Landmark Healthplan of California, Inc.
2629 Townsgate Road, Suite 235
Westlake Village, CA 91361
Phone: (800) 298-4875, Option 2
Fax: (916) 307-5250
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Group Application – Voluntary Plans

PLEASE PRINT **Coverage Effective Date** ____________________

EMPLOYER INFORMATION

Group Name ________________________________
Street Address ________________________________
City ______________ State ______ Zip ________

Eligibility and Service Contact:
Name ________________________________
Title ________________________________
Phone ______________ Fax ______________
E-mail ________________________________

Billing Contact: ☐ *Check if same as Eligibility and Service Contact*
Name ________________________________
Title ________________________________
Phone ______________ Fax ______________
E-mail ________________________________

Billing Address – If different from street address:
Street Address ________________________________
City ______________ State ______ Zip ________

Multi-Employer Groups *(Please provide a copy of trust agreement and/or bylaws)*

❑ Association ❑ PEO ❑ Trust ❑ Other (Please Specify) ________________

NATURE OF BUSINESS

Description ________________________________

BENEFIT PLAN

Plan 1: Group Voluntary	**Office Visits:**	
❑ Chiropractic Plan $25 Copayment	❑ 10 Visits per plan year ❑ 15 Visits per plan year ❑ 20 Visits per plan year	Employer may offer more than one plan, but each plan offered must have a minimum of two employees enrolled.
Plan 2: Group Voluntary	**Office Visits:**	
❑ Acupuncture Plan $35 Copayment	❑ 10 Visits per plan year ❑ 15 Visits per plan year ❑ 20 Visits per plan year	Employer may offer more than one plan, but each plan offered must have a minimum of two employees enrolled.

RATES

Plan 1:
Employee Only: $ ________________
Employee + One: $ ________________
Employee + Family: $ ________________

Plan 2:
Employee Only: $ ________________
Employee + One: $ ________________
Employee + Family: $ ________________

08/01/2018

ENROLLMENT SUMMARY *(Enrolled members must have a major medical plan in place to be eligible)*

Total # of employees	Total # of employees eligible for medical benefits	Employees to be enrolled in Landmark Healthplan

CURRENT MEDICAL CARRIER(S) *(Enrolled members must have a major medical plan in place to be eligible)*

Carrier(s)	# Employees enrolled	Will Landmark coverage be provided to these employees?
______	______	❑ Yes ❑ No
______	______	❑ Yes ❑ No
______	______	❑ Yes ❑ No

NEW EMPLOYEE WAITING PERIOD

Options – select one:

❑ 1st of the month following______________days/months *(circle one)* from the date of hire
❑ Date of hire
❑ Other *(please be specific)* ______________________________

TERMINATED EMPLOYEE COVERAGE

Options – select one:

❑ Covered through the last day in the month of termination
❑ Date of termination
❑ Other *(please be specific)* ______________________________

COBRA

How many COBRA participants are enrolling?__________ Your Group is: (circle one) Federal COBRA Cal-COBRA
COBRA enrollment applications need to be identified as such by writing "COBRA" in large letters in the top portion of the application.
Please indicate COBRA eligibility date and duration for the employee and all dependents.

DEPENDENT ELIGIBILITY

Per the provisions of the Patient Protection and Affordable Care Act of 2010, children of eligible subscribers are eligible until the age of twenty-six.

PREMIUM PAYMENT

Employer agrees to pay premiums to Landmark Healthplan when invoiced.

BROKER INFORMATION

Broker Name______________________ Agency Name ______________________

Commissions to be paid to ❑ Individual ❑ Agency Tax ID # ______________________

Phone______________ Fax______________ **E-mail**______________

Street______________________________Landmark Broker ID: ______________

City______________________ State__________ Zip______________

Dept. of Insurance License #______________ Landmark Healthplan Sales Rep ______________

General Agent (if applicable)______________________________

PAYMENT FOR FIRST MONTH'S COVERAGE *(Please make checks payable to Landmark Healthplan)*

The Group herewith tenders the amount of $__________*(Premium and rate quotes are subject to change until Group and Landmark Healthplan execute a Group Agreement.)* and, in consideration of approval of this application and in the event of such approval, promises to pay Landmark Healthplan, as appropriate, any balance necessary to constitute the full initial payment for the group benefits herein identified. **By executing this application, Group hereby accepts and agrees to all of the terms and conditions contained in the Group Agreement which is incorporated herein by this reference.**

Signature of Responsible Party ______________________________

Print Name and Title ______________________________