Capital On-Boarding Submission

## Group Information

|  |  |  |  |
| --- | --- | --- | --- |
| Group Name: | | | SIC Code: |
| Physical Address: | City: | | |
| State: | Zip Code: | County: | |
| Mailing Address: Same as physical | City: | | |
| State: | Zip Code: | County: | |
| Phone Number: | Fax if possible: |  | |

## Agent Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Writing Agent Name: | Agency Name: | | | |
| Type of Agent:  No Access  Billing  Enrollment  Billing and Enrollment | | | | |
| If Billing and Enrollment Agent: Agent Street Address: | | City: | State: | Zip Code: |

## Plan Information

|  |  |  |  |
| --- | --- | --- | --- |
| Effective Date: | Group Segment:  Small group ACA  ASO  Mid-Market | | |
| Medical Plan 1 Name: | Medical Plan 2 Name: | | Medical Plan 3 Name: |
| Dental Plan Name: | | Vision Plan Name: | |
| Proposal Number if possible: | | | |

## Policy Maker and Group Administrator Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Policy Maker Name: | | | Policy Maker’s Title: | | |
| Policy Maker’s Email: | | Phone Number: | | Fax if possible: | |
| Group Administrator  Same as Policy Maker | | Group Administrator’s Name: | | Group Administrator’s Title: | |
| Group Administrator’s Email: | | Phone Number: | | Fax if possible: | |
| Additional Contact Authorized to Receive PHI:  Yes  No | | | Authorized Contact Name: | | |
| Authorized Contact Email: | Phone: | | Organization: | | Authorized Contact Date Effective: |

## Enrollment Information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| New Hire Waiting Period: | | | Tax ID Number: | | Date Business Established: | |
| PA Act 4 Coverage:  Yes  No | | Number Hours per Week to be Full Time Eligible: | | | | |
| Workers Compensation:  Yes  No | Carrier Name: | | | Effective Date: | | Policy Number: |
| How many employees are employed under the MSP Law:  1-19  20-99  100+ | | | | | | |
| What was your average number of employees during the 2020 calendar year:  Under 51  51-100  101+ | | | | | | |
| Are you purchasing these group benefits as part of a trust, consortium, coalition, association, union, or an arrangement involving multiple employer groups:  Yes  No | | | | | | |
| Are you combining with another entity as a controlled group:  Yes  No | | | | | | |
| Group name exactly as filed on the IRS W-9: | | | | | | |
| If you have an ERISA plan year end date, please provide: | | | | | | |
| ERISA Plan Classification: select one  ERISA Plan  Non-Federal Government Plan  Federal Government Plan  Non-Government/Non-ERISA Plan | | | | | | |
| Federal Tax Classification: select one  Individual/Sole Proprietor Trust/Estate  Partnership  C-Corporation  S-Corporation  Exempt Payee  Limited Liability  C-Corp  Limited Liability Partner  Government  Non-Profit | | | | | | |
| Does this group require additional subgroups: YesNo | | | | Does this group require additional classes:  Yes  No | | |

## Billing Information

|  |  |
| --- | --- |
| Name of Financial Institution: | Name on Bank Account: |
| ABA/Routing Number: | Bank Account Number: |
| Amount of Payment to be Withdrawn for Binder Payment: | |
| Group Check it Out (reoccurring auto payment):  Yes (if yes complete account information below)  No  If Yes,  Same as Billing Information Above | |
| Name of Financial Institution: | Name on Bank Account: |
| ABA/Routing Number: | Bank Account Number: |
| Type of Account:  Checking Account  Savings Account | |