Bridgewell Health

EMPLOYER APPLICATION

Please complete the below form in its entirety in order to ensure the most efficient implementation of your group with Bridgewell Health. Any missing information may delay group implementation and processing.

Requested Effective Date (Must be 1st of the Month): ________ / 01 / 2018

SECTION 1: COMPANY INFO / KEY CONTACTS

1. **Company Legal Name:** ____ **Affinity Program: LICA**
2. **Street Address:** ____**City:** ______________**State:** ____ **Zip:**_______
3. **Mailing Address:** _______________________________________**City:** ______________**State:** ____ **Zip:**_______
4. **Phone Number:** ________________________ **Fax Number:** ________________________
5. **Key Contact Name:** ____________________________________**Title:** ____________________________
6. **Key Contact's E-mail Address:** ____
7. **Federal Tax ID#:** _____________________________ **Nature of Business:** _______________________

SECTION 2: EMPLOYEE STATUS

8. **Total Number of ALL Employees** ______________ **(Full-time, Part-time, COBRA, FMLA, Disability and Other)**
9. **How many are Full-time (FT)?** ______________ **(eligible employees are full-time, active working at least 25 hours per week)**
10. **How many are Part-time (PT)?** ______________ ☐ **Check if N/A**
11. **How many are on COBRA?** ______________ ☐ **Check if N/A**

(Please complete below for all employees who qualify for COBRA, FMLA, or Disability and check appropriate status.)

First Name	Last Name	COBRA	FMLA	Disability	Other (please specify)

(Please use additional pages as necessary)

SECTION 3: COVERAGE COUNT AND ELIGIBILITY

➔ **LIMITED BENEFIT PLANS SOLD (Select all that apply):** ☐ Limited Edge ☐ Limited Care ☐ Limited Plus ☐ Check if N/A

12. **How many employees are electing coverage? ________________ (minimum of 4 enrolled employees required)**
13. **COBRA Administration Coordination (Available for groups with 20 or more full time employees):** ☐ yes ☐ no

SECTION 4: BILLING AND ENROLLMENT INFORMATION

14. **Billing Method:** ☐ email ☐ mail **Pre-tax:** ☐ yes ☐ no
15. **Divisional Billing by Location?** ☐ yes ☐ no **(If yes, please attach list of locations to this form.)**
16. **Billing Contact (Group or PEO): ___________________________________ E-mail: __________________________________**
17. **Billing Address: ______________________________________City: _________________________State: _____ Zip:________**
18. **Enrollment Method:** ☐ census ☐ enrollment forms ☐ online **(minimum of 25 enrolled)**

SECTION 6: SIGNATURE AND AUTHORIZATION

As a part of the group submission process, we hereby attest to the accuracy of the information provided above. We recognize and assume all legal responsibility in the event that the information provided above is not correct and a member's benefits are denied or incorrectly administered by Medova Healthcare based on the information disclosed in this employer application form.

Employer Name: ____ Title: ____

Employer Signature: ____ Date: _______________________________

Agent Name: _______________________________________ Agent Signature: ____ Date: ___________