

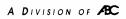


12137 Rhea Dr, Unit A, Plainfield, IL 60585 phone 815-609-6715 fax 815-609-9645

Participating Employer Form

Company:	Association:				
Address:	email:				
City:	Telephone:				
State / ZIP:					
Nature of Business:	Year Company Established:				
Type of Ownership:	Tax ID#				
Existing Policy/Replacing:	Policy#				
	e: Minimum 51% participation requirement, based on Quarterly Wage & Tax (and/or Schedule C) ess, injury or disability during this enrollment? absence:				
Workers' Compensation Policy Name	and Number:				
Anyone not covered by Workers' Com	ıp. Policy/Explain:				
Requesting Dental Plan	CompBenefits Advantage AlwaysCare PPO				
Requested Effective Date:					
Billing Mode: bank draw NO admin fee	monthly quarterly semi- annual annual (For hard-copy invoicing, a \$10 per billing period administrative fee will be added.)				
All checks made payable to	COMMUNITY HEALTHCARE ALLIANCE (or CHCA)				
Waiting Period for New Hires 1:	st of month following: 30 days 60 days 90 days				
age discrimination in relation to pregn have selected are contrary to any suc coverage shall become effective as of Community HealthCare Alliance, which	ENT LAWS: ay be subject to state and/or federal laws, such as, but not limited to, COBRA, ancy benefits. I further understand and agree that if the insurance benefits I h laws, I am solely responsible for compliance with it. It is understood that if the above requested effective date or as of the effective date approved by thever is later. We also understand that the agent/agency does not have the sto change or modify the coverage/conditions relating to the coverage with				
Print Name:	Title:				
Signature:	Date:				
Agent Name:	Agent Signature:				





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Eligibility Certification Form

Company:					
This form and/or your state wage and tax report will be used by the insurance company and its affiliates to determine who is eligible under your group plan and if your group meets the plan's eligibility and participation requirements. Please list all individuals below, WHETHER OR NOT THEY ARE TO BE CONSIDERED FOR COVERAGE UNDER YOUR GROUP PLAN WHO ARE:					
Actively working for you; OR Not working, but who are currently covered for reasons, such as, state and federal continuation or coverage or total disability, etc.					
Please use the follow	ving letter cod	ding to indicate	e staus:		
SP or MS Sole Proprie FT Full Time PT Part Time TM Temporary of TD Totally Disa	employee	Stockholder	RE CO DC WA OI	Retired Employee Employee under state or federal continuation of coverage Dual Choice, Waiving - Another group plan offered Waiving due to other qualifying coverage Other Insurance	
Employee	Date of Hire	Hour/week	Status code	If Status was DC, WA or OI - List Other Carrier Name	
1					
2					
3					
4					
5					
6					
7					
8					
9					
11					
12					
13					
14					
15					
If you need additional room, you may use the back of this form.					
You hereby certify that you have read this document and that the information provided is accurate and complete. You also certify that the information provided here can be substantiated by business records maintained by you. Upon request, you agree to provide any documentation we request (including wage and tax reports, taxpayor ID numbers, W-2 forms, etc.) that would establish all eligibility and participation requirements for the plan certifying that they are met the entire time coverage is provided to you by the insurance company. You understand that providing incomplete, inaccurate, or untimely information may void, reduce or terminate any individual's coverage or the group's coverage.					
Signature of Employe	er:			Date:	



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Automatic Withdrawal Request Form

Pay to the Order of: Integra Bank For Deposit Only - CHCA Premium Trust

Name of Depositors as it Appear	s on Bank Records:
Name of Bank or Branch:	
Address:	
Checking/Savings Account # or	Symbol:
drawn by and payable to the san	uest and authorize you to pay and charge my account electronic debits, checks or drafts e upon presentation. I agree that your rights for such draw will be the same as if it were a f. This authority will remain in force, until revoked by myself in writing and until you actually
I agree that you will be fully prote	cted in honoring any such draw.
	shonored, whether with or without cause and whether intentionally or inadvertantly, you will such dishonor results in the forfeiture of insurance.
Signature:	Joint Account Signature:
Date:	
notice or without notice, if any dr 2) This authorization is revocable 3) If any such draw is dishonore	his manner may be discontinued at any time by the Company upon thirty (30) days of written aw is not paid upon presentation. by the undersigned upon receipt by the Company of written revocation. d, the premium for which the draw is made shall be considered in default.
Signature:	Joint Account Signature:
So that you may comply with you	r depositor's request, Community HealthCare Alliance (CHCA) agrees:
in connection with the execution	u harmless from any loss you may suffer as a consequence of your actions resulting from or and issuance of any electronic debit, check or draft whether or not genuine, supporting to u in the regular course of business for the purpose of payment to this Company including y incurred in connection therein.
	ctronic debit, check or draft is dishonored whether with or without cause, and whether idemnify you for any loss through dishonor which results in a forfeiture of the insurance.
	d expense any action which might be brought by any depositor or any other person because his request, or in any manner arising due to your participation in this plan of premium
	→ Attach Voided Check Here →