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300 S. Park Road, Hollywood, FL 33021 (954) 962-3008

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Lennar Building, Commercial Marketing Department  
760 NW 107<sup>th</sup> Avenue 4<sup>th</sup> Floor, Miami, FL 33172 (305) 222-3000

# Universal Employer Group Application Package

Vista Healthplan, Inc., Vista Healthplan of South Florida, Inc. and Vista Insurance Plan, Inc. will be referred to as "VISTA".

## Instructions

**1. COMPLETE ALL QUESTIONS IN FULL. INCOMPLETE APPLICATIONS WILL DELAY PROCESSING.**

Employer must complete entire application

**2. PRINT CLEARLY USING INK**

**3. DO NOT MODIFY, ADD, OR DELETE ANY PART OF THIS FORM.**

**4. SIGN AND DATE APPLICATION**

Application must be signed and dated by owner or officer of the company requesting coverage and Agent

**5. SUBMIT THE FOLLOWING ITEMS TO YOUR AGENT AND/OR VISTA REPRESENTATIVE:**

- Completed Application
- Premium deposit made payable to: Vista Healthplan, Inc.; Vista Healthplan of South Florida, Inc.; or Vista Insurance Plan, Inc. (as applicable, depending on product selected in Section H)
- UCT-6 (most recent available)
- Current premium statement from current health plan carrier
- Employee Applications
- Waiver Forms
- Large Group Medical Questionnaire *for Large Group Employers Only (Over 50 full-time eligible employees)*
- Other requested supporting documentation (if applicable)
- Selected rates and corresponding Benefit Plan Summaries as proposed by VISTA
- Case Submission Checklist *for Small Group\* Employers Only (50 or fewer)*

\*A small group is any group with 50 or fewer full-time eligible employees (working 25 hours or more per week) as defined by Florida Statute 627.6699, as may from time to time be amended.

Any and all attachments to this Universal Employer Group Application Package (Application), including but not limited to medical records obtained by VISTA in conjunction with this Application, are considered part of this Application and are fully incorporated in this Application.

**DO NOT CANCEL EXISTING COVERAGE**

**Coverage will not commence until the application is approved by VISTA  
and the conditions of coverage are accepted by the employer**



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Vista Healthplan       Vista Healthplan of South Florida       Vista Insurance Plan

Effective Date	Group Number
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**A) Employer Group Information**

Company Name	DBA	Tax ID Number		
Address (physical location)		City	State	Zip
Contact Name	E-mail address		Telephone	

**B) Prior Coverage Information – check all that apply**

Types of Coverage  
 HMO     POS     PPO     HSA     ASO    Other \_\_\_\_\_

Will you offer any other health carrier, other than VISTA?  Yes  No

If yes, please explain:

**C) Workers Compensation Coverage**

Do you currently have a workers' compensation policy in force?  Yes  No    Policy Renewal Date: \_\_\_\_\_

List current workers' compensation carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Are all employees covered under workers' compensation?  Yes  No

If no, please explain: \_\_\_\_\_

Please list the name and job title of all individuals to be included for medical coverage not eligible for workers' compensation:

	Name	Title
1)		
2)		
3)		

**D) Employee Eligibility**

Waive waiting period on initial installation?  Yes  No

New Hires - Description	Commence coverage (check one per class)	Waiting Period (check one per class)	
Class 1	<input type="checkbox"/> Immediately <input type="checkbox"/> 1 <sup>st</sup> of the month following	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	<input type="checkbox"/> 60 days <input type="checkbox"/> other _____
Class 2	<input type="checkbox"/> Immediately <input type="checkbox"/> 1 <sup>st</sup> of the month following	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	<input type="checkbox"/> 60 days <input type="checkbox"/> other _____
Class 3	<input type="checkbox"/> Immediately <input type="checkbox"/> 1 <sup>st</sup> of the month following	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	<input type="checkbox"/> 60 days <input type="checkbox"/> other _____

Terminations will be effective at the end of the month.

