



Hollywood Office Commercial Marketing Department
300 S. Park Road, Hollywood, FL 33021 (954) 962-3008

Tallahassee Office Commercial Marketing Department
1650 Summit Lake Drive, Suite 200, Tallahassee, FL 32317 (850) 668-3000

Miami Office Commercial Marketing Department
760 N.W. 107 Avenue, Suite 400, Miami, FL 33172 (305) 222-3000

Universal Employer Group Application Package

Vista Healthplan, Inc. and Vista Insurance Plan, Inc. will be referred to throughout as "VISTA".

Instructions

1. COMPLETE ALL QUESTIONS IN FULL

Employer must complete entire application

2. PRINT CLEARLY USING INK

3. INITIAL ALL CORRECTIONS

4. SIGN AND DATE APPLICATION

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

5. EMPLOYER RETAINS PINK COPY

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

- Completed Application
- First month's premium made payable to: Vista Healthplan, Inc.; or Vista Insurance Plan, Inc. (as applicable, depending on product selected in Section C)
- UCT-6 (most recent available)
- Current invoice 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.

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



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Section A **Employer Information**

Employer or Contracting Entity *(Include Parent Company, D/B/As and All Covered Affiliates)*

Benefit Administrator Name **E-mail address**

Business Location - Street Address, City, State, ZIP *(actual location(s))¹*

Billing Address - Street Address, City, State, ZIP *(if different from above)*

Telephone Number **Requested Effective Date of Coverage** **Tax ID Number**

Do You Want Separate Bills For Location or Other Billing Method? Yes No **If yes, please explain.**

Description of Employer's Business (SIC) **How Long Has Employer Been In Business?**

Employee Participation (Application is incomplete unless State or Federal Tax Forms are attached.)

1) Date of last UCT-6 filing (for Self-Employed, most recent year's IRS schedule C or F):	1)
2) Total number of employees shown on tax form:	2)
a) Number of employees hired since last filing:	2a)
b) Number of employees terminated since last filing:	2b) -
c) Number of employees NOT enrolled and covered by spouse, Medicare, Medicaid or CHAMPUS: (Note: Individual Coverage is not a valid waiver)	2c) -
d) Number of employees ineligible due to new hire probation:	2d) -
e) Number of part-time employees NOT enrolling:	2e) -
3) Total employees (Line 2 plus 2a minus 2b, 2c, 2d and 2e):	3) # Employees:
4) Number of employees enrolling at time of application (excluding COBRA):	4) # Enrolled:
5) Divide Line 4 by Line 3. This is the participation: Minimum participation is 75%	5) %

Excluding Officers and Owners, are all Employees covered by Workers' Compensation? Yes No **Explain** _____

Please include the name of the Workers' Compensation carrier. _____

Section B **Prior Carrier Information**

Name of current or most recent health carrier/insurer **Policy Number** **Type of Coverage**

How long was Employer covered by current or most recent carrier? **Scheduled Renewal Date**

Will the Employer offer multiple carriers to provide health coverage? Yes No **If yes, please explain.** _____

Has the Employer had a lapse in coverage for more than 63 days in the last year? **If yes, please explain.** _____

Section C **Sold Plan Design Information**

Selection of Products²

- HMO - Vista Healthplan, Inc. _____ POS - Vista Healthplan, Inc. _____ PPO - Vista Insurance Plan, Inc. _____
- HMO - Basic Plan – Vista Healthplan, Inc. HMO - Standard Plan – Vista Healthplan, Inc.

Employer Contribution to Premium (% or \$ amount)

Employee _____ Dependent _____

Eligibility Requirements

- Dependents age 19 / 25
- For Large Groups only (Subject to Underwriting Approval)**
- Retirees Domestic Partner Coverage Part-time Employees _____ *Will your spouse or d*
- Other Dependents age _____ EOM EOY

Premium Grace Period – Large Group Only. Small Groups are only offered the Standard Grace Period.

- Standard (10 Days) Other (subject to Underwriting approval) _____

¹ If applying for HMO or POS coverage, primary business locations must be in a VISTA approved service area.
² The underwriting guidelines are applied collectively for all products selected under this Application and purchased by the Employer. For example, the 75% participation requirements apply overall to all products offered by or to the Employer.

Commencement of Coverage/Waiting Period (subject to Underwriting approval)

If waiting periods vary by employee class, please attach a descriptive schedule.

- Standard (1st of month following date of hire) Date of Hire (for Large Groups only)
- Rehires _____ (1st - 15th / full month's premium due; 16th - 31st / no premium due)
- Other – 1st of month following _____ days of employment

Termination of Coverage (subject to Underwriting approval) – Large Group Only. Small Groups are only offered the Standard Grace Period.

- Standard (Last day of month) Date of employee termination
- Other _____ (1st - 15th / no premium due; 16th - 31st / full month's premium due)

Section D 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. 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] of each month for which coverage is provided. A grace period is provided as indicated in Section C of this Application. 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. 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. If the information provided to VISTA contains material misrepresentations, as determined by VISTA, coverage may be terminated or premiums adjusted accordingly, at VISTA's sole discretion. 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 certify that all of the information contained in this Application is correct to the best of my knowledge and 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 me. I am duly authorized to execute this Application.

For Small Group Employers (2-50): 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)

The state mandated benefits for Group Employers 1) Mental Health and 2) Alcohol and Drug Abuse were offered to me as an inclusive part of the medical benefit or as an optional benefit. Premium will be adjusted to reflect the acceptance or rejection of optional benefits. _____

(Benefit Administrator's signature here)

You hereby agree to obtain the Certificate of Coverage (or "Contract") through the VISTA website at 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. You shall provide a copy of the Contract to all employees who request the Contract.

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)

Section E 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 _____

Section F 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