Employer Application

EMPLOYER INFORMATION

Name of Company (full legal name of firm):

Billing Address	County
City	State / Zip

Physical Address (if different from Billing Address)	County

City	State	Zip

Contact/Title	Phone	Fax	Email

Owner/Officer	Phone

Type of Entity: ☐Proprietorship ☐Partnership ☐Corporation ☐Other ______________ Tax ID #

Requested Effective Date of Coverage:

ELIGIBILITY INFORMATION

Number of hours required per week to be eligible for coverage? ☐ 20 hours ☐ 25 hours ☐ 30 hours ☐ Other: ___
(Cannot Be Less Than 20 Hours Per Week)

Total Number of Employees	Number eligible for health coverage:	Number NOT eligible for health coverage:

What is the waiting period for new employees?

First Day of the Month Following: ☐ Date of Hire ☐ 30 days ☐60 days ☐90 days ☐180 days ☐____days

Will the initial group of employees be required to meet the waiting period? ☐Yes ☐No

Are any employees related? ☐Yes ☐ No
Names: ________________________________ Relationship ________________________________
Names: ________________________________ Relationship ________________________________

Will the employees be excluded from health coverage? ☐Yes ☐ No If Yes, Why? ______________________
(All excluded employees must submit a Waiver Form.)

CONTRIBUTION LEVELS

What portion of the EMPLOYEE only contribution will the employer contribute? ☐100% ☐50% ☐Other ___ % OR $________
(Cannot be less than 50%)

What portion of the DEPENDENT premium will the employer contribute? ___ % OR $ ____

OTHER COVERAGE

Does your company offer more than one health plan to its employees? ☐Yes ☐No
(Please submit a copy of the last billing statement showing employees' names.)

Are you applying for coverage with The Wyoming Lawyers Health Benefit Plan to replace other Group Health coverage? ☐Yes ☐No

If you checked YES, please answer the remaining questions in Section 4.

(DO NOT terminate any existing coverage until you receive written confirmation of coverage from ALPS Risk & Insurance Services)

Name of insurance Carrier	Policy/Group Number	Phone Number
Effective Date of Coverage	Termination Date of other Coverage	Is coverage still in force? ☐Yes ☐No

Section 5: SIGNATURE

I certify that the above information is true and correct. I understand that this information will be used to underwrite my group, and for the determination of eligibility. I further certify that I have the employer's authority to submit this information. I further acknowledge that the Wyoming Lawyers Health Benefit Plan is not insurance and does not participate in the state guaranty association.

Printed Name ________________________________ Title: ______________________

Signature:____________________________________ Date:__________________

wyoming STATE BAR

ALPS Health Solutions

Employee Census Data

SECTION 1

Employees who work ___ hours per week or more are eligible to enroll for coverage. List below each employee, including those waiving coverage, who meet the firms work week limit.

Employee Name (First Middle Last)	Gender	Date of Birth	Date Began Full Time Employment	Number of Dependants + Spouse (if any)	Hours Worked Per Week	Application Status	State Bar Member?
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No
						□ Applied □ Waived	□ Yes □ No

SECTION 2

Please list below all employees, including those waiving coverage, who work less than the firm's work week limit.

Employee Name (First Middle Last)	Gender	Date of Birth	Date Began Full Time Employment	Number of Dependants + Spouse (if any)	Hours Worked Per Week	State Bar Member?
						□ Yes □ No
						□ Yes □ No
						□ Yes □ No
						□ Yes □ No
						□ Yes □ No
						□ Yes □ No
						□ Yes □ No
						□ Yes □ No
						□ Yes □ No

SECTION 3 (COBRA)

Are there any former employees or dependents currently covered under continuation? □ Yes □ No Are there any employees or dependents eligible for continuation who have not yet elected such coverage?□ Yes □ No If you answered yes to either question above please complete the information below. Please indicate the person is either: ENROLLED IN CONTINUATION *(We require completion of the employee application.);* OR ELIGIBLE BUT HAS NOT ELECTED CONTINUATION

Beneficiary Name (First Middle Last)	Date of Termination	Date COBRA Coverage Began

SECTION 4

I hereby certify that this is a complete listing of all employees and their census data and that I am authorized to distribute this information for purposes of attaining health coverage with the Wyoming Lawyers Health Benefit Plan.

Signature ______________________ Title ______________________ Date ______________