

WMI® MUTUAL INSURANCE™ COMPANY

P.O. Box 572450 Salt Lake City, Utah 84157-2450
(801) 263-8000 (800) 748-5340 Fax: (801) 263-1247

EMPLOYER APPLICATION

Please complete this application for group health insurance, including any optional plan benefits, provided by WMI Mutual Insurance Company. Before signing in the appropriate space, check each section. Signature applies to all sections.

Section I: General Information

Date _____

Company Name _____ Federal EIN _____ Contact Person _____

Address _____ City _____ State _____ ZIP _____

Phone (____) _____ Fax (____) _____ E-mail address _____

Will the employer treat the health benefit plan as part of a plan or program for the purposes of sections 106, 125 or 162 of the Internal Revenue Code? Yes ___ No ___ If yes, is any part of the plan or program funded by the employer? Yes ___ No ___

Does the company currently have group health insurance with another company? Yes ___ No ___

Present Insurer _____ Date Coverage to Terminate _____

~ Please attach a copy of current group health plan information (plan summary, schedule of benefits, etc.).

Section II: Employee Classification Information

The following employee classifications are eligible to participate in the company's group health plan: _____

Waiting Period for New Employees: 30 days ___ 60 days ___ 90 days ___ 120 days ___ Other _____

Employees are required to work a minimum of _____ hours per _____ to be eligible for group insurance.
(Cannot be less than 20 hours per week)

Total number of employees of all related companies: _____ Full-time: _____ Part-time: _____ Seasonal: _____

Total number of employees *eligible to participate* in the company's group health insurance plan: _____

Total number of employees *participating* in the company's group health insurance plan: _____

Total number of eligible employees *NOT participating* in the company's group health insurance plan: _____

Reason(s) for waiving coverage: _____

~ Please attach a current copy of company payroll (FICA or Workers' Compensation).

Section III: Premium Contribution* Information

* WMI requires that employers contribute at least 75% of the premium for employee only coverage or at least 50% of the total premium for employee and dependent coverage.

The Employer pays _____ % of employee health insurance premium.

The Employer pays _____ % of dependent health insurance premium.

Will the Employer reimburse employees and/or their dependents for amounts paid toward the satisfaction of the policy deductible?
Yes ___ No ___ If yes, how much and/or at what percentage? _____

Section IV: Benefit Information

Medical:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Plan Selected: _____
Dental:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
Vision:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Requested effective date: _____
Life (“VGL”):	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
Disability:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	WPMA membership: Yes _____ Pending _____
Other	_____		

Does employer currently carry workers’ compensation insurance? Yes ___ No ___ If owners and partners are not covered under workers’ comp, do they want normal plan coverage while on the job for additional premiums? Yes ___ No ___

Is anyone currently on COBRA? Yes ___ No ___ If yes, please list those participating: _____

Please list any information on any claims over \$10,000 in the past 12 months: _____

Section V: Group Benefit Eligibility Criteria

The undersigned employer hereby certifies that the company employees are required to work a minimum of _____ hours per week in order to qualify to participate in the company’s group benefit program(s) through WMI Mutual Insurance Company, and that the forgoing policy and criteria is applicable to all employees and has been conveyed to all employees.

Section VI: Terms and Conditions

The undersigned employer hereby requests group insurance with the WMI Mutual Insurance Company. By signing this agreement, the employer agrees to adopt and subscribe to all terms and conditions of this document as well as those set forth in the insurance policy booklet. The employer understands and agrees that all insurance underwriting and participation requirements must be maintained during the insurance period. Insurance applied for hereunder will not be effective until this application has been approved in writing by WMI Mutual Insurance Company. The employer agrees to notify WMI Mutual Insurance Company within ten (10) days of any material change affecting the employer or which may render the employer ineligible for insurance with the company. The employer agrees that it is the administrator of the plan as that term is contemplated under the Employee Retirement Income Securities Act (“ERISA”) and that WMI Mutual Insurance Company does not assume any obligations imposed by that law or any amendments thereto, including, but not limited to, the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) and the Health Insurance Portability and Accountability Act (“HIPAA”), except when specifically required by that law. The employer also agrees that WMI Mutual Insurance Company may conduct periodic audits to ensure that eligibility, participation, and contribution requirements are being satisfied and that the employer will provide each insured employee and qualified beneficiary with prior written notification of termination in situations in which the employer requests termination for issues other than non-payment of the group premium. WMI Mutual Insurance Company agrees that it will provide notice of termination in situations when specifically required by law.

Section VII: Signature

I hereby certify that the information provided herein is true and complete to the best of my knowledge. I have also read and understand the group enrollment requirements* as explained in the benefit description booklet and the terms and conditions set forth herein.

By: _____
Signature of Authorized Company Officer

Title: _____ Date _____

* WMI requires that companies with 2-5 eligible employees enroll 100% of eligible employees; companies with 6-9 employees must enroll at least 80% of all eligible employees; and companies with 10+ employees must enroll at least 75% of all eligible employees. An eligible employee is one who works a minimum of 80 hours per month, satisfies the employer’s eligibility criteria, and does not carry other major medical insurance coverage.

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 civil fines and criminal penalties.