

This form must be filled out by **Renewing Groups** and **New Groups**.
New Groups must also fill out, sign, and attach the *Group Application for Coverage*.

Section I. Group/Plan Sponsor Information		
Group/Plan Sponsor Name		
Effective Date/Renewal Date (MM/DD/YYYY)	Name of Broker/Agent of Record	Agency Name

Section II. Medical Enrollment Count *This section is required, or form cannot be processed.*

IMPORTANT: For purposes of determining group size, the Patient Protection and Affordable Care Act (“PPACA”) defines the number of employees as “the average number of employees employed by the company during the **preceding calendar year**.” An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time, or seasonal status, or whether or not they have medical coverage.

Number of employees on the last day of each month divided by 12 for previous year: Average Total Number of Employees (ATNE) = _____

NOTE: If you are part of a controlled group or an affiliated service group, you may be considered an applicable Large Employer as defined by PPACA and subject to Large Employer underwriting and enrollment rules. If you are not sure, consult with your accountant regarding your employer status.

MEDICAL ONLY — Provide current Employee Counts. <i>(Full-time means an active employee working at least 30 hours/week and 48 weeks/year.)</i>	In State	Out of State	Total
No. of Full-Time Employees Enrolling Include those satisfying their waiting period within 90 days after the effective date.			
No. of Full-Time Employees Declining Coverage Include those satisfying their waiting period within 90 days after the effective date.			
No. of Retirees eligible for coverage			
No. of COBRA or AR State Continuation Coverage enrollees			
Total Enrolling and Declining			
Part Time/Seasonal/Temporary Employees			
Total Number of Employees			

In the preceding calendar year, has the group had 20 or more employees on at least 50% of the group’s working days? Yes No

Section III. COBRA Administration **PEPM rates reflect minimum monthly fee required by PrimePay.*

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, PrimePay, to assist you in administering COBRA. Both full-time and part-time employees are counted to determine if a plan is subject to COBRA.

NOTE: A minimum of 20 enrolled subscribers is required for QualChoice to bill for COBRA Services.

As an employer, are you currently obligated by law to comply with COBRA?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you want to use the services of PrimePay? <i>If YES — please answer the following questions:</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are you currently contracting with PrimePay?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If you have a minimum of 20 enrolled subscribers on your plans, is QualChoice billing the group for PrimePay?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Is QualChoice sending electronic eligibility to PrimePay? NOTE: Only available for groups of 100+ eligible employees.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Number of Enrolled Employees (EEs)	20	21-29	30-39	40-59	60+
COBRA Fee Per Employee Per Month (PEPM)	\$4.50	\$3.25	\$2.25	\$2.00	\$1.50

Section IV. ID Cards

If purchased, Medical and Dental ID cards are to be delivered to: Group Always Group (Initially) Individual
 If purchased, Vision ID Cards are mailed to the member's address by Superior Vision (*administrator of QualChoice Vision Benefits*).

Section V. Enrollment and Eligibility Rules. Enrollment and eligibility rules apply to all ancillary products offered through QualChoice.

Are all employees covered by workers' compensation? Yes No

If YES, name of the workers' compensation carrier: _____

Please check the eligibility classes of employees for medical, vision, or dental coverage.

- Full-Time** active employees. *Full-Time* is active employee working at least 30 hours/week and 48 weeks/year.
 COBRA.
 Retirees. Only available to groups of 100+ employees.

New Hire Enrollment For multiple waiting periods, please define employee class.	Open Enrollment	New Groups Only
<p>Waiting Period (Check One)</p> <p><input type="checkbox"/> Date of Hire <input type="checkbox"/> First of month after date of hire <input type="checkbox"/> First of month after 30 days <input type="checkbox"/> First of month after 60 days</p> <p>Class _____</p> <p>Waiting Period (Check One)</p> <p><input type="checkbox"/> Date of Hire <input type="checkbox"/> First of month after date of hire <input type="checkbox"/> First of month after 30 days <input type="checkbox"/> First of month after 60 days</p> <p>Class _____</p>	<p><input type="checkbox"/> 30 days before renewal date <input type="checkbox"/> Other (subject to underwriting approval). <i>Explain below.</i></p>	<p>Are you waiving the initial waiting period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>NOTE: Only applies to employees in their initial waiting period and would be effective on date of the group contract.</p>

