Colorado Choice Health Plans
Benefit Contract for Employer Groups
SIGNATURE SHEET

Anniversary Date:______________________________ Group No.:______________ AE:________

Benefit & Premium Modification Date:________________ Broker: ____________________________

This Agreement, consisting of the Benefit Schedule(s) and other related documents, as supplemented by this Signature Sheet and attachments, has been entered into between Colorado Choice Health Plans, Inc. (Colorado Choice) and the Employer Group named below, in order to provide eligible Employers and eligible Dependents electing to enroll hereunder with health care benefits as specified in the Benefit Schedule(s) and related documents. This Agreement may be amended pursuant to the Benefit Schedule(s) and related documents of at any time by mutual written consent between the Employer Group and Colorado Choice.

1. Name and Address of Employer Group:

____________________________________ Employer Tax I.D. No.: ________________________

____________________________________ Administrator: ______________________________

____________________________________ Title: ____________________________________

2. Eligibility: _____ Standard-1st of month following 60 days. ____ Other – 1st of month following _____days

Full time employees must work at least ____________ hours per week (must be at least 24 hours per week).

Employer contribution: Employee _______________Dependents _______________

3. Monthly Prepayment Schedule (premium): The rates are in effect for coverage through: __________________

See attached for Employer Group rates. It is the Employer Group's responsibility to prepay for healthcare coverage prior to the month of coverage (for example, payment for February coverage must be received by Colorado Choice in January) to maintain coverage. **Colorado Choice has no responsibility to extend coverage beyond the month for which premiums have been received or to send Employer Group billings or statements for any period of coverage.**

4. Contract Type Rate Tier Structure:

Employer groups of 1-99 employees:

☐ Age-Rated Only ☐ Composite Only

5. Please attach copy of all Group Rate Quote sheets applicable to your group.

Plan Name 1: ______________________________

Plan Name 2: ______________________________

Plan Name 3: ______________________________

Note: (Offering more than 2 Plans require prior approval)

Type of Benefit Plan: Benefit Plan:____

6. Riders: ☐ Vision ☐ Pediatric Dental ☐ Dental

Special Instructions & Other Attachments:

Executed at:_____________________, Colorado Effective Date:______________________________

Employer Group:____________________________ Colorado Choice Health Plans

Signature:________________________________ Signature: ______________________________

Print Name & Title:__________________________ **Cynthia Palmer, CEO**

Date:____________________________________ Date:__________________________________

7. ACA – Compliant: ☐ Yes ☐ No Grandfathered: ☐ Yes ☐ No

Colorado Choice Health Plans
700 Main Street, Suite 100, Alamosa, CO 81101 * 719-589-3696 or 1-800-475-8466

SIGNATURE SHEET

Group Name: ____

1. We wish to enroll our firm as a group account with Colorado Choice Health Plans, Inc.
2. We understand the eligibility rules applicable to employee enrollment and the prepayment requirements of Colorado Choice Health Plans.
3. Participating requirements for specific coverage(s) have been explained in detail, and we fully understand that they must be met and maintained in order for the group to remain eligible for coverage.
4. The group herewith tenders the amount of $______________; and in consideration of approval of the application by the Plan, it promises to pay the Plan, as appropriate, any balance necessary to constitute the full initial payment for group benefits herein identified in the application. It is understood that the Plan has the right to accept or reject this application, and coverage will not commence until the application has been accepted.

This Agreement, consisting of the Evidence of Coverage (EOC) and Benefit Schedule(s), as supplemented by this Group Application and Signature Sheet, has been entered into between Colorado Choice Health Plans, Inc. and the Employer Group named above, in order to provide eligible Employers and eligible Dependents electing to enroll here under with health care benefits as specified in the Benefit Schedule(s). This Agreement may be amended with mutual written consent between the Employer Group and Colorado Choice Health Plans, Inc. at any time.

Executed at:______________________, Colorado

Employer Group: ______________________

Date: ______________________

Signature: ______________________

Print Name: ______________________

Title: ______________________
Authorized Representative

Effective Date: ______________________
Colorado Choice Health Plans

Date: ______________________

Signature: ______________________

Print Name: Cynthia Palmer

Title: CEO
Authorized Representative

PRODUCER STATEMENT

Name: ______________________

Production Split: ______________________

Address: ____

Make Check Payable to: ____

Telephone: ______________________

Fax #: ______________________

Federal Tax I.D. #: ______________________

Producer #: ______________________

I certify that all the information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm is a bona fide business establishment.
2. All participation requirements have been met.
3. Coverage's, enrollment provisions, eligibility requirements, limitations, exclusions, the effect of misrepresentations and termination provisions have been fully explained and understood by the employer. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be coverage.

Dated this ______________________ day of: ______________________

Print Name of Producer: ______________________ Producer Signature: ______________________

Any change to this Producer statement does not constitute an amendment to the Group Application and Signature Sheet.

Colorado Choice Health Plans

COLORADO CHOICE HEALTH PLANS

Certification of Completed Group Application/Renewal

Please complete the following

I hereby certify that the following required documentation has been submitted to Colorado Choice Health Plans as part of this group Application/Renewal.
The documentation requested below may be required each year at renewal.

REQUESTED EMPLOYER INFORMATION IS ATTACHED.
Please provide the most recent quarterly UITR (Unemployment Income Tax Report), or a similar payroll report verifying employment status of eligible employees.

☐ **YES** I have provided the necessary documentation.

Please provide copies of each employee signed waver for eligible employees **NOT** participating in the group health plan.

☐ **YES** I have provided the required waivers.

NOTE: This page is required for all new and renewal groups. IF there are no plan changes at renewal, this page will act as renewal confirmation.

GROUP BENEFITS ADMINISTRATOR

Name: ______________________ Title: ______________________

Address: ____

Telephone: ______________________ Fax #: ______________________

BILLING CONTACT PERSON

Name: ______________________ Title: ______________________

Address: ____

Telephone: ______________________ Fax #: ______________________

Signed: ______________________________

Printed Name: ______________________________

Date: ______________________________

Business Name: ______________________________