Montana Health CO-OP
P.O. Box 5358
Helena, MT 59604
855-447-2900

APPLICATION FOR GROUP CONNECTED CARE COMPREHENSIVE HEALTH INSURANCE POLICY

Employer Information-Group Policyholder			
Legal Name of Group Policyholder			
Physical Address	**City**	**State**	**Zip Code**
Mailing Address (If different from above)	**City**	**State**	**Zip Code**
Billing Address (If different from above)	**City**	**State**	**Zip Code**

Primary Phone Number	**Tax ID Number**	**Email Address**

Type of Business *(Select One)*	Sole Proprietorship	Corporation	Limited Liability Company (LLC)
	Partnership	S Corporation	Other_____

Name of Human Resource Contact	**Phone Number**

Benefit Plan Selection *(Select One)*	Gold Silver Plus Silver Silver Option 2 Bronze Plus Bronze Expanded Bronze
Proposed Effective Date of Policy _____/_____/_____	***Number of Full-Time Employees*** _____
Employer Contribution *(Select One)*	None-Coverage is Voluntary Employer Contribution Employee $_____or _____% per month Dependents $_____or _____% per month
Enrollment Eligibility *(Indicate all that apply)*	All Full-Time Active Employees working ___ hours per week All Part-Time Active Employees working ___ hours per week Dependents Other _____
Annual Open Enrollment Period	Yes No *If "Yes" specify enrollment period dates _____to_____*

Initial Enrollment	Total Number of Eligible Employees Being Enrolled _____ Total Number of Employees Eligible for Enrollment _____
Mode of Premium Payments	Monthly

Payment Method for Initial Binder Payment Only:

ACH/EFT

Checking Account Number	Name of Financial Institution	Routing Number
_____	_____	_____

CREDIT CARD

Credit Card Number	Card Type	Name on the Card	Security Code
_____	_____	_____	_____

If you would like an alternate payment method, please contact us at 406-447-9510

Representations-Agreement

I agree: (1) that the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) that this application will be part of the group policy for which I apply; (3) I will notify Montana Health Cooperative (the Company) if any statements or answers given in this application change prior to policy delivery.

I understand that that the group policy will be renewed each year on the policy anniversary date, unless I notify the Company to terminate the group policy. Such notification will be provided to the Company at least 60 days prior to the termination date. I understand that termination of group policy is subject to the terms and conditions provided in the group policy.

I understand and agree that I may only elect one open enrollment period per year for the group policy. I understand and agree that the annual open enrollment period I indicated for the ***Annual Open Enrollment Period*** in this Application will be applied every year, unless I give a written request to the Company to change the annual open enrollment period at least 60 days in advance of the next policy anniversary date. I understand that the open enrollment date will be subject to open enrollment periods required by the Health Insurance Marketplace. I agree to notify my employees of the open enrollment period.

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application ***before*** action can be taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return any premium deposit submitted with this application. I understand that the initial premium for the group policy must be paid in advance of the due date. I understand that the Company will issue the group policy to me. I understand that the Company will provide me with

employee certificate forms and any required notifications and Outline of Coverage forms that I must distribute to insured employees.

I understand that the Company will rely on the information I provide in this application in determining eligibility for the group policy coverage for which I apply, setting premium rates, and other enrollment purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, or other consequences as permitted by law. I agree that the Company will be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under the group policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any insurer rights or requirements; and (c) waive any information that the insurer requests.

READ YOUR POLICY CAREFULLY.

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 may be guilty of a crime and may be subject to fines and confinement in prison, and may result in denial of coverage under the Group Policy.

_____	_____
Signature of Group Policyholder (Employer)	Date signed
_____	_____
State in which Group Policy will be delivered	State in which Group Policyholder signed Application
_____	_____
Printed Name of Licensed Insurance Agent	Signature of Licensed Insurance Agent
_____	
Agent License Number	