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Sidecar Health Insurance Company
Georgia Large Group Employer Application for Major Medical Insurance

Step 1: Tell us about your company.

Group/Company/Entity Legal Name		Tax ID	
Street Address			
City	State	Zip Code	County
Billing address (if different)			
City	State	Zip Code	County
Phone Number			

Organization Type
◯ C-Corp ◯ S-Corp ◯ LLC ◯ LLP ◯ Partnership ◯ Sole Proprietor ◯ Other ___________________

Ownership Structure ◯ Public ◯ Private ◯ Other ___________	**Name(s) of owner(s) or partner(s)**
Does your organization have multiple locations, companies, or subsidiaries? ◯ Yes ◯ No	**Names and addresses of other locations, companies, or subsidiaries. (May be provided on additional page.)**

Do all locations, companies and/or subsidiaries have common ownership such they are a controlled group as defined by Sec. 414 of the Internal Revenue Code?
◯ Yes ◯ No

Number of years in business	Primary Nature of Business	SIC Code

Has the company or any related entity filed for federal or state bankruptcy in the past 36 months? ◯ Yes ◯ No	**Has the company or any related entity filed received a demand or suggestion of bankruptcy from a creditor in the last 36 months?** ◯ Yes ◯ No
Is your company situated in the state of application? ◯ Yes ◯ No If the majority of your employees are not located in your state of application, insurance law may require that your policy be written out of a different state.	**Is your plan subject to ERISA? (most plans sponsored by private-sector employers are subject to ERISA):** ◯ Yes ◯ No **If no, does one of the following describe your organization?** ◯ Federal Government ◯ State or Local Government ◯ Indian Tribal Government ◯ Church ◯ Other ___________________

Total number of all employees in current calendar year*:

*Employer have at least 51 total employees to be eligible for this plan. Include non-eligible employees and part-time employees. Do not include non-employees such as 1099 independent contractors, non-employee board members, and/or consultants.

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Step 2: Tell us about your health insurance terms and eligiblity.

Eligibility and Plan Terms for Sidecar Health Coverage

Health Insurance Coverage Period (for Sidecar Health coverage):

◯ **Calendar Year (coverage begins 1/1) ____________(Insert Year)**

◯ **Policy Year (other than 1/1) beginning on the first day of ____________________ (Insert Month and Year)**

Deductible and Out-of-Pocket Maximums are tracked on (for Sidecar Health coverage):

◯ **Calendar Year (1/1-12/31)**

◯ **Policy Year listed above (other than 1/1-12/31)**

If your plan has a non-calendar year coverage period with Deductible and OOPM tracked on a calendar year, do you wish to have deductible credit from your previous carrier?

◯ **Yes** ◯ **No** ◯ **N/A**

Open Enrollment Period (list dates below):

Waiting Period for new hires (cannot exceed 90 days):

◯ **1st of Month Following Date of Hire**

◯ **1st of Month following ___ months**

◯ **1st of Month following ___ days**

◯ **No Waiting Period (Insurance is effective as of Date of Hire)**

◯ **Other:____**

Will employees pay for their portion of coverage through pre-tax payroll deductions? ◯ **Yes** ◯ **No** ◯ **N/A**

Which employees are eligible to enroll in this plan?

☐ **Full-Time Employees:** Any employee regularly scheduled to work at least 30 hours per week.

☐ **Part-Time Employees:** Any employee regularly scheduled to work at least ____ hours per week but less than 30 hours per week. (Please fill in part-time hours threshold)

☐ **Retired Employees (list eligibility terms below):**

____

____

☐ **Other Eligibility Requirements (list below):**

____

____

Are any employee groups or classes excluded from participation in this plan?

☐ **Hourly** ☐ **Salaried**

☐ **Union** ☐ **Non-Management**

☐ **Other Exclusions (list below):**

____

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When does coverage terminate when an individual is no longer eligible for coverage?
◯ On the date eligibility is lost ◯ Last day of the month following date eligibility loss Example: If an employee terminates employment, does their coverage end on the date of employment termination or the last day of the month following their employment termination date?

Does your plan offer Domestic Partner Coverage?	In the past 12 months, has your company been denied coverage? If so, by whom and why?
◯ Yes ◯ No If yes, coverage will be available to domestic partners, both same and opposite sex.	◯ Yes ◯ No Please provide additional information if yes:

Step 3: Tell us about your employees and enrollees.

