Section One: General Group Information

1. Group name or DBA name, if applicable: ______________________________

2. Legal entity name, if different than group name: ______________________________

3. Name of owner/partners: ______________________________

4. Physical location of employer: ______________________________

5. Mailing address of employer (if different than physical address): ______________________________

6. Information for contact person at employer group:

   ______________ ______________ ______________ ______________
   Name Title Phone # Email Address

7. Description of business:______________________ SIC code: ________ EIN/TIN #: ________

8. Type of group sponsor: (check one)
   Employer ____ Union ____ Trustees of Fund ____ Association ____ Other: ______________________

9. Organization type: (check one) State government ___ Local government ___ Church group ____
   Nonprofit ____ Trust ____ Publicly traded organization ____ Privately held corporation ____
   Privately held non-incorporated ____ Not-for-profit ____ Other: ______________________

10. Is coverage obtained through a Chamber Trust or Association, including a Professional Society?
    Yes _X__ No __ (check one)
    CTA Name: Webster Chamber of Commerce____ Professional Society Name ______________________

11. Are you a subsidiary company? Yes ___ No ___ (check one)
    If yes, list parent company name & address ______________________________

12. Are you a parent company with subsidiary companies? Yes ____ No ____ (check one)
    If yes, please attach a list of the related companies, the locations and the number of eligible employees working at each location

13. Are there any other health plans in place for your group? Yes ____ No ____ (check one)
    If yes, type of plan(s) ______________________ Number of employees enrolled in this plan _______

PLEASE SUBMIT ALL REQUIRED UNDERWRITING DOCUMENTATION WITH THIS FORM

REFER TO SMALL GROUP ENROLLMENT CHECKLIST FOR REQUIRED DOCUMENTATION

Section Two: Regulatory Information

	Medical	Dental
14. Group Size		
a) Total number of employees at all locations	______	______
b) Total number of eligible full-time & part-time employees at all locations	______	______
c) Total number of eligible retirees at all locations	______	______
d) Total number of employees enrolled due to COBRA/NYS Continuation at all locations	______	______
e) Total eligible employees: (**e = b + c + d**)	______	______
f) Employees working at other locations not eligible for the programs offered through our plan	______	______
g) Eligible employees declining coverage due to a valid waiver (please see instructions)	______	______
h) Retirees who are offered a Medicare Advantage or Retiree Health Plan group product	______	NA
i) Net eligible employees for our health plan **(i = e – f – g – h)**	______	______
j) Eligible employees enrolling in group products (excluding those enrolled in a Medicare Advantage or Retiree Health Plan group product)	______	______
k) Group participation percentage (**k = j ÷ i**)	______	______
15. Group size for federal Mental Health Parity and federal medical loss ratio reporting average number of total employees, at all locations, for the prior calendar year	______	
16. Do you employ any Vermont residents who work at employer locations in Vermont, including telecommuters working from their home in Vermont? Yes ____ No ____ (check one) If yes, please provide the number	______	______
17. Do you employ any other out-of-state residents who work at out-of-state employer locations other than Vermont? Yes ____ No ____ (check one) If yes, please provide the number	______	______

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.

______________________________	__________	______________________________
Signature of Member Firm Administrator	Date	Fax Number or Email Address
______________________________	__________	Webster Chamber of Commerce
Signature of CTA Plan Administrator	Date	Chamber, Trust Association Name

Calendar Year Employer Contribution
(for calendar year coverage is effective)

Group Name ______________________________

Coverage Effective Date _____________
Contribution Effective Date _____________
Contribution End Date ______________

Please note: If your contribution amount/type changes you are required to notify the Health Plan of these changes.

Rate Tier:
- □ 2 - Tier
- □ 3 - Tier
- □ 4 - Tier

Premium Contribution Type:
- □ Fixed $ amt.
- □ % of premium

Other-please explain:

If your group's number of plan options per class exceeds three, please complete an additional form(s) or attach a spreadsheet with the contribution details.

Class Names:

A001 - All Actives
A002 - Hourly
A003 – Salaried
A004 - Management
A005 - Non-Management
A006 - Union
A007 - Non-Union
A008 - Full-Time
A009 - Part-Time
R001 - Retired Non-Medicare Eligible
R002 - Retired Medicare Eligible

Class Name	Plan Offering	Monthly Tier Contribution				HSA/HRA Annual Contribution if applicable
		Single	Subscriber & Spouse	Subscriber & Child / Children	Family	

Signature: The undersigned certifies that, to the best of my knowledge and belief, the information provided above is true and complete.

Name / Signature of Group Contact Person ______________________ **Date** ________ **Phone Number** ______________ **Email Address** ______________________