

ASI GROUP PARTIALLY SELF-FUNDED MEDICAL PLAN

GROUP APPLICATION

NAME OF CONTRACTING ENTITY _____

Contact Person _____ Tax ID # _____

Entity Type: Sole Prop. Partnership C-Corp S-Corp Govt. LLC Prof. Serv. Corp.

LLC – Please check one to show form of taxation applied: Partnership Corporation S Corp.

Phone No. _____ Fax No _____

Address _____
Street City State Zip

Billing Address _____
Street City State Zip

CONSULTANT/BROKER _____

Address _____
Street City State Zip

Agent TIN or Social Security Number _____ Broker Fee _____

Phone No. _____ Fax No _____

PLAN EFFECTIVE DATE _____ Plan Year _____

PRIMARY CARRIER _____ **PLAN** _____

EFFECTIVE DATE _____

BENEFIT DESIGN

Deductible: Individual\$ _____ Family\$ _____ (Please include prior plan EOB if applying deductible carry-over)

Co-Insurance: Employer _____% Employee _____%

Office Visit Co-Pay: \$ _____ (Subject to deductible: Yes _____ No _____)

RX Benefits: 1. _____ Reimbursement Only
2. _____ Co-Pay: Brand:\$ _____ Generic:\$ _____
3. _____ Co-Insurance: Brand: _____% Generic: _____%

Coordinate Benefits to match above after satisfaction of Major Carrier Deductible: _____ Yes _____ No

ELIGIBILITY

First of the month following complete of _____ months of continuous employment at _____ hours per week.

Dependent Coverage: Children to age _____ Students to age _____

Employer Contributions:

Employer: _____% Employee: _____%

Premium Only Plan In Force: Yes _____ No _____

ASI Partially Self-Funded Health Plan Start-Up Charge: _____ \$ 250.00 (10 or fewer employees);
_____ \$500 (over 10 employees)

POP Plan Charge: _____ \$ 200.00 (if necessary)

Administration Charge Per Employee (monthly) _____ \$15.00

Agent Fee Per Employee (monthly) \$ _____ (Commission Payable to Agent _____ or Agency _____)

This plan shall become effective only upon issuance of a written agreement.

EXECUTED THIS _____ DAY OF _____, 20____, AT _____

AUTHORIZED SIGNATURE _____ TITLE _____

1. _____ ASI Group Application
2. _____ Employee Applications
3. _____ Signed Employee Authorization Forms
4. _____ ASI/Agency Proposal/Illustration
5. _____ Banking Option 1 - A Voided check must be sent to ASI before any claims can be paid. All checks will be prepared on the employers checks, produced by ASI. These checks will be sent to the employer to sign and forward to the provider of the services being provided. Please attached a voided check and indicate the starting check number:

Check Starting # : _____

6. _____ Banking Option 2 – ASI opens a separate account FBO Client's Name. ASI prepares the checks then notified client of check runs. Client may pre-fund account or fund each check run. ASI signs and forwards checks to provider or employee. Administration Fee \$25.00 per month.

ASI USE ONLY:

DATE RECEIVED: _____ BY: _____

DATE PROCESSED: _____ BY: _____

ID CARDS SENT: _____ BY: _____