

PIEDMONT COMMUNITY HEALTHCARE HMO, INC.

2316 Atherholt Road
Lynchburg, Virginia 24501

I. Large Group Application (51+ FTE Employees)

Group Name ("the Group")		Type of Business		Federal Tax ID	
Group Mailing Address		City	State	Zip Code	E-Mail Address
Billing Address	Billing Contact		Phone # ()		Fax # ()
Group Contact	Title		Phone # ()		Fax # ()
Group Number	Effective Date	Renewal Date		For Office Use Only: Plan Code:	

Basic Benefit Description:

☐ LocalSelect ☐ HMO ☐ Non-Grandfathered Plan

Full Name 1. _____
of Plan: 2. _____
3. _____

In Plan Benefits

Deductible: 1. _____ Copay: 1. _____
2. _____ 2. _____
3. _____ 3. _____

Out of Pocket: 1. _____ Coinsurance: 1. _____
Maximum: 2. _____ 2. _____
3. _____ 3. _____

Rx Benefit: 1. _____
2. _____
3. _____

✧Please Attach a Copy of Rate Sheet ✧

Rider Options: ☐ Vision ☐ Plan Year ☐ Calendar Year (default)

☐ Supplemental ☐ Accidental ☐ Male Impotence

% of Employer Contribution: _____

Wellness Program: ☐ Yes ☐ No

COBRA Administration: ☐ Yes ☐ No

Open Enrollment Period: Start Date _____ # Enrolled Under This Contract _____ # of Eligible Employees
End Date _____ # Total Employees _____ Average # of Employees from Previous year _____

New Hire Eligibility Date: ☐ The first day of the month following date of employment
☐ Date of Hire
☐ First of month following _____ days of continuous employment
☐ Date following _____ days of continuous employment
☐ _____

Termination Effective Date: ☐ End of Month in which Employment Ends ☐ Other _____
☐ Date of Termination of Employment

I hereby certify that all the information in the Group Application and Employee Applications is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual requesting coverage, except as noted in the claims experience, as required. I have complied with Piedmont's underwriting rules and guidelines and have explained in detail the coverage to the group and its employees.

Broker Name: (print) _____ Broker #: _____ Broker Phone: (_____) _____

Broker Signature: _____ Date: _____ Broker Fax: (_____) _____

This Group Application is Section I of the Policy. Sections I-XIII of the Policy incorporated herein as though they were recited over the signature below. The Group must provide prior written notice of a Participant's termination and pay premiums during the period in which Piedmont Community Health Care HMO, Inc. provides coverage to such participants.

Group _____

Piedmont Community HealthCare HMO, Inc.

Signature _____

Signature _____

Title _____ Date _____

Date _____