



Care Access Health Plan, Inc., P.O. Box 4276, Hallandale, Florida 33008
Group Application and Certification

SECTION II - GROUP INFORMATION

Business and / or Association Name (include D/B/A)
Benefit Administrator / Contact Person for Group
Business / Association Location / Street Address, City, State, Zip (actual location)
Billing Address / Street Address, City, State, Zip (if different from above)
Telephone Number Toll Free Number Fax Number
Requested Effective Date of Coverage Tax ID Number / FEIN
Type of Business Corporation Partnership Association Municipality Other (Please specify below)
Nature of Business SIC Code How long has entity been in current business?

Name of current or most recent health carrier:

Name
Policy Number Type of Coverage How long covered?
Will Group offer other health coverage in addition to this Plan? If yes, Please specify:

SECTION III - EMPLOYEE PLAN INFORMATION

Number of hours per week Employees must work to be eligible for benefits
Do you want to exclude a class of Employees? NO YES
If yes, check class to exclude: union non union salary management non management
Eligibility Requirements: 1st of the Month following Date of Hire Other: 1st of the Month following days of employment
If waiting periods vary by class, please attach a descriptive schedule.
Number of Employees eligible for coverage (Minimum participation 25%)
Group Premium Contribution: Employee (Minimum 25%) \$ / % Dependents \$/%

Workers' Compensation Carrier:

This Contract excludes expenses for any service or supply to diagnose or treat any condition resulting from or in connection with a Member's job or employment (e.g. any service or supply which is paid by Worker's Compensation) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Worker's Compensation and that lack of coverage did not result from any intentional action or omission by that individual. This exclusion applies to an individual who elects exemption from Worker's Compensation coverage and to an individual who forgoes Workers' Compensation coverage available to employees in the Group.

Plan Rider Options Dental Other (Please specify)

SECTION IV - GROUP STATEMENT OF UNDERSTANDING AND ACCEPTANCE

You, the participating employer, policyholder, contract holder, or group sponsor, understand and agree to the following:
You have read this document and the information you provided is accurate and complete to the best of your knowledge. You agree to make available your business records which we determine are relevant to this application and group coverage for inspection.
The first month's estimated premium and fully completed enrollment information for all eligible persons requesting coverage must be submitted with this application. Our acceptance of premium does not guarantee coverage.
You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met.
Premium rates: Premiums are due in full by the 1st day of month for the month for which coverage is provided and is subject to a 10 day Grace Period. Grace period means that if any required Premium is not paid on or before the date it is due, it may be paid during the Grace Period. During the Grace Period, Coverage under this Group Contract will stay in force. If the Premium payment is not received by CAHP within the Grace Period, Coverage under this Group Contract will terminate on the last day of the month for which the last Premium was paid.
Premium Adjustments: Subject to the approval of the Florida Department of Financial Services, CAHP reserves the right to adjust the premium charged upon forty-five (45) days written notice to the Group. All premium adjustments will be deemed accepted by the Group unless notice of non-acceptance is received by CAHP any time prior to the effective date of the adjustment. If notice of non-acceptance is received from the Group, this contract will terminate on the date the adjustment would have been effective.
Group Statement: Group shall: 1) Notify each enrollee of the benefits selected by the Group, their Effective Date, and coverage termination date (in this regard, Group acts as the agent of the enrollee, and in no event shall the Group be deemed an agent of CAHP for this or any other purpose); 2) Deliver if requested to covered enrollees, CAHP identification cards, and Certificate of Coverage furnished by CAHP; 3) Notify CAHP promptly of any changes in the eligibility of enrollees covered under this Agreement; 4) Collect enrollee contributions, as required, and remit Premium payments to CAHP as specified in the Group Contract; and 5) shall consult with its own tax and other advisors as to any matter hereto. The Group certifies that all the information contained in this Application is correct to the best of its knowledge and all eligibility requirements, benefits, limitations and exclusions have been thoroughly explained. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
NOTE: Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.

Dated this day of 20 By: Officer or Authorized Representative of Group (print)
Authorized signature Title (print)

SECTION V - AGENT INFORMATION AND CERTIFICATION

Agent Statement: I certify that all the information contained in this application is correct to the best of my knowledge. I certify that the Group is a bona-fide business entity or association. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the Group. I recommend that such coverage be offered and know of no reason why coverage should be declined.

Agent must complete the following to receive proper credit.

Signed this day of 20 Writing Agent/Broker (Print Name and Sign)

Agent Signature (for commission and non-commission)

Name (print) Tax Id/Social Security Number State Agent License ID Number
Commission Split No Yes If Yes, percentage: (total should equal 100 %) Writing Agent/Broker/Producer:
Name Agent License Number
Commission Split: No Yes If Yes, percentage: (total should equal 100 %)

Name (print) Tax Id/Social Security Number State Agent License ID Number
Percentage of Sales: No Yes If Yes, percentage: (total should equal 100 %) Writing Agent/Broker/Producer:
Name (print) Agent License Number
Percentage of Sales: No Yes If Yes, percentage: (total should equal 100 %)
Agent Address (Street Address, City, State, Zip)
Telephone E-Mail

SECTION VI - FOR CARE ACCESS HEALTH PLAN USE ONLY

Account Executive Signature Date
VP/Sales Signature Date
Underwriting Signature Date
Check # Check amount
Group # Effective Date Plan Code