Rehires?  Yes  No      Leave of Absence/FMLA?  Yes  No

**E) Payment**

The contracting entity herewith tenders the amount \$\_\_\_\_\_ and, in consideration of approval for the application it will make and in event of such approval, promises to pay this company as appropriate any balance necessary to constitute the full initial payment for the group benefits herein identified. It is understood that the rates will be determined from final enrollment data. It is understood that coverage will not commence until the application has been approved and the conditions of coverage are accepted by the employer.

**F) Billing Option/Division**

Are there multiple units/locations to be billed separately?  Yes  No  
 If yes, list names and addresses of all multiple units/locations to be billed separately.

Company Name	Contact	Telephone		
Billing Address (if different)	City	State	Zip	
Company Name	Contact	Telephone		
Billing Address (if different)	City	State	Zip	

**G) Underwriting**

List the Standard Industry Code (SIC), in which the business is classified. \_\_\_\_\_  
 Does the organization have, intend to have a PEO, or leased employees?  Yes  No  
 Are there any affiliates or subsidiaries as defined in IRS sec 414?  Yes  No  
 If yes, are all affiliates or subsidiaries enrolling?  Yes  No

**For employers with fewer than a total of 20 employees:**  
 Do you currently have any employees who are 65 years or older and are eligible for Medicare?  Yes  No  
 Are all eligible employees being offered health coverage?  Yes  No

If no, please explain: \_\_\_\_\_

Does the contracting entity have a flex plan under Section 125 or 132 of the IRS code?  Yes  No

**Participation**

Total number of employees shown on UCT-6 or payroll roster:	
Number of employees hired since last tax filing:	
Number of employees terminated since last tax filing:	
Number of employees NOT enrolled and covered by spousal coverage, Medicare or Medicaid: (Note: Employer is responsible for collecting waivers)	
Number of eligible employees in waiting period (if applicable):	
Total employees eligible:	
Total employees enrolled:	

**COBRA**

Are there any COBRA participants?  Yes  No      Number of COBRA or State Continuation (mini-COBRA) participants? \_\_\_\_\_  
 Applications are required for all COBRA participants.

**H) Plans/Rates Selected**

Company						
Plan Name:						
Plan Code:						
LOB:						

Rates:

EE					
ES					
EC					
FM					

**Contribution** (Note: A minimum 50% contribution is required.)      Employee: \_\_\_\_\_      Dependent: \_\_\_\_\_

Regions eligible for coverage: SFL\_\_\_\_ MSL\_\_\_\_ GNS\_\_\_\_ TLL\_\_\_\_ PNS\_\_\_\_

Check here if table rates apply. Table rate sheet must be signed and returned to VISTA prior to being approved for coverage.

**I) Employer Statement of Understanding and Certification**

**Minimum Participation:** VISTA requires a minimum number of employees be enrolled to maintain group coverage. Failure to maintain participation requirements may result in termination of the group coverage. VISTA reserves the right to review your group's enrollment to determine ongoing compliance with this requirement. Participation is based on overall employee enrollment in all products offered to Employer by any of the affiliated Plans. Seventy-five (75%) of your employees must participate with VISTA throughout the contract period. Employer must also meet group eligibility guidelines as specified in this Agreement at each policy renewal period. VISTA may request written documentation to verify eligibility and participation requirements at any time. Failure to timely return the appropriate documentation may result in the termination of this Employer Agreement at any time during the coverage period.

**Employer Contribution:** The Employer must contribute toward the cost of employees' coverage. Employer contribution must be at least 50% of Employee premium as determined by VISTA. Employer's failure to comply with this contribution requirement may result in termination of the group coverage at any time.

**Special Eligibility Requests:** A bona-fide employee/employer relationship is required to be maintained. Employer must continually compensate the individual in the form of annual, weekly or hourly wages. Furthermore, Employer and Employee must maintain an employment relationship pursuant to which Employer pays those payroll costs (e.g. FICA, FUI, SUI and Workers' Compensation) normally associated with a bona-fide employee relationship. Any other eligibility arrangements require prior approval by the VISTA Underwriting Department.

