# Employer Application

**Date:**

The Policyholder named below hereby makes application to Health Resources, Inc. (HRI), for a Group Dental and or Group Vision Insurance Policy to be issued in accordance with the specifications outlined in this application. Refer to final Proposal Document/Covered Services for additional plan details.

| **Legal Entity Information for Policy Holder** | | | |
|---|---|---|---|
| *Specify the group's business domicile address, the location which is treated for tax and legal purposes, as the headquarters of the business for this section.* | | | |
| *Legal Business Name: | | | |
| dba/Assumed Name: | | | |
| *Address 1: | | | |
| Address 2: | | | |
| *City: | | *State: | *ZIP: |
| **Other Company Info** | | | |
| *SIC Code | *Total Eligible Employees | *Contribution % by Employer | TAX ID |
| | | | |

| ID | Plan Description | Type of Plan | Monthly Policy Rates | | | |
|---|---|---|---|---|---|---|
| | | | EE | EE+1 | EE + Children | Family |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| **Dental Plan Info** | | **Vision Plan Info** | |
|---|---|---|---|
| Contractual Period | Effective Date | Contractual Period | Effective Date |
| | | | |

| **Dental Wellness Credit** | | | | **Preventive Boost** | |
|---|---|---|---|---|---|
| Threshold | Max RO | Well Credit | Max Acct Limit | Yes | No |
| | | | | | |

| **Member Eligibility & Termination** | | | | | |
|---|---|---|---|---|---|
| ***Subscriber Effective** (must check 1) | | | ***Dependent Eligibility** | | |
| | 1st of Month Following (x) days of employment: | x = | | Dependent | Full Time Student |
| | Immediately upon employment | | Age Max: | | |
| | Other- specified here: | | Orthodontia Age Max: | | |
| ***Subscriber Coverage Termination Rules** (must check 1) | | | ***Dependent Termination Occurs** (must check 1) | | |
| | EOM – End of Month (Default) | | | End of Birthday Month (Default) | |
| | DOT – Date of Termination | | | End of Plan Year | |
| | EOP – End of Plan Year | | | Date of Birth | |
| | EOY – End of Calendar Year | | | Other: | |

HRI DENTAL &VISION

# Employer Application

Date:

Continuation of Employer Application for:

Effective:

| *COBRA Administration covering both Dental and Vision (must check 1) | |
|---|---|
| | Group has no COBRA administration responsibility by law |
| | Employer assumes all responsibility as required by law for COBRA Administration (Default) |
| | Employer elects Health Resources, Inc. as their COBRA plan administrator for **$0.36** per subscriber (Employee) per month upon Effective Date. (Group must be required by law to provide COBRA benefits) |

| *Agent/Broker Information | | | |
|---|---|---|---|
| Name: | | | |
| Agency: | | | |
| Commission Type: | | | |
| Rate Type: | | | |
| Frequency: | | | |
| Amount: | | Yes | No |
| * Named Broker above should have portal access for Group/Member Administration (Must check 1) | | | |

| General Agent | Commission Instructions |
|---|---|
| | |

| Additional Info for this Group/Policy |
|---|
| |

## Agreement, Confirmation, and Approval

A copy of this Employer Application shall be attached to and made a part of the Master Group Policy. Health Resources, Inc. reserves the right to rescind any contract or policy or to take any other action which Health Resources, Inc. deems necessary if the information provided on this Employer Application is false or inaccurate. It is agreed that the Health Resources Inc. Policy applied for shall become effective after receipt, review, and approval of this application and the executed Master Group Policy on the effective date stated herein.

### Fraud Notice

**Indiana:** A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Iowa and Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

| *Plan Sponsor/Employer | | *Broker/Agent | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| | | | |
| **Printed Name** | **Date Signed** | **Printed Name** | **Date Signed** |
| | | | |

* Required Fields