

John Deere Health Plan, Inc. Small Employer Application

Phone: 309-765-1200

Fax: 309-748-1049

EMPLOYER INFORMATION

Employer: (Full Legal Name of Company) _____
Physical Address: _____ **Phone:** (____) _____
City: _____ **State** _____ **Zip** _____ **Fax:** (____) _____
County: _____ **Domicile State:** _____
Mailing Address: _____ **Years in Business:** _____
City: _____ **State** _____ **Zip Code** _____ **Tax ID Number:** _____
Other locations for this business: _____
Nature of Business: _____ **Years in Business:** _____
Name Of Contact Person: _____ **Phone:** (____) _____
Contact Person Email Address: _____
Requested Begin Date: _____ **Cultural-Linguistic Needs:** _____

PARTICIPATION REQUIREMENTS

Iowa/Illinois: At least 75% of total eligible full-time employees who do not have other creditable coverage must enroll.

Tennessee/Virginia: At least 75% of total eligible full-time employees and no less than 50% of all full-time employees must enroll.

Total Number of Employees: _____
Number of Full-Time Employees: _____
Number of Part-Time Employees: _____
Number of Employees on Leave of Absence: _____
Number of COBRA Applicants Requesting Coverage: _____ (Include Begin Date on Application)
Number of State Continuation Applicants Requesting Coverage: _____ (Include Begin Date on Application)
(Not applicable in Virginia)
Number of Employees in Waiting Period: _____ (Include Name(s) and the employees FT DOH on W&T Register .)
Number of Eligible Employees Waiving Coverage: _____
Total Number of Employees Requesting Coverage: _____

CONTRIBUTION REQUIREMENTS

The employer must contribute 50% of the employee premium for age rated groups and 50% of the single premium for composite rated groups.

Percent of Employer Contribution: **Employee:** _____% **Dependent:** _____%

ELIGIBILITY

Eligibility Requirements: The employer chooses the new hire eligibility period, which cannot be changed until the renewal date.

Waive Initial Waiting Period: ___ Yes ___ No

Coverage Limited to: (Management only, wage only, etc.) _____

New Hire Eligibility Waiting Period: ___ 30 days ___ 60 days ___ 90 days ___ Date of Hire
___ Other waiting period: _____

Employee Effective Date: ___ Immediately after waiting period completion
___ First of month following waiting period completion

GROUP REPLACEMENT: MEDICAL PLAN

Name of Current Insurance Carrier: _____

Current Carrier Termination Date: _____ Length of Time with Carrier: _____

Current Plan: _____ Rx _____ Dental ___ Vision ___ Chiro. ___

Do you wish to have deductible credit authorization (Not applicable for Illinois groups)? ___ Yes ___ No

Have you ever been enrolled with John Deere Health Plan, Inc. in the past? ___ Yes ___ No If yes, when? _____

Do you carry Worker's Compensation Coverage? ___ Yes ___ No

Name of Worker's Compensation Carrier: _____ Policy #: _____

Are any workers not covered? ___ Yes ___ No Specify who: _____

AGREEMENT: TO BE COMPLETED BY EMPLOYER

The undersigned Employer agrees to contribute _____% of the employee premium.

The undersigned certifies that the proposed client employs _____ full-time employees and no part-time employees are included for coverage. Full-time employees must work at least 30 hours per week, unless otherwise required by law.

The Employer agrees to make all benefit plans included available to all eligible employees who satisfy eligibility requirements. It is understood that applications for enrollment or waivers of coverage for new hires must be submitted within 31 days of the eligibility date.

The Employer agrees to satisfy the participation requirements. Iowa/Illinois: 75% of total eligible employees must enroll. Tennessee/Virginia: 75% of total eligible employees and no less than 50% of all full-time employees must enroll. A verification of participation may be requested upon renewal or anytime throughout the contract period.

The Employer understands that no coverage will become effective without prior written approval and notification from John Deere Health Plan, Inc. and that current coverage should not be terminated until this is received.

The Employer has been advised that provisions including those related to enrollment for new hires, renewal, and termination will be set forth in the Group Health Contract.

The Employer hereby certifies that the above information is complete and true to the best of his or her knowledge. Any material misrepresentation may result in rerating of premium, claim denial, and/or termination of coverage. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment and fines, in addition to rerating, denial of benefits and/or termination of coverage.

Employer Signature Title Date

Print General Agency Name (if applicable) Print Agent Name Date

General Agent Signature Date

Print Brokerage Firm Name (if applicable) Print Broker Name Date

Broker Signature Date

FINAL RATE PROPOSAL

Please complete and submit the following in order to receive final rates:

- Small Employer Application
- Enrollment Applications/Waivers of Coverage
- Wage & Tax Register
- Copy of current benefits summary and renewal rates