

# Verification of Eligibility

Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete this form to verify eligibility. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1. Employer's name and phone number \_\_\_\_\_  
 Group Number \_\_\_\_\_
2. Total number of employees on payroll \_\_\_\_\_
3. Total number of employees working part-time (as defined by employer in the employer application) (include temporary and/or seasonal employees) \_\_\_\_\_
4. Total number of employees in waiting period \_\_\_\_\_
5. Number of full-time eligible employees (subtract numbers 3 and 4 from number 2) \_\_\_\_\_
6. Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file) \_\_\_\_\_
7. Number of eligible employees (subtract 6 from 5) \_\_\_\_\_
8. Number of full-time employees enrolled \_\_\_\_\_
9. Premium information: \_\_\_\_\_ 100% employer paid **OR** employer pays \_\_\_\_\_% of employee premium and \_\_\_\_\_% of dependent premium.

### Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by IHC Health Solutions, Inc.
2. Insurance will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.
4. The employer applicant agrees to notify IHC Health Solutions of any changes to the above numbers representing a change of five percent or more and the employer further agrees to provide IHC Health Solutions with payroll records verifying number of employees upon request by IHC Health Solutions.
5. The employer applicant agrees and understands that if the contributory status or participation percentages change that IHC Health Solutions reserves the right to adjust the premiums and rates accordingly.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Writing Agent                      Agent Code

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Type or Print Agent's Name(s)

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Agent's Business Address (City, State & Zip Code)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency    Agency Code

\_\_\_\_\_  
Company Name

**Note: This form is not applicable to voluntary groups.**

