

**York County Builders Association
Master Application
Inter County Hospitalization/Health Plan, Inc.**

GHAI USE ONLY	
GROUP #	_____
PLANCODE	_____
CHECK \$	_____
ASSOCIATION	_____
MARKETING REP. INITIALS	_____



GROUP NAME: _____ BY: _____ TITLE: _____

SIGNATURE

The above named Employer is eligible to participate in the above described Plan and is approved as a participant therein.

EFFECTIVE DATE: ____ / ____ / ____

Gettysburg Health Administrators By: _____ / ____ / ____

GHAI FOR ADMINISTRATORS USE ONLY

The Insurance benefits, eligibility requirements and effective date of the insurance are requested herein. I certify, as the employer, that to the best of my knowledge and belief all statements and answers in this Application are true. I have read and understand the Notice Regarding Limitations on Health Coverage.

Administrator: Gettysburg Health Administrators, 404 Baltimore Street, P.O. Box 1060, Gettysburg, PA 17325-1060 (717-334-9247)

Please Return all pages to YCBA Insurance Trust, 540A Greenbriar Road, York 17404

PLAN OF COVERAGE

NAME OF FIRM _____ TAX ID # (E.I.N.) _____

CORRESPONDING PERSON & TITLE _____ TEL. # (____) _____

STREET ADDRESS _____ FAX # (____) _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

(1) Effective Date: The requested effective date for this plan is _____, 20_____

(2) Type Of Business Corporation Partnership Sole Proprietor

(3) Nature Of Business _____ SIC Code _____

(4) How long has this particular business been in operation? _____

(5) Subsidiary or affiliated companies to be covered (if trusteeship or association, list contributing employers or employer-members on a separate sheet and attach with this application):

Name & Address Relationship to Policyholder (Subsidiary or Affiliate)

a) Are any employees outside coverage area quoted by Gettysburg Health Administrators? # of employees _____ Location _____

(6) Total Number Of Employees: Full-Time _____ To Be Insured _____ Waivers _____ COBRA _____ (30 or more hours per week or 1560 hours per year)

a) List classes of employees to be covered: _____ All Employees _____

All full-time employees who devote a minimum of 30 hours each week to the service of the applicant at their regular and customary place of employment are considered eligible. It is agreed that the insurance applied for shall not become effective unless the number of persons insured is no less than the minimum number of lives required by law. It is also agreed that if contributions are required, at least 75% of the persons eligible for insurance make written request for the insurance. In addition to part-time and temporary employees, the following classes of employees or employees by name are NOT to be considered eligible: _____

b) Individuals to be covered receiving extended benefits under COBRA? NO YES Identify individuals, effective date and termination date of COBRA: _____

(7) Waiting Period For Eligible Full-Time Employees:

a) Initial employees employed ON or BEFORE effective date: No Waiting Period 0 Months

b) Subsequent employees employed AFTER the effective date: _____ Months

c) Are any employees currently absent due to illness or injury or receiving disability benefits? YES* NO

*If YES, specify whom and provide explanation on separate sheet.

NOTE: Eligible employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to active work. If a dependent of an insured employee is hospital confined on the effective date, he or she shall be covered under this plan when discharged from the hospital.

(8) Does your company have a policy for Continuation of Coverage for disabled employees or those on leave of absence? YES* NO

*If YES, attach copy of policy.

(9) Does your company provide health benefits for laid off employees? NO YES, # of Days: " 30 " 60 " 90 " 90

(10) Are all employees and owner/partners covered by Workers' Compensation? YES NO Name of Carrier _____

Name of owner/employee not covered by Workers' Compensation: _____

(11) Is HMO currently offered? YES* NO *Specify HMO: _____

*Specify HMO Enrollment Period: _____

(12) Insurance coverage hereby applied for is to replace insurance in force as stated below: (Attach copy of previous carrier's bill.)

a) Coverage applied for is is not in addition to coverage below:

TYPE OF INSURANCE DATE DISCONTINUED INSURANCE COMPANY YEARS WITH CURRENT CARRIER

(13) EMPLOYEE CONTRIBUTIONS: Insurance is non-contributory Insurance is contributory
 The Applicant Employer agrees to make the payroll deduction authorized in writing by each employee.

EMPLOYEE'S CONTRIBUTION TOWARD COST

MEDICAL	LIFE/LIFE & SHORT TERM DISABILITY
_____/ ____	_____/ ____
Employee/Dependent	Employee

COVERAGES REQUESTED

MEDICAL COVERAGE REQUESTED: (Select 1 if 24 or less employees are applying; or Select 1 or 2 if 25 or more employees are applying)

Plan A _____ Plan B _____ Plan C _____ Plan D _____ Plan E _____ Plan F _____

MINMAX _____ MINMAX DEDUCTIBLE \$5,000 _____ \$7,500 _____ \$10,000 _____ \$12,500 _____ \$15,000 _____

MATERNITY COVERAGE: Normal Delivery Included

LIFETIME MAXIMUM: \$2,000,000

DRUG CARD: \$100 deductible then \$20 Generic / \$35 Brand / \$60 Mail Order

OTHER COVERAGES- YORK COUNTY BUILDERS ASSOCIATION INSURANCE TRUST:

LIFE INS/LIFE INS SHORT-TERM DISABILITY – **THE HARTFORD LIFE** –
 (Selection of One Plan is Mandatory when selecting medical coverage – See Blue Brochure)

Plan 1 _____ Plan 2 _____ Plan 3 _____

LONG TERM DISABILITY – **THE HARTFORD** (Optional-any number may participate)
 Yes _____ No _____

NOTICE REGARDING LIMITATIONS ON HEALTH INSURANCE COVERAGE

While we believe that the insurance coverage you are purchasing is among the finest obtainable, you should be aware of certain limitations in the coverage being offered. In particular, please note the following:

- There may be a "waiting period" which would delay the insurance coverage effective date (see page 2 of this form);
- Certain exclusions from coverage are contained in the policy (see the policy);
- Some "pre-existing conditions" may not be covered for up to 12 months (see the policy);
- The policy discusses the various optional coverages and limitations upon some of these benefits.