CHCA Community HealthCare Alliance

A DIVISION OF ABC

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: Facsimile:

Nature of Business: Year Company Established:

Type of Ownership: Tax ID#

Existing Policy/Replacing: Policy#

Full-Time Employees: _____ Note: Minimum 51% participation requirement, based on Quarterly Wage & Tax (and/or Schedule C)

Are any employees absent due to illness, injury or disability during this enrollment? _____

If yes, please list name and nature of absence: _____

Workers' Compensation Policy Name and Number: _____

Anyone not covered by Workers' Comp. 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 1st of month following: ☐ 30 days ☐ 60 days ☐ 90 days

IN COMPLIANCE WITH EMPLOYMENT LAWS:

I understand that as an employer I may be subject to state and/or federal laws, such as, but not limited to, COBRA, age discrimination in relation to pregnancy benefits. I further understand and agree that if the insurance benefits I have selected are contrary to any such laws, I am solely responsible for compliance with it. It is understood that coverage shall become effective as of the above requested effective date or as of the effective date approved by Community HealthCare Alliance, whichever is later. **We also understand that the agent/agency does not have the authority to approve effective dates to change or modify the coverage/conditions relating to the coverage with this plan.**

Print Name: Title:

Signature: Date:

Agent Name: Agent Signature:

CHCA Community HealthCare Alliance

A DIVISION OF ABC

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

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 following letter coding to indicate staus:

SP or MS	Sole Proprietor or Majority Stockholder	RE	Retired Employee
FT	Full Time	CO	Employee under state or federal continuation of coverage
PT	Part Time	DC	Dual Choice, Waiving - Another group plan offered
TM	Temporary employee	WA	Waiving due to other qualifying coverage
TD	Totally Disabled	OI	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				
10				
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 Employer: Date:

CHCA Community HealthCare Alliance
A DIVISION OF ABC
12137 Rhea Dr, Unit A, Plainfield, IL 60585 phone 815-609-6715 fax 815-609-9645

Automatic Withdrawal Request Form

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

Name of Depositors as it Appears on Bank Records: _____

Name of Bank or Branch: _____

Address: _____

Checking/Savings Account # or Symbol: _____

As a convenience to myself, I request and authorize you to pay and charge my account electronic debits, checks or drafts drawn by and payable to the same upon presentation. I agree that your rights for such draw will be the same as if it were a draw personally signed by myself. This authority will remain in force, until revoked by myself in writing and until you actually receive such notice.

I agree that you will be fully protected in honoring any such draw.

I agree that if any such draw is dishonored, whether with or without cause and whether intentionally or inadvertantly, you will be under no liability even though such dishonor results in the forfeiture of insurance.

Signature: _____ Joint Account Signature: _____

Date: _____

I agree to the following conditions:

1) The payment of premiums in this manner may be discontinued at any time by the Company upon thirty (30) days of written notice or without notice, if any draw is not paid upon presentation.

2) This authorization is revocable by the undersigned upon receipt by the Company of written revocation.

3) If any such draw is dishonored, the premium for which the draw is made shall be considered in default.

Signature: _____ Joint Account Signature: _____

So that you may comply with your depositor's request, Community HealthCare Alliance (CHCA) agrees:

1) To Indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any electronic debit, check or draft whether or not genuine, supporting to the executing and received by you in the regular course of business for the purpose of payment to this Company including any costs or expenses reasonably incurred in connection therein.

2) In the event that any such electronic debit, check or draft is dishonored whether with or without cause, and whether intentionally or inadvertantly, to indemnify you for any loss through dishonor which results in a forfeiture of the insurance.

3) To defend at our own cost and expense any action which might be brought by any depositor or any other person because of your action taken pursuant to this request, or in any manner arising due to your participation in this plan of premium collections.

→ Attach Voided Check Here ←