AMHIC
A RECIPROCAL ASSOCIATION

Request for Quote and Group Application

Group Application Submission Checklist:

Please attach a copy of the following (when applicable) to receive an AMHIC proposal

- ☐ 1. Completed Group Application (below)
- ☐ 2. IRS determination letter that indicates your status as a nonprofit organization
- ☐ 3. A written narrative describing how your organization supports education, research and/or public service
- ☐ 4. A completed census report using the template *"AMHIC Census Template for Rating"*
- ☐ 5. A copy of your most recent bills from your current carriers: 1) medical 2) dental and 3) vision plans
- ☐ 6. A copy of your most recent **renewal** for: 1) medical 2) dental and 3) vision plans
- ☐ 7. A copy of your carrier provided benefit summaries for: 1) medical 2) dental and 3) vision plans
  Benefit summaries should include copays, deductibles, out-of-pocket maximums, coinsurance, etc.
- ☐ 8. A copy of your current employer and employee payroll contribution schedule for: 1) medical 2) dental and 3) vision plans, for each employee (if using age banded rates, please provide details for each employee)
- ☐ 9. If insurance coverage is offered to retirees, please provide a copy of your post-retirement health policy
- ☐ 10. If you offer an employer sponsored Health Reimbursement Account (HRA), please provide the most recent HRA utilization report.

SECTION I: Employer Contact Information:

Employer (full legal name) _____

_____

Main Address _____

Contact Name _____

Contact Title _____

Contact E-mail _____

Telephone Number _____

Website Address _____

Proposed Effective Date _____

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SECTION II: Current Group Insurance Information

Medical Insurance

1. Do you contribute at least 75% of the monthly employee only premium for the least expensive medical plan you offer? Yes ☐ No ☐
2. Do you have at least five active employees? Yes ☐ No ☐
3. a. Total number of full time equivalent employees (FTE) _____
   b. Total number of benefit eligible employees _____ (Total of c + d below)
   c. What is the expected enrollment in the medical plan? _____
   d. What is the **total** number of waivers of coverage for medical benefits? _____
   e. What is the number of **valid** waivers* of coverage for medical benefits included in d? _____

*Valid waivers of medical coverage are taken out of the total number of employees before calculating the participation requirements. Valid waivers of coverage are signed by employees choosing to decline coverage typically due to other coverage such as through a spouse's or parent's plan.

4. Do you have at least 75% of all benefit-eligible employees enrolled in a medical plan? Yes ☐ No ☐
   a. Calculation example:

$$\frac{c}{b - e} \quad \text{or} \quad \frac{\text{(Expected enrollment in the medical plan)}}{\text{(Total number of benefit eligible employees - valid waivers)}}$$

5. If you contribute to a Health Savings Account (HSA) or Health Reimbursement Account (HRA), please indicate the type and amount of the contribution below for each applicable medical plan.
   a. Plan Name(s) _____
      Contribution Type (HSA or HRA) _____
      Annual Contribution (Individual) _____ (Individual + Dependents) _____
   b. Plan Name(s) _____
      Contribution Type (HSA or HRA) _____
      Annual Contribution (Individual) _____ (Individual + Dependents) _____

Dental Insurance

1. Do you contribute at least 50% of the monthly employee only dental premium? Yes ☐ No ☐

Additional Insurance Information

1. Number of COBRA participants: _____
2. Number of employees not actively at work due to medical leave or disability: _____
3. Is coverage offered to retirees? Yes ☐ No ☐
   Number of retirees on the: 1) Medical plan: _____ 2) Dental plan: _____ 3) Vision plan: _____
4. What other forms of health and welfare plans are available to your employees?

_____

_____

SECTION III: Underwriting

1. Has the company changed health carriers three (3) times in the past five (5) years? Yes ☐ No ☐
2. Has the company's coverage been cancelled or is it in the process of being cancelled by the company's current carrier? Yes ☐ No ☐
3. Has the company filed for or is in the process of filing for bankruptcy? Yes ☐ No ☐

SECTION IV: Request for Quotation

I declare that the information given on this application is true and complete to the best of my knowledge and belief.

My organization hereby requests approval to participate in the Employee Benefit Plan(s) offered by AMHIC, A Reciprocal Association and its subsidiary, Select Benefit Plan Administrators.

Printed Name	Date
Authorized Signature	Title
Company Name	

AMHIC Coverage Options:	
Medical Insurance	• CareFirst PPO Health Plan • CareFirst Network Only Health Plan • CareFirst Qualified High Deductible Health Plan • Kaiser Permanente HMO Signature Plan
Dental Insurance	• MetLife Premium Dental Plan • MetLife Standard Dental Plan
Optional Vision Insurance	• UnitedHealthcare Vision
Optional Employer Paid Basic Life Insurance Options	MetLife Options • 1X Annual Salary • 1.5X Annual Salary • 2X Annual Salary • Flat $50,000
Additional Optional Insurances and Resources	• Health Advocate Employee Assistance Plan (must be 100% employer paid) • Prepaid Legal Plan (Legal Resources) • Connect Your Care Flexible Spending Account • Connect Your Care Health Savings Account