



Group Application

PLEASE PRINT

EMPLOYER INFORMATION

Group Name _____
 Street Address _____
 City _____ State _____ Zip _____
 E-mail Address _____

Billing address — If different from street address:

Street Address _____
 City _____ State _____ Zip _____

Eligibility and service contact:

Name _____ Title _____
 Phone _____ Fax # _____

Billing contact:

Name _____ Title _____
 Phone _____ Fax # _____

BENEFIT PLAN

Please check one: Chiropractic only
 Acupuncture only
 Combined — chiropractic & acupuncture
 Co-Pay _____ Maximum Visits _____

Herbal Benefit (for Acupuncture & Combined only)
 \$500
 \$750
 \$1000

RATES

Employee Only _____ Employee & Spouse _____
 Employee & Children _____ Employee & Family _____

LEGAL ENTITY — For trustee group and/or association, copy of trust agreement and/or bylaws must be forwarded.

Corporation Partnership Sole Proprietorship Other (Please specify) _____

NATURE OF BUSINESS

Description _____

WORKERS' COMPENSATION

Do all employees, officers and partners have workers' compensation coverage?

Yes If yes, please give name of carrier _____
 No If no, please explain _____

OTHER COMPANY BENEFITS (TO BE FILLED OUT BY EMPLOYER GROUPS OF 50+)

Behavioral Health Plan	Name: _____	Phone: _____
EAP	Name: _____	Phone: _____
Child/Eldercare Program	Name: _____	Phone: _____
Health plans	Name: _____	Phone: _____
	Name: _____	Phone: _____

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PRIOR COVERAGE

Is Landmark coverage replacing prior chiropractic coverage? Yes — who was the prior carrier? _____
 No

CURRENT MEDICAL CARRIER(S) — Landmark enrollment must match medical enrollment

Carrier(s) _____ Employees enrolled _____ Is Landmark coverage provided to these enrollees?
_____ Yes No
_____ Yes No

ENROLLMENT SUMMARY

Total # of employees	Total # of employees eligible for health benefits	Employees enrolled in Landmark HMO Plan	Total # of employees declining benefit

NEW EMPLOYEE WAITING PERIOD — MUST MATCH MEDICAL PLAN WAITING PERIOD

Options — select one:

- 1st of the month following _____ months from the date of hire
- Date of hire
- Other (please be specific) _____

TERMINATED EMPLOYEE COVERAGE — MUST MATCH MEDICAL PLANS

Options — select one:

- Covered through the last day in month of termination
- Date of termination
- Other (please be specific) _____

DEPENDENT ELIGIBILITY — Must match medical plan dependent eligibility.

Dependent coverage ceases on their _____ birthday. (Contract will default to 19th birthday if not completed)
Overage dependent coverage based on full time student and/or IRS dependent status ceases on their 23rd 24th 25th birthday.
(Contract will default to 25th birthday if not completed)

COBRA

How many COBRA participants are enrolling? _____
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.

BROKER INFORMATION

Broker name _____ Agency name _____
Commissions should be paid to Individual Agency
Phone _____ Fax No. _____ E-mail Address _____
Street address _____ Landmark broker # _____
City _____ State _____ Zip _____
Dept. of Insurance License # _____ IRS Reporting # _____
Landmark Healthplan California sales representative _____ Phone _____
General agent (if applicable) _____

PAYMENT FOR FIRST MONTH'S COVERAGE

The Group herewith tenders the amount of \$_____ and, in consideration of approval of this application and in the event of such approval, promises to pay the company 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 _____
Intended Effective Date of Coverage _____