# Total Health Care USA, Inc. Group Administration Form

(Attachment 'A' of Group Operating Agreement)

❑ GRANDFATHERED PLAN
❑ NON-GRANDFATHERED PLAN

GROUP NUMBER_______________

Company Name (to be listed on GOA):_______________ Industry:_______________

Contact Person:_______________ Title:_______________

Company Address:_______________ P.O. Box:_______________

City:_______________ State:_______________ County:_______________ Zip Code:_______________

Employer Tax ID Number:_______________ Requested Effective Date of Coverage:_______________

Phone Number:_______________ FAX Number:_______________

| BILLING CONTACT NAME AND ADDRESS (If different from above) | ELIGIBILITY AND PARTICIPATION | EMPLOYER CONTRIBUTION TOWARD MONTHLY PREMIUM (Employer contribution must be 50% or more of the single rate) | |
|---|---|---|---|
| | | Tier | Contribution |
| _______________ | 1. Number of total employees on your payroll ___________ | Single | |
| _______________ | 2. Number of employees applying to THC ___________ | Double | |
| _______________ | 3. Number of employees with other coverage ___________ | Family | |
| Email Address: _______________ | 4. Number of employees waiving health coverage _______ | Sponsored Dependant | |

Do you currently offer Group Medical Coverage? ❑ Yes ❑ No (If yes, provide copy of most recent bill.)

| 521 BASE MEDICAL PLAN | | 321 BASE MEDICAL PLAN | | T SERIES BASE MEDICAL PLAN | | | | SELECT | PPN |
|---|---|---|---|---|---|---|---|---|---|
| ❑ Option A | ❑ Ded | ❑ Option A | ❑ Ded | ❑ 521 | ❑ Ded | ❑ 321 | ❑ Ded | ❑ Low 09 - POS | ❑ HMO |
| ❑ Option B | ❑ Ded | ❑ Option B | ❑ Ded | ❑ 522 | ❑ Ded | ❑ 322 | ❑ Ded | ❑ Mid 09 - POS | ❑ Select - POS |
| ❑ Option C | ❑ Ded | ❑ Option C | ❑ Ded | ❑ 523 | ❑ Ded | ❑ 323 | ❑ Ded | ❑ High 09 - POS | |
| ❑ Option D | ❑ Ded | ❑ Option D | ❑ Ded | ❑ 524 | ❑ Ded | ❑ 324 | ❑ Ded | | |
| ❑ Option E | ❑ Ded | ❑ Option E | ❑ Ded | ❑ 525 | ❑ Ded | ❑ 325 | ❑ Ded | Rx___________ | Rx__________ |
| ❑ _______ | ❑ Ded | ❑ _______ | ❑ Ded | ❑ _____ | ❑ Ded | ❑ _____ | ❑ Ded | | |
| Other_____________ | | Other_________________ | | Other____________ | | Other______________ | | | |

## ENROLLMENT AND ELIGIBILITY CRITERIA

**Effective date for New Hires:** 1st of the month following
❑ 30 day waiting period ❑ 60 day waiting period ❑ 90 day waiting period ❑ Other (Total Health Care USA Approval)

**Effective date of Subscriber Termination:**
❑ EOM following term date ❑ Other (Total Health Care USA Approval)

**Effective date for Return to Employment (i.e., Layoff, Leave, Strike):** 1st of the month following
❑ Date of return ❑ ___________day waiting period ❑ Other (Total Health Care USA Approval)

**Effective date for Status Change (i.e., Part-time, Full-time):** 1st of the month following
❑ Date of change ❑ ___________day waiting period ❑ Other (Total Health Care USA Approval)

**Former Total Health Care Coverage:** ❑ Yes ❑ No ❑ Cancellation Date:_______________

**Workers Compensation Carrier:**_______________ Policy #:_______________ Effective Date:_______________

## ORGANIZATION AND AFFILIATION

Union: ❑ Yes ❑ No National/International Name:_______________ Number of Union Employees:_______________

Local #:_______________ Local Rep:_______________ Contract Expiration Date:_______________

PEO/ASO: ❑ Yes ❑ No Organization Name:_______________ Contract Expiration Date: _______________

## AUTHORIZATION

Name of person who will sign the agreement (GOA):_______________ Title:_______________

Agent of Record:_______________ Agency:_______________

_______________ (Person completing form – printed) _______________ (Signature) _______________ (Date)

_______________ (Total Health Care Representative – printed) _______________ (Signature) _______________ (Date)