



**PRINT IN INK**

**SECTION I.**

Group Applicant's Name	Date
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Address

City	State	Zip	County	Telephone No. ( )
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Fax No. ( )
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Company Officer's Name

Title

Contact Person	Title	Telephone No.
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Consultant Company Name and Address (if any)

Please print the name of the GHI plan for which you are now applying. (Please refer to the enclosed chart of plans and rates.)  
 \_\_\_\_\_ Desired Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION II.**

1. a. How many employees are eligible for coverage? \_\_\_\_\_  
 Please note that, by regulation, all employees who work 20 hours or more per week must be eligible for coverage.  
 Please note that by regulation all employees who return to work after a leave of absence are eligible for coverage immediately upon return.

- b. Will any part of the premium be contributed by insured employees?  Yes  No  
 If yes, at least 50% of eligible employees or at least 50 employees, whichever is less, must be covered by GHI in order to obtain coverage.

Please indicate the percent of premium to be contributed by insured employees.

Individual Coverage	Family Coverage
_____ %	_____ %

- c. Please state the required time period of employment, if any, before an employee becomes eligible for health coverage. \_\_\_\_\_

2. How many employees (excluding spouse and dependents) do you intend to cover under the GHI plan for which you are now applying? \_\_\_\_\_

3. Do you currently offer a health benefits plan to your employees?
- No. Go to question 5.
- Yes. If yes, is the GHI plan for which you are applying:
- a replacement for an existing plan? Go to question 4a.
- an option in addition to existing plans? Go to question 4b.

Please note, according to GHI's overinsurance guidelines, GHI will not issue a health insurance plan to anyone who is covered by a similar insurance plan. However, you may purchase a GHI health insurance plan if you are replacing the similar existing plan.

4. a. Please complete the information below for your existing policy.

Type of Plan	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Policy	Termination Date
Hospital						
Medical						

b. Please complete the information below for any plan you intend to keep.

Type of Plan	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Policy	Termination Date
Hospital						
Medical						

5. a. Has your health insurance coverage been terminated within the last twelve months due to non-payment of premiums?

No  Yes

b. Please complete the information below for your prior policy.

Type of Plan	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Policy	Termination Date
Hospital						
Medical						

### SECTION III.

#### BILLING INFORMATION.

Premium invoices should be sent to:

Address

Contact Person

Telephone No.

The information provided in this application is true to the best of my knowledge. I hereby authorize any person, organization or other entity to release to GHI any information requested by GHI in connection with the processing of this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Name

Signature

Title

Date