

PIEDMONT COMMUNITY HEALTHCARE, INC.

1937 Thomson Drive
Lynchburg, Virginia 24501

I. Group Application

Group Name ("the Group")		Type of Business		
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 POS PPO

Full Name of Plan: _____

In Plan Benefits

Deductible: _____ Copay: _____

Coinsurance: _____ Rx Benefit: _____

Out of Pocket Max: _____

◆Please Attach a Copy of Rate Sheet◆

Riders:

Vision Contraception Coverage

Supplemental Rider Accidental Rider Conversion

Note: Conversion is only available for groups that are not eligible for COBRA and have not opted for state-mandated 90-day continuation coverage.

% of Employer Contribution: _____

Value Added Participant: Yes No If Yes,

Organization Name: _____

Wellness Program: Yes No

COBRA Administration: Yes No

The following health benefit carriers are also available to the Group's employees: _____

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

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

Student/ Dependent Coverage Age: _____ (If left blank, defaults to 23/23 – no student status)

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 on the health questionnaire, 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 Group Enrollment Agreement (*Agreement*). Sections I-XIII of the Agreement are 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 _____

Piedmont Community HealthCare, Inc.

Signature _____

Signature _____

Title _____

Date _____