# PIEDMONT COMMUNITY HEALTHCARE, 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 ☐ PPO ☐ Non-Grandfathered Plan

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

**In Plan Benefits**

| | | | |
|---|---|---|---|
| Deductible: | 1. _____ | Copay: | 1. _____ |
| | 2. _____ | | 2. _____ |
| | 3. _____ | | 3. _____ |
| Out of Pocket Maximum: | 1. _____ | Coinsurance: | 1. _____ |
| | 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, Inc. provides coverage to such participants.**

**Group** _____

**Signature** _____

**Title** _____**Date**_____

**Piedmont Community HealthCare, Inc.**

**Signature** _____

**Date** _____