UNDERWRITING SUMMARY SHEET

Welborn Health Plans Sales Representative:	Agent/Broker:	
Employer Group Name:	Tax ID #:	
Street Address: City: State: Zip Code:	**SIC Code**	**Industry Factor**

EMPLOYER INFORMATION

Type of Business: Contact Person/Title:

Contact Phone #: Contact Fax #: Contact Email:

Requested Effective Date: Current Plan Anniversary Date:

Dependent Limiting Age: Dependent Student Maximum Age:

Dependents to Age:
- ☐ Date of Birth (Standard)
- ☐ Thru End of Month
- ☐ Thru End of Year

Full Time Student to Age:
- ☐ Date of Birth (Standard)
- ☐ Thru End of Month
- ☐ Thru End of Year

Eligibility for Coverage BEGINS on:
- ☐ Date of Employment
- ☐ ____Days after Employment Begins
- ☐ 1st of Month Following Date of Hire
- ☐ Other ________________________

Eligibility for Coverage ENDS on:
- ☐ Date Employment Terminates
- ☐ ____Days after Employment Termination
- ☐ End of month employment terminates
- ☐ Other ________________________

Employer Contribution: Portion of total Monthly Premium ______ %
Portion of Employee Only Premium _____ % $ ________

Current Carrier(s):	**Current Rates:** Employee $ ____________ Employee & Spouse $_________ Family $ ____________ Employee & Child(ren) $_________

How Long with Current Carrier(s)? ______years Number of carriers in the last 5 years ______

Has Group Been Insured By Welborn Before? ☐ Yes ☐ No

Are any current or former employees or dependents eligible for Medicare? ☐ Yes ☐ No
If yes, how many current or former employees or dependents are eligible for Medicare? _______

Total Employees – **All** Locations: _________
a. Total **Part-Time** Employees: _______
b. Total **Full-Time(Eligible)**Employees: _______

Eligible Retirees: _______
Employee Turnover Rate: _______

Minimum Employer Contribution. In order to make the premiums more affordable to employees, the Employer agrees to contribute from its funds a minimum of either **50% of the "Employee only" monthly premium.**

Minimum Group Participation. If less than seventy-five percent **(75%)** of all eligible employees of Employer participate in the health plan(s) made available to such employees by Employer, Plan may elect to terminate this Group Contract.

Eligible Employee(s). Means an employee who is employed to work at least thirty (30) hours each week and who meets an applicable waiting period required by their employer before gaining coverage under a health insurance policy. The term does not include an employee who works on a temporary or substitute basis or a seasonal employee. **The employee(s) is someone who lives and/or works in Welborn Health Plans service area**.