Employer Application

Chamber Membership is with: ______________________

General Information					Requested Effective Date:	
Company's Legal Name						
Street Address					Tax ID	
City	State	Zip Code	Names of Owners/Partners (if applicable)			Internet Access?
Contact Person			Email Address			# of Years in Business
Billing Address (If different)				Telephone	Fax	
Multi-location group/company * ☐ Yes ☐ No		# of Locations	Address(es) (or list on additional sheet of paper)			
Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Other					Nature of Business	Industry Code
Waiting Period for Medical coverage **cannot** exceed 60 days please select from: 1st of the month following 0, 30 or 60 days ☐ 1st of the Month following Date of Hire ☐ 1st of the Month following ________Days					Waiting Period waived for initial enrollees ☐ Yes ☐ No	Medical Benefit Plan ■ Calendar Year
Number of Person currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents)			Number of Employees Termed in last 12 Months		Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Salary	
Have Workers' Comp? ☐ Yes ☐ No	Name of Workers'Compensation Carrier				Domestic Partner Coverage ☐ Yes ☐ No	
Names of Owners/Partners nor covered by Workers' Compensation						

Participation		**# Employees Appyling for:**		**# Employees Waiving**		**Contribution**	**Employer %**	**Employer % for Dep**
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		

# of Hours worked per week _____(ACA law requires 30 hours minimum to be covered as full time)	Plans you are offering		
	Medical	**Dental**	**Life/AD&D**
	Plan 1 ☐	Plan 1 ☐	Basic Life comes with Medical Employer Paid
	Plan 4 ☐	Plan 2 Ortho ☐	Basic Life without Medical ☐ Yes ☐ No
	Plan 5 ☐	Plan 3 Max 2,000 ☐	Voluntary Life ☐ Yes ☐ No
	Plan 6 ☐	Plan 4 Ortho Max 2,000 ☐	
	Plan 7 ☐	**Vision**	
		Plan 1 ☐	

Enter the Prior Calendar Year Average Total Number of Employees	Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically a person for which the company issues a W-2, Regardless of full-time, part-time or seasonal status or whether or not they have medical coverage. To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year. When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage or not. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).
Enter the Prior Calendar Year Total Number of Eligible Employees	For purposes of determing your number of eligible employees, Eligible employees are those who are eligible to enroll in any medical plan you offer, even if they aren't eligible to enroll in the Wyoming Chambers Health Benefit Plan. Here you may add COBRA. Calculate your number of eligible employees from the preceding calendar year: (1)Count the total number of eligible employees at the end of each month (2)Add all the monthly eligible totals from line (1) and divide by 12. Use whole numbers only (no decimals, fractions or ranges and round down).
Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees	For purposes of determing your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year. In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

HSA Information

Health Savings Account (HSA) if selected: Which bank will you be using?_______________________________

By signing and intialing below for my business, I acknowledge that once accepted and approved through underwriting and notified in writing on such acceptance our Group Life and Health Insurance Programs, Dental Insurance, and Vision Insurance, if applicable, will be provided by the Wyoming Chambers Health Benefit Plan. I agree to abide by the provisions of administration established by the Plan as described in the Plan Documents, Adoption Agreement, and Administration Agreement. As such I acknowlege that I understand the following by intialling each of the following items.

1. I will maintain a 75% or greater participation of eligible employees.
2. I will abide by the provisions of the Plan Documents as distributed by the Plan.
3. I acknowledge that premiums are due by the 1st day of each month. The consequence of a late payment made after the 20th your benefits will be suspended, if not received by end of month coverage will be canceled.
   Premiums may be remitted via check or ACH. A separate form is required for ACH transfer ability.
4. I understand that the employer must pay a minimum of 50% of Medical premium for the employee.
5. I acknowledge the importance of a long term commitment to the Wyoming Chambers Heath Benefit Plan.
6. I acknowledge that all future changes in employee enrollment or addition/deletion of dependents must be completed using the on-line system Ease. The paper application must be retained by the employer.
   All changes made after the 15th of the month are reflected on the next month's invoice.

Employer Printed Name	Employer Signature	Date

Note: In Addition to this form an employer signed Adoption Agreement and BAA form are required.

Agent Printed Name	Agent Signature	Date

Agency	Agent Email Address
Hub Mountain States Limited	

Address	City	State	Zip
400 East 1st Street	Casper	WY	82601

Eligibility and System Coordinator	Email Address
Kae Jones	kae.jones@hubinternational.com