))

Total number of employees of all related companies: _______ Full-time:______ Part-time:______ Seasonal: ________________

Total number of employees ***eligible to participate*** in the company's group health insurance plan:______________________________

Total number of employees ***participating*** in the company's group health insurance plan: ____________________________________

Total number of eligible employees ***NOT participating*** in the company's group health insurance plan: ________________________

Reason(s) for waiving coverage: ____

~ Please attach a current copy of company payroll (FICA or Workers' Compensation).

Section III: Premium Contribution Information

The Employer pays _________ % of employee health insurance premium.

The Employer pays _________ % of dependent health insurance premium.

Section IV: Benefit Information

			Medical Plan Selected:			
Medical:	Yes: ☐	No: ☐	Bronze ☐	Silver 1 ☐	Gold 1 ☐	Platinum 1 ☐
Dental:	Yes: ☐	No: ☐		Silver 2 ☐	Gold 2 ☐	Platinum 2 ☐
Vision:	Yes: ☐	No: ☐			Gold 3 ☐	Platinum 3 ☐
Life (“VGL”):	Yes: ☐	No: ☐			Gold 4 ☐	Platinum 4 ☐
Short term Disability:	Yes: ☐	No: ☐				Platinum 5 ☐

Requested effective date: ___________________________

Does employer currently carry workers’ compensation insurance? Yes____ No___ If owners and partners are not covered under workers’ comp, do they want normal plan coverage while on the job for additional premiums? Yes_____ No______

Is anyone currently on COBRA? Yes _____ No _____ If yes, please list those participating: ______________________________
____

Washington employers only: This Policy offers an Extension of Coverage for a time period of ninety (90) days. If you would like an alternative time period, or if you would like to remove this benefit from your policy, please indicate by marking one of the following:

Remove benefit ________ Thirty (30) days ________ Sixty (60) days _________

Section V: Group Eligibility Criteria

WMI requires that companies with 2-3 employees must enroll 100% of eligible employees, and companies with 4 or more employees must enroll at least 75% of all eligible employees. An eligible employee is one who works a minimum of 120 hours per month (or another minimum amount determined by the employer in Arizona) and does not carry other major medical insurance coverage. WMI also requires that employers contribute at least 75% of the premium for employee only coverage or at least 50% of the total premium for employee and dependent coverage. Employers who do not meet these requirements are only eligible to enroll for coverage during the open enrollment period of November 15 through December 15 for an effective date of January 1.

Section VI: Terms and Conditions

The undersigned employer hereby requests group insurance with the WMI Mutual Insurance Company. By signing this agreement, the employer agrees to adopt and subscribe to all terms and conditions of this document as well as those set forth in the insurance policy. The employer understands and agrees that all insurance participation requirements must be maintained upon renewal. Insurance applied for hereunder will not be effective until this application has been approved in writing by WMI Mutual Insurance Company. The employer agrees to notify WMI Mutual Insurance Company within ten (10) days of any material change affecting the employer or which may render the employer ineligible for insurance with the company. The employer agrees that it is the administrator of the plan as that term is contemplated under the Employee Retirement Income Securities Act (“ERISA”) and that WMI Mutual Insurance Company does not assume any obligations imposed by that law or any amendments thereto, including, but not limited to, the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) and the Health Insurance Portability and Accountability Act (“HIPAA”), except when specifically required by that law. The employer also agrees that WMI Mutual Insurance Company may conduct periodic audits to ensure that eligibility, participation, and contribution requirements are being satisfied and that the employer will provide each insured employee and qualified beneficiary with prior written notification of termination in situations in which the employer requests termination for issues other than non-payment of the group premium. WMI Mutual Insurance Company agrees that it will provide notice of termination in situations when specifically required by law.

Section VII: Signature

I hereby certify that the information provided herein is true and complete to the best of my knowledge. I have also read and understand the group eligibility requirements as explained in Section V above and the terms and conditions set forth herein.

By: ____

Signature of Authorized Company Officer

Title: ____ Date ________________________________

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.