PIEDMONT COMMUNITY HEALTHCARE, INC.

1937 Thomson Drive
Lynchburg, Virginia 24501

I. Group Application

Group Name ("the Group")	Type of Business	Federal Tax ID

Group Mailing Address	City	State	Zip Code	E-Mail Address

Billing Address	Billing Contact	Phone # ( )	Fax # ( )

Group Contact	Title	Phone # ( )	Fax # ( )

Group Number	Effective Date	Renewal Date	*For Office Use Only:* Plan Code:

Basic Benefit Description:

☐ LocalSelect ☐ POS ☐ PPO ☐ Grandfathered Plan
☐ Non-Grandfathered Plan

Full Name of Plan: _____

In Plan Benefits

Deductible:_____ Copay: _____

Coinsurance: _____ Rx Benefit: _____

Out of Pocket Max: _____

✧Please Attach a Copy of Rate Sheet ✧

Riders: ☐ Vision ☐ Contraception Coverage ☐ Plan Year

☐ Supplemental Rider ☐ Accidental Rider ☐ Conversion

Note: Conversion is only available for groups that are not eligible for COBRA and have not opted for state-mandated continuation coverage.

% of Employer Contribution:_____

Value Added Participant: ☐ Yes ☐ No If Yes,

Organization Name:_____

Wellness Program: ☐ Yes ☐ No

COBRA Administration: ☐ Yes ☐ No

The following health benefit carriers are also available to the Group's employees: _____

Open Enrollment Period: Start Date _____ _____ # Enrolled Under This Contract _____ # of Eligible Employees
End Date _____ _____ # Total Employees

New Hire Eligibility Date:
☐ The first day of the month following date of employment
☐ Date of Hire
☐ First of month following _____ days of continuous employment
☐ Date following _____ days of continuous employment
☐ _____

Termination Effective Date:
☐ End of Month in which Employment Ends ☐ Other _____
☐ Date of Termination of Employment

I hereby certify that all the information in the Group Application and Employee Applications is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual requesting coverage, except as noted on the health questionnaire, as required. I have complied with Piedmont's underwriting rules and guidelines and have explained in detail the coverage to the group and its employees.

Broker Name: (print) _____ Broker #:_____ Broker Phone: (_____)_____

Broker Signature: _____ Date:_____ Broker Fax: (_____)_____

This Group Application is Section I of the Group Enrollment Agreement (*Agreement*). Sections I-XIII of the Agreement are incorporated herein as though they were recited over the signature below. The Group must provide prior written notice of a Participant's termination and pay premiums during the period in which Piedmont Community Health Care, Inc. provides coverage to such participants.

Group _____ **Piedmont Community HealthCare, Inc.**

Signature _____ **Signature** _____

Title _____ **Date** _____