**Premiums:** All premiums are due in full on the first (1<sup>st</sup>) of each month for which coverage is provided. If total payment is not received from Employer during the grace period, coverage for all enrollees will be terminated on the last day of the month for which premiums were received, not to exceed 45 days retroactively. For large groups, terminations over 90 days are not accepted. For small groups, terminations over 30 days are not accepted. Any other payment arrangements require approval by VISTA. The initial quoted premiums determined by VISTA are based on information provided to VISTA by Employer and/or its representative. Premiums are subject to change annually on the anniversary of the effective date of coverage or as otherwise agreed to by VISTA and the Employer. Notice of premium changes will be provided prior to renewal in accordance with applicable law. In the event that Employer continues coverage under the applicable Binder and Agreement, all applicable terms and conditions set forth in this Application shall survive in full force and effect and be binding on the Employer. This Application, the medical questionnaire and all information provided by Employer shall be the basis for the issuance of coverage under the Binder and Agreement or Certificate of Coverage and shall become a part thereof. VISTA reserves the right to terminate group coverage or the coverage for any individual member if Employer or a member has made any fraudulent or material misrepresentations. To the extent that any provision of this Application is inconsistent with the terms of Employer Agreement, Binder and Agreement or Policy, the Application shall prevail, as permitted by law.

**Employer Statement:** I have read and understand the terms of this Application. By signing this application, I agree to these terms. I certify that the information I have provided on this Application is true and complete to the best of my knowledge. I understand that VISTA reserves the right to rescind or terminate coverage due to any material misrepresentation on this Application. Material misrepresentation is determined at the sole discretion of VISTA. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to me. I am duly authorized to execute this Application.

**For Small Group Employers (1-50):** The State of Florida requires group insurers to offer state-mandated plans to all prospects. If you are not enrolling in one of the "State Plans," please initial the following: I acknowledge that I was offered the opportunity to purchase the BASIC and STANDARD small business health plan in compliance with the Employee Health Care Access Reform Act and declined such coverage. \_\_\_\_\_(Initials).

I hereby agree to obtain a Certificate of Coverage (or "Contract") through the VISTA website at [www.vistahealthplan.com](http://www.vistahealthplan.com), or by calling the VISTA Customer Service Department and requesting a hardcopy be mailed via U.S. regular mail. Employees/Subscribers will be required to obtain a copy of the Contract through the VISTA website, contacting the Group Benefit Administrator, or by calling the VISTA Customer Service Department and requesting a hard copy be mailed via U.S. regular mail. I hereby agree to provide a copy of the Contract to all employees who request the Contract.

I hereby agree that the Contract shall automatically renew on each subsequent anniversary of the coverage effective date subject to any and all amendments to the Contract, including but not limited to rate or benefit changes, as determined by VISTA or elected by me on behalf of myself and all Applicants, without my express consent unless I, any Applicant, or VISTA determines to terminate the Contract in accordance with its terms and applicable law.

**Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.**

Dated at (city) \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Authorized Employer Signature \_\_\_\_\_

(Officer or Owner Only)

**J) Agent information and Certification**

License Number	IRS Number	
Agent Address	Phone	E-mail Address

**Agent Statement:** I certify that all the information contained in this application is correct to the best of my knowledge. I certify that the applicant is a bona-fide business establishment. I certify that all participation and contribution requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to Employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

Dated at (city) \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_ Agent Signature \_\_\_\_\_

**K) For VISTA Use Only**

Account Executive Signature \_\_\_\_\_ Date \_\_\_\_\_ Group #: \_\_\_\_\_ Parent Code #: \_\_\_\_\_

SVP/Sales Director Signature \_\_\_\_\_ Date \_\_\_\_\_ Underwriting Signature \_\_\_\_\_ Date \_\_\_\_\_

Enrollment Signature \_\_\_\_\_ Date \_\_\_\_\_ Contract Preparer Signature \_\_\_\_\_ Date \_\_\_\_\_

BP Code: \_\_\_\_\_ BP Code: \_\_\_\_\_ BP Code: \_\_\_\_\_ BP Code: \_\_\_\_\_

- If applying for HMO or POS coverage, primary business locations must be in a VISTA approved service area.
- The underwriting guidelines are applied collectively for all products selected under this Application and purchased by the Employer.

White Copy: Enrollment    Canary Copy: Underwriting

Pink Copy: Employer

Blue Copy: Marketing

Green Copy: Agent/Broker