



GROUP CONTRACT APPLICATION

The Employer hereby named makes application to Health Plan Select (Athens Area Health Plan Select Inc. of Georgia) for a Group Contract to be issued in accordance with the specifications of this application:

EMPLOYER NAME:				
PHYSICAL ADDRESS:				
BILLING ADDRESS: (if different)				
COUNTY:		LOCAL PHONE:	LOCAL FAX:	
GROUP ADMINISTRATOR:				
EMAIL:				
FEDERAL TAX ID:		AGENT:	AGENT PHONE:	
CEO NAME:				
LEGAL STATUS: <input type="checkbox"/> CORPORATION <input type="checkbox"/> S-CORP <input type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> TRUST <input type="checkbox"/> OTHER:				
NATURE/TYPE OF INDUSTRY:				
TOTAL # OF EMPLOYEES:	FULL TIME:	PART TIME:	# COVERED:	# WAIVING:
MINIMUM HOURS PER WEEK:		SECTION 125: <input type="checkbox"/> YES <input type="checkbox"/> NO		
CURRENT COBRA PARTICIPANTS: <input type="checkbox"/> YES <input type="checkbox"/> NO (ATTACH A LIST WITH EXPIRATION DATES)				
HPS COBRA IS ADMINISTERED BY ADP: <input type="checkbox"/> YES <input type="checkbox"/> NO				
NEWLY HIRED EMPLOYEE WAITING PERIOD: <input type="checkbox"/> 30 DAYS <input type="checkbox"/> 60 DAYS <input type="checkbox"/> 90 DAYS <input type="checkbox"/> OTHER:				
PLEASE CIRCLE YES OR NO TO RECEIVE AN EVIDENCE OF COVERAGE IN SPANISH				
<i>COVERAGE BECOMES EFFECTIVE THE 1ST DAY OF THE MONTH FOLLOWING THE WAITING PERIOD UNLESS OTHERWISE AGREED UPON BY THE POLICYHOLDER AND ATHENS AREA HEALTH PLAN SELECT.</i>				
EFFECTIVE DATE: THE GROUP CONTRACT WILL BE DELIVERED IN AND GOVERNED BY THE LAWS OF THE STATE OF GEORGIA AND SHALL TAKE EFFECT ON _____, 20____ BUT ONLY IF THIS APPLICATION IS ACCEPTED AND SIGNED BY HEALTH PLANS SELECT/ATHENS AREA HEALTH PLAN SELECT INC.				
ANNUAL RENEWAL DATE: _____				
Plan Choices:				
HMO _____	POS _____	PPO _____	H.S.A _____	Deductible _____ Rx option _____
Dental Plan Choice: (Please circle one)				
Voluntary: Low Medium Standard High		Contributory: Low Medium Standard High High with Ortho		
X		X		

AGENT OF RECORD	DATE:	OFFICER OF APPLICANT COMPANY	DATE:
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