



Group Enrollment/Change Form

www.hcgaz.com • 602.417.6755 • 800.247.2289 (outside Maricopa County)
701 E. Jefferson St. • MD 1400 • Phoenix, AZ 85034

A State-Sponsored Health Plan

Business Name _____

Group # _____

Enrollment: New Business/Group Re-enrollment Existing

Requested Effective Date (date not guaranteed) _____

Change (Complete Section A Only): Street Address Change Mailing Address Change

Contact Person Change Business Name Change Phone/Fax/E-mail Change

County Change Ownership Change* Tax ID Change*

Other _____

* Proof is needed for verification

HCG USE ONLY

Eff. Date _____ Late Enroll: Yes No

SP Event _____

W/P _____ Renewal _____

Rep. _____

Today's Date _____

DATE

SECTION A

Business Name _____ DBA Name _____

Phone _____ Fax _____ E-mail Address _____

Business Mailing Address _____ City _____ State _____ Zip Code _____

Business Street Address _____ City _____ State _____ Zip Code _____

Business Owner Name _____ Additional Authorized Contact _____

County _____ Tax ID/SSN _____ Date Business Established _____ Nature of Business _____

SECTION B

Proof of Business (Check the type of documents you are providing to verify your valid business status):

Sales Tax Return Personal Tax Return with Schedule C and SE or SEZ form Corporate Tax Return 60 days of Payroll Records Unemployment Tax and

Wage Report (with employee listing) Worker's Comp Report (with employee listing) Other (please specify) _____

Specify waiting period before new employees are eligible for healthcare coverage:

None 1 month 2 months 3 months 4 months 5 months 6 months

Legal Status of Business: Sole Proprietor Limited Liability Company (LLC) Corporation Partnership Other (please specify) _____

Do you participate in Workers Compensation: No Yes If yes, enter carrier name _____

Do you have other medical coverage: No Yes If yes, enter carrier name _____

How did you hear about Healthcare Group of Arizona: Newspaper Magazine Outdoor Advertising Received a Mailing Phone Book Radio

Television Friend/Relative Membership in Association Health Plan Representative Conference/Presentation Internet Broker/Agent

Doctor AHCCCS Other (please specify) _____

SECTION C

Employees must work 20 or more hours per week and reside in Arizona to be eligible. Employees who participate in a government subsidized healthcare program or employees who have other health coverage through a spouse, parent or legal guardian can validly waive participation in the Healthcare Group program. Employees who do not wish to participate in Healthcare Group coverage for other reasons are not validly waived.

Number of employees working 20 or more hours per week _____

Number of employees who are enrolling in Healthcare Group coverage _____ **Number of employees who are waiving coverage** _____

The minimum number of eligible employees must participate in order for the business to obtain Healthcare Group coverage.

If your business size is:

Two to five employees working 20 or more hours per week

Your employee participation must be:

100% of these employees must either enroll or validly waive coverage. Complete an Employee Enrollment/Change Form for each employee who is enrolling or waiving.

Six or more employees working 20 or more hours per week (up to a maximum of 50).

80% of these employees must either enroll or validly waive coverage. Complete an Employee Enrollment/Change Form for each employee who is enrolling or waiving.

Disclaimer: See "New Group Enrollment" section for information regarding effective dates.

List all employees, including yourself, who are working 20 or more hours per week.

For each eligible employee waiving coverage, an Employee Enrollment/Change Form must be submitted with a copy of his or her insurance card. Use the Premium Rate Charts to determine the correct Medical Premium for each employee using the employee's Health Plan, Benefit Option, Rate Tier, Age Range, and Gender. Use the Dental and Vision charts to determine the correct premiums for each employee, using the employee's Rate Tier.

Use the following worksheet to determine the total premium amount for your group. Use additional sheets if necessary.

¹ **Health Plans:** MHG = Mercy Healthcare Group UPH = University Physicians Network

² **Benefit Options:** H520 = Classic *Healthstyles* \$1,000 deductible H530 = Classic *Healthstyles* \$2,000 deductible H540 = Classic *Healthstyles* \$3,000 deductible
H710 = Active *Healthstyles* \$500 deductible H720 = Active *Healthstyles* \$1,500 deductible

³ **Medical Rate Tier for Groups of Two Participating Employees:** A = Employee Only B = Employee and Spouse C = Employee and Family D = Employee and Child(ren)

Medical Rate Tier for Groups of 3-50 Participating Employees: 1 = Employee Only 2 = Employee and Spouse 3 = Employee and Family 4 = Employee and Child(ren)

⁴ **Rate Tier for Dental and Vision:** 1 = Employee Only 2 = Employee and Spouse 3 = Employee and Family 4 = Employee and Child(ren)

⁵ **Dental Plans:** EDS = Employer Dental Services PRIN = Healthcare Group's Principal Plan Dental PPO

Employee Name	Waived	Hire Date mm/dd/yy	Hours/ Week	Health Plan ¹	Benefit Option ²	Age Range	Gender M/F	Medical Rate Tier ³	Dental Rate Tier ⁴	Dental Plan Option ⁵		Vision Rate Tier ³	Total Premium
								Medical Premium	Dental Premium	EDS	PRN	Vision Premium	
Example Joe Employee		09/15/08	35	MHG	X020	45-49	M	1 \$xxx.xx	4 \$xxx.xx		X	1 \$xxx.xx	\$xxx.xx
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
Total Group Premium													

Please Note: Employer Groups must have a minimum of two and maximum of fifty eligible employees on the effective date of their first contract. Check(s) issued to HCG for a premium payment does not bind coverage. The checks will be processed and placed in a credit account pending completion of your group's enrollment. If determined to be eligible, the amount will be used toward your premium payment. If not determined to be eligible, a refund check will be issued to the employer.

New Group Enrollment:

- The completed required paperwork must be submitted to the Healthcare Group Administration with your premium payment(s).
- If all required paperwork is received and approved by the 15th day of the month and two months of premiums are enclosed, enrollment will begin the first day of the next month.
- If all required paperwork is received and approved by the 15th day of the month and only one month premium is enclosed, enrollment will begin the first day of the second month (in 45 days).

Changes: Paperwork will be processed by Healthcare Group Administration upon receipt of all required documentation.

Termination of Group Coverage: The Employer Group can only terminate mid-contract year if a qualifying event has occurred. Written notice via the HCGA termination form must be received by Healthcare Group Administration 30 days prior to the termination date and will be effective at 11:59 p.m. on the last day of the month following the 30 day termination notice.

By signing this application, I declare that I have carefully read, understand and agree to all of the terms and conditions of the HCG Group Service Agreement. I certify that the information on this form is true and correct to the best of my knowledge. I understand that any misrepresentation or omission may nullify coverage of employees and dependents.

Business or Group Contact Signature _____ Date _____