Enrollment Information

Current Medical Insurance Carrier(s)	
Number of employees enrolled in current health insurance plan. (Include only employees that have elected coverage, do not include dependents.)	Number of employees eligible for current health insurance plan. (Include employees that have enrolled in coverage and employees that could enroll but didn't, do not include dependents.)
Number of enrollees in current health insurance plan. (Include employees and dependents.)	Number of enrollees currently on COBRA, short- or long-term disability. (Include employees and dependents.)
Does your group sponsor a health plan that covers only employees (and their dependents) of your own company or commonly owned subsidiaries? ◯ Yes ◯ No If your organization has multiple entities/subsidiaries, only answer yes if you answered on page 1 that all companies are part of a controlled group.	If no, to the question to the left, is your organization one of the following multiple employer groups: ◯ Professional Employer Organization (PEO) ◯ Employer Association ◯ Taft-Hartley Union ◯ Government ◯ Church
Within the last three (3) years, has any employee or dependent filed a claim for short-term disability, long term disability, SSDI, workers' compensation, Medicare, Medicaid, or other type of disability benefits on any policy? ◯ Yes ◯ No	With the exception of parental leave, within the past three (3) years, has any employee applied for a leave of absence (FMLA or other leave) for greater than two (2) weeks due to an injury, disability or illness of the employee or dependent? ◯ Yes ◯ No
In the past two (2) years, has any employee incurred an absence for greater than two (2) consecutive weeks due to an injury, disability, or illness of the employee? ◯ Yes ◯ No	Is any employee or their dependent currently hospitalized? ◯ Yes ◯ No

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Please check the corresponding box if any employee or dependent has been diagnosed, treated, received prescription medication for <u>any type</u> of the following conditions within the past three (3) years:

☐ **Cancer** ☐ **Lung disease or respiratory problems** ☐ **Heart disease or disorder** ☐ **Diabetes**

☐ **Liver disease or disorder** ☐ **Transplant of an organ, tissue, or cell** ☐ **Kidney disease** ☐ **Pancreatic Disorder**

☐ **Hepatitis** ☐ **Morbid Obesity** ☐ **Congenital abnormality** ☐ **Vascular disease** ☐ **Neurological disorder**

☐ **Immunological disorder (reportable types)** ☐ **Alcohol or drug addiction or abuse** ☐ **Hemophilia or Blood disorder**

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, WE MAY REQUEST ADDITIONAL INFORMATION.

Please include the following information with this application:

- Two years of rate history and renewal rates.
- Two years of high-cost claims (>$100k), including diagnosis and current enrollment status; and
- Two years of claims experience.

Information should be deidentified before providing.

Step 4: Your agreement and signature.

The undersigned, on behaf of the group applicant, understands, represents and acknowleges that:

- The answers given to all questions on this application are true and accurate to the best of the applicant's knowledge and belief, and we understand they are being relied on by Sidecar Health in accepting this application. I also understand any person, group, or entity who, with intent to defraud or knowing he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and, any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in rating adjustments, denial of benefits, rescission or cancellation of coverage(s).

  We must include a deposit in the amount of the first month's premium payment with this application, payable by check. Submission of the check and this application does not mean coverage has been approved.

- To the extent permitted by law, Sidecar Health has the right to accept or decline this application. If this application is denied, any deposit paid will be returned. If this application is accepted, the deposit amount shall be applied to the first month's premium charge.

- We must inform Sidecar Health, in a timely manner, of any change to the information provided in this application, including but not limited to changes in the number of eligible employees or dependents changes in health status of employees or dependents.

- Upon receipt of the signed and completed application and the payment of the required premiums, the group policy shall be executed. This deposit amount is not considered payment of required premium charges. **Coverage is not effective until Sidecar Health receives the binder payment. No benefits will be provided for your enrollees until the payment is received.**

- After issuance of the policy, Sidecar Health shall furnish a certificate of coverage, policy document and/or summary plan description describing the benefits provided under this policy and shall provide other documents, notices and/or communications (collectively "documents"). These

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documents all shall be remitted to the group and/or its employees via electronic means. Consent to receive these documents electroncially shall remain in effect until withdrawn. Paper copies of documents may be requested at any time.

- The applicant group is applying for group health coverage that will be offered to employees of the group and the applicant is solely responsible for timely payment of all required premium payments.

- The group acknowledges and agrees to follow all terms and conditions of the Policy Contract, when issued.

- Producer Compensation Statement. In some instances, Sidecar Health may pay compensation to brokers and agents (called “producers”) for services related to sale of our products, in compliance with applicable law. Sidecar Health may pay “base commissions” based on factors such as product type, amount of premium, group/company size and number of employees. These commissions, when payable, are reflected in the premium rate. In addition, Sidecar Health may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. Please note Sidecar Health also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation may be subject to disclosure on Schedule A of the ERISA Form 5500 for groups governed by ERISA. Sidecar Health provides Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your policy, please contact your producer.

I sign this application for coverage on behalf of the applicant entity. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Sidecar Health absent the acknowledgement and consent of Sidecar Health.

By signing this application on behalf of the group, the applicant certifies the foregoing as true.

Applicant to complete and sign below:

Group/Company Name (print below)	
Signature of Authorized Represenative of Group Applicant	Date
IMPORTANT: DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE OF APPROVAL.	

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PRODUCER INFORMATION (where applicable)			
Producer Name		**Agency**	
Street address			
City	**State**	**Zip code**	**County**
Agent Tax ID Number		**National Producer Number**	
Producer Commission Schedule (if applicable):			

GENERAL AGENCY INFORMATION (where applicable)			
Name		**Agency**	
Street address			
City	**State**	**Zip code**	**County**
Agent Tax ID Number			