



Wayne County Four Star Health Program

EMPLOYER GROUP APPLICATION

SECTION A - GENERAL EMPLOYER INFORMATION - PLEASE PRINT

OFFICE USE ONLY

1. Legal name of employer (include dba):	Main Group #(s):
2. Street address (include city, state, zip):	Cobra:
3. Mailing address if different (include city, state, zip):	
4. Phone Number:	
5. County:	
6. Subsidiaries included: <input type="checkbox"/> No <input type="checkbox"/> Yes, give legal name and address:	
7. Business Type: <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	
8. Years in Business?	
9. Nature of Business:	
10. Employer Administrative Contact Person name, title, phone number:	
11. Employer Management Contact Person name, title, phone number:	

SECTION B - PLAN INFORMATION

1. Regular active full-time employees working 20 hours per week are eligible if employed by YOU and paid a reasonable salary or wage. This includes actively employed proprietors, partners, corporate officers and directors. Part-time and seasonal employees are not eligible for coverage. Please state:

a. Total number of eligible employees Single _____ Married Couple _____

b. Total number of active employees Single _____ Married Couple _____

c. Total number of employees enrolling Single _____ Married Couple _____

2. Do at least half of your employees earn \$16.00 per hour or less?
 Yes No, If no you are not eligible for coverage.

3. Do you currently provide health insurance coverage for your employees or have you provided health insurance coverage during the last year?
 Yes No, If yes you are not eligible for coverage.

4. Have you ever had a group health insurance application declined by another insurer?
 Yes No, If yes please provide name of insurer, date declined and reason.

5. Is the employer subject to COBRA?
 Yes No, If yes please provide name and Social Security numbers of persons currently on COBRA.

6. Probationary Period (New Employees): None (date of hire) First of month after hire date Following probationary period
 30 days 60 days 90 days Other:

Termination of Employees: Date of Event First of month after termination date Other:

Reinstated Employees: Date of reinstatement First of month after reinstatement date Other:

7a. Is the primary business location in Wayne County?
 Yes No

7b. Are 1/2 or more of employees residents of Wayne County?
 Yes No

If you answered No to either 7a) or 7b) you are not eligible for coverage.

8. Have you been an established business for at least 6 months?
 Yes No

NOTE: Employee must have been working at least 20 hours per week for the past 90 days to be eligible for coverage.