Effective Date for Rehires	Termination Date
<p><input type="checkbox"/> No rehire policy. Employee must fill out waiting period as new hire. <input type="checkbox"/> Effective date is first of the month following rehire date. <input type="checkbox"/> No. of months between termination date and rehire date. <i>Please fill in no. of months or check no. of months.</i> _____ months No. of Months: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Rehire Policy, Other _____</p> <p>NOTE: <i>If rehire date is greater than 6 months from termination date, employee is subject to new hire waiting period. Large groups may be subject to penalties under the employer-shared responsibility mandate if certain rehired employees are required to complete a waiting period.</i></p>	<p>Termination date will be on the last day of the month of termination for employees or dependents.</p>

Section VI. Employer Contribution

% of Employee Only: _____ % (*cannot be less than 50%*) or \$ _____ PEPM **% of Dependents:** _____ %

Section VII. Medical Plan Selection

Depending on the type of health plan your group falls under, complete and submit **one** of the following attachments with your form.

- Attachment 1:** Non-Grandfathered Small Group (2-50 eligible employees) Plan — *ACA Metallic Plans*
Attachment 2: Grandfathered Small or Large Group Plan — *Not available for purchase with ACA Metallic plans*
Attachment 3: Non-Grandfathered Small or Large Group Plan — *Non-Metallic Plans — Not available for purchase with ACA Metallic plans*

Section VIII. Ancillary Products

<p>Group Term Life and AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Amount of Coverage Selected: \$ _____ Total PEPM Amount: \$ _____ PEPM</p>	
	<p>Multiple of Salary</p> <p><input type="checkbox"/> _____ x annual salary up to \$100,000 <input type="checkbox"/> _____ x annual salary up to \$100,000</p>	<p>Class Description (if applicable)</p>

Dependent Life YES NO

Spouse \$2,500/Children \$2,500 Spouse \$5,000/Children \$5,000 Spouse \$7,500/Children \$7,500 Spouse \$10,000/Children \$10,000

IMPORTANT: Dependent life amount cannot be more than 50% of employee amount.

Group Term Life and AD&D benefits reduce 35% at age 65, 50% at age 70, and 70% at age 75. Employee must be actively at work on his/her effective date for Group Term Life and AD&D coverage to take effect. QualChoice Life and Health Insurance Company, Inc. is an independent company and operates separately from QCA Health Plan, Inc. QCLHIC is solely responsible for life insurance.

Section IX. Ancillary Products (cont'd)

Dental Benefits YES NO

- PLAN ID No. _____
- Selected rates (rates based on selected tier) 2 Tier Rates 3 Tier Rates 4 Tier Rates
- Is dental coverage a medical match: YES NO

Employer Dental Contribution

% of Employee Only	% Dependents	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
		\$	\$	\$	\$

QualChoice Vision Benefits YES NO

- PLAN ID No. _____
- Selected rates (rates based on selected tier) 2 Tier Rates 3 Tier Rates 4 Tier Rates
- Is vision coverage a medical match: YES NO

Employer Vision Contribution

% of Employee Only	% Dependents	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
		\$	\$	\$	\$

Section X. Authorization and Signatures

On behalf of the Group/Plan Sponsor, the undersigned agrees and attests the following:

- That the information entered on this *Product Selection & Sold Rate Form* is correct and complete.
- That submission of a *Product Selection & Sold Rate Form* containing a false statement, material misrepresentation, or omission constitutes insurance fraud and may result in termination of coverage. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- That coverage will not be effective prior to written approval from QualChoice, and current coverage should **not** be cancelled prior to such approval.
- That the Group/Plan Sponsor agrees to the terms of the **Group Master Contract** and further agrees that this *Product Selection & Sold Rate Form* will be part of the agreement between the Group/Plan Sponsor and QualChoice.
- That, consistent with the requirements of the Genetic Information Nondiscrimination Act of 2008, QualChoice does not use genetic information for underwriting purposes, or any other purpose prohibited by applicable law. The undersigned acknowledges that, as part of the application process, QualChoice requested that it not be provided with any plan participant's family medical history or any plan participant's information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which the participant believes he/she may be at risk for.
- That as the authorized representative of the Group/Plan Sponsor, you confirm receipt and accuracy of the conditions and assumptions made by QualChoice as set out in the fully insured proposal/quote. You further acknowledge that the final sold rates and benefits issued by QualChoice were based on these conditions and assumptions. You agree that if it is subsequently determined that any of these conditions and assumptions are incorrect, QualChoice has the option to immediately either retrospectively modify the rates and benefits provided or terminate the **Group Master Contract**.
- QualChoice disclosure regarding producer compensation: Brokers and agents (referred to collectively as "producers") may receive commissions and other compensation from us, and these costs may be reflected in your premium or fee. Separately, you may have contracted with producers to provide services directly for your group and have to pay them a service fee. Since service fees are not a contingency of the purchase of health insurance, such fees are not part of your premium but may be included in your bill under **Total Amount Due**. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals, or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of general administrative expenses. At your request, a service fee to be paid to your producer/service agent will be added as an expense item where service fees apply.
- Producer compensation for large groups (100+) may be subject to disclosure on *Schedule A* of the *ERISA from 5500* for customers governed by ERISA. We provide *Schedule A* reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Print Legal Name	Title
Signature X	Date (MM/DD/YYYY)
Approved by Broker/Agent or QualChoice Representative – PLEASE PRINT NAME	Title
Signature X	Date (MM/DD/YYYY)

POS and HMO plans underwritten by QCA Health Plan, Inc. | PPO plans underwritten by QualChoice Life and Health Insurance Company, Inc.
Group Term Life and AD&D and Dental Benefits underwritten by QualChoice Life and Health Insurance Company, Inc.
Vision Benefits underwritten by National Guardian Life Insurance Company. Administered by Superior Vision

PLEASE PRINT

Section I. Group/Plan Sponsor Information		
Name of Group/Plan Sponsor	Name of Authorized Group Representative	Phone No.
<p>Authorization for Automatic Payments</p> <p>I authorize QualChoice to debit from our group bank account the amount necessary to pay the monthly premium owed under our group’s QualChoice contract. This authority will remain in effect until I, or another authorized group representative, notify QualChoice, or the bank/financial institution listed below in writing to cancel it in such time (30 days) as to afford the bank a reasonable opportunity to act on the cancellation.</p>		

Section II: Bank/Financial Institution Information			
Name of Bank/Financial Institution	City	State	Zip Code
Please deduct our group’s monthly premium from (<i>check one</i>): <input type="checkbox"/> Checking <input type="checkbox"/> Savings			
Account Number: _____ 9 Digit Routing Number: _____			
Signature of Authorized Group Representative	Date (MM/DD/YYYY)		
X			

Section III: Account Holder Information	
Print Name of Authorized Account Holder	
Signature of Authorized Account Holder	Date (MM/DD/YYYY)
X	

Section IV: Instructions
<p>Mail: QualChoice ATTN: Finance Dept. P.O. Box 25610 Little Rock, AR 72221</p> <p>Fax: 833.681.2496</p> <p>Email: qca_finance@qualchoice.com</p>

If you have any questions, or if there is a change in your banking information, please call:

QualChoice Finance Department
501.228.7111 or 800.235.7111
Monday-Friday, 8:00 a.m. to 5:00 p.m., Central Time

Non-Grandfathered Small Group*: ACA Metallic Plans

*Not available for purchase with non-Metallic plans
2-50 eligible employees

Name of Group/Plan Sponsor: _____

NOTE: If offering more than two (2) options, this form may be copied as needed. Multiple plan options may be offered only if the same type — all POS or all PPO. Plans must be different metallic levels; for example: a Gold and a Silver plan, but not two Gold plans.

Point of Service (POS) Plan

Option 1	Option 1 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups: \$ _____

Option 2	Option 2 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups: \$ _____

Preferred Provider (PPO) Plan

Option 1	Option 1 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups: \$ _____

Option 2	Option 2 Rates
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups: \$ _____

Note: Pediatric Dental was included in your original quote. The