SL Healthplans LLC
Self Funded Marketing Experts

Employer Application

1. Company Information

Requested Effective Date:___________________

Company Name:____

Street Address:___________________________________ City:______________________

State:_______________ Zip Code:________

Billing Address:___________________________________ City:______________________

State:_______________ Zip Code:________

Business Organization Type: Corporation: Sole Proprietorship: LLC: Partnership:

Other: (Please Specify)_____________________________________ SIC Code:______________

Date Company Established: _______________ Tax Id Number:_______________________

Company Contact:____________________________________ Contact Phone Number:________________

Contact Fax Number:_____________________ Contact E-Mail Address:_______________________________

Company Privacy Officer____

Individuals with access to Personal Health Information

(PHI)____

2. Billing Information

Billing Address: (if different from above)____

Billing City:__________________ Billing State:__________ Billing Zip Code:_____________

Billing Contact Name:________________________________ Billing Contact E-Mail:__________________________

Billing Contact Phone:___________________ Billing Contact Fax Number:______________________

3. Billing Configuration Options

Please select the option below which will support your specific billing needs:

____ **Billing Entity** (*Note this option is only used for entities which require entities or divisions to be billed and Remit payments separately*)

____ **Billing Location/Division** (This option will allow for tracking and subtotaling the bill by specific Cost centers which you will provide on your census information.

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4. Banking Information

The Loomis Company's standard funding payment policy requires payment through ACH. The deduction from your account will be processed on the 25th of the month prior in which payment is due. Please provide the necessary information to facilitate this payment.

____ The Company opts to pay the first month's expenses by check and thereafter elects to pay expenses via ACH Withdrawal

____ The Company opts to pay the first month's expenses and all subsequent expenses via an ACH withdrawal

Please complete the following:

Name of bank:________________________________ Name on the account:_________________________________

Routing Number:_________________________ Account Number:_______________________________

5. Eligibility/Participation Information

Number of Full Time (30 hours or more/week) Eligible W2 Employees:__________________

Are you offering coverage to the Part Time Employees:

Number of part time (20 hours to 30 hours per week) W2 Employees: ____________

7. Eligibility/Participation Information Continued……

Employee Waiting Period:

Other – Please Specify

Employee coverage begins on:

Employee coverage ends on:

Plan benefits accumulate based upon:

Deductible Credit from Prior Carrier:

Payroll Frequency:

Number of pay periods in the year:_____________ Pay Period Begin Date:______________

Domestic Partners Covered:

Open Enrollment Period: Start Date:___________ End Date:______________

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Initial batch of ID Card's to be mailed

CIGNA PHCS____________ MagnaCare___________ Evolutions: ______________

Plans: ____

8. COBRA Information

Is anyone in your firm currently enrolled in COBRA, a state continuation plan, or within their election period?

If you answer yes to this question, a member of our enrollment team will contact you for further information.

Company Name:______________________

By:_

Print Name:__________________________

Title:________________________________

Date:________________________________