



Health Plus of Louisiana
 Post Office Box 32625
 Shreveport LA 71130-2625
 www.wkhealthplus.com

FOR HEALTH PLUS USE ONLY		
GROUP NUMBER		
UNDERWRITING (CIRCLE ONE)	AGE/SEX-RATED	TIER-RATED
GROUP EFFECTIVE DATE	PLAN NUMBER	

APPLICATION INSTRUCTIONS

1. **DO NOT CANCEL EXISTING COVERAGE UNTIL WRITTEN NOTIFICATION OF APPROVAL RECEIVED FROM HEALTH PLUS.**
2. DO NOT LEAVE ANY QUESTIONS UNANSWERED—IF NOT APPLICABLE—WRITE “NONE” OR “N/A.”
3. Submit most recent premium statement listing those currently insured and current rates.
4. Submit most recent copy of Louisiana Department of Labor Employer’s Wage Report (if less than 36 employees).

1. Company Name (Legal Name)	2. DBA/Doing Business As (if applicable)		
3. Street Address (P.O. Box not acceptable)	4. City	5. State	6. Zip Code
7. Billing Address (if different than above)	8. City	9. State	10. Zip Code
11. Benefits Administrator/Contact Person – Title	12. Phone Number	13. Fax Number	
14. Executive Contact Person – Title	15. Federal Tax ID Number	16. Date Business Established (Mo/Yr)	
17. Nature of Business	18. Requested Effective Date		
19. In the past 36 months, has the company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws (chapter 11 or 7)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
20. In the past 36 months, has any creditor filed or threatened to file a petition requiring company or any affiliated entity to be placed voluntarily into bankruptcy? <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. Total number of employees (ELIGIBLE + INELIGIBLE)	_____		
22. Number of part-time employees	- _____		
23. Number of temporary, substitute, seasonal employees, or other (identify in Question 32)	- _____		
24. Total number of ELIGIBLE employees (Question 21 - Questions 22 and 23)	= _____		
25. Number of employees WAIVING health coverage (completed waiver)	- _____		
26. Total number of eligible ENROLLING employees (Question 24 - Question 25)	= _____		
27. Number of COBRA or Continuation participants	_____		
28. Number of covered Retirees	_____		
29. Number of employees who reside outside of the service area (included in Question 21)	_____		
30. Percent premium paid by company for employee and dependents:	Employee _____ % <small>Please write 50 to 100—Do Not Leave Blank</small>	Dependents _____ % <small>Please write 0 to 100—Do Not Leave Blank</small>	
31. Are part-time employees to be covered? <input type="checkbox"/> YES <input type="checkbox"/> NO	32. Are there excluded classes of employees other than part-time and temporary employees (e.g., union employees)? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, describe excluded class(es):		
33. Has the company employed 20 or less employees (including non-eligible employees) for at least 20 weeks in the current calendar year or preceding calendar year? <input type="checkbox"/> YES <input type="checkbox"/> NO	34. Eligibility Date will be the first of the month following the waiting period. Waiting period for new hires: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other:		
35. Name of Current Health Insurance Carrier	For How Long? _____ Years	Renewal Date:	
36. To the best of your knowledge, has any person applying for coverage had medical claims in excess of \$5,000 in the past 12 months? <input type="checkbox"/> NO <input type="checkbox"/> YES, explain:			
37. To the best of your knowledge, has any person applying for coverage been diagnosed with, or been advised to have surgery or treatment for, any medical condition that may reasonably be expected to exceed \$5,000 in the next 12 months? <input type="checkbox"/> NO <input type="checkbox"/> YES, explain:			
In compliance with Louisiana law, Health Plus routinely provides coverage for severe mental illness. In addition to the state-mandated coverage for severe mental illness, Health Plus routinely provides coverage for other than severe mental health illness, as described in the Certificate of Coverage.			

IMPORTANT – PLEASE READ CAREFULLY

Employer shall notify Health Plus 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 or dependents. Health Plus shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this Agreement.

During and after termination of the Agreement, Employer grants Health Plus permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in Health Plus' possession. The parties shall maintain the confidentiality of any information relating to Members in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without the prior written consent of that party.

It is understood and agreed that: (1) renewal rates will be based on several factors which will include, but will not be limited to, the projected future claims experience of the Employer, except where prohibited by law; (2) insurance will be effective only on the date specified by Health Plus after the application has been approved by Health Plus and after the first full premium has been paid. The Employer's cancelled check is a receipt for the deposit. The deposit will be applied to the first premium due if the application for group coverage is approved. The deposit is not refundable after the Employer's coverage has been approved and issued.

The Employer acknowledges that that it has selected this plan based upon written information provided by Health Plus and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. Employer agrees to make payroll and other records directly related to employee's coverage under the Agreement available to Health Plus for inspection at Health Plus' expense, at Employer's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Agreement.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Health Plus. Health Plus does not provide health or dental services and, therefore, cannot guarantee any results or outcome.

The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums.

Fraud Statement. 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 fines and confinement in prison.

I hereby apply for coverage with Health Plus. I certify that all information provided in this application is accurate and complete. I understand that this application will form part of the Agreement issued by Health Plus (a sample of which may be available upon request), and by my signature below I agree to be bound by the terms and conditions of that Group Agreement. I understand that Health Plus may choose not to accept this application at its sole discretion.

Name of Company Officer	Title of Company Officer
Signature of Company Officer X	Date (Month/Day/Year)

AGENT/BROKER CERTIFICATION

I hereby certify that I am not aware of any information not disclosed in this application by the employer which may have bearing on this risk. I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Health Plus that the coverage being applied for by this application is accepted.

Broker Name (Please Print)	Agency Name
Broker Signature X	Date (Month/Day/Year)
Commissions Payable To	Tax ID/SSN
Phone Number	E-Mail Address

FOR HEALTH PLUS USE ONLY		
Health Plus Account Executive	Broker Commission <input type="checkbox"/> Standard Scale	<input type="checkbox"/> Flat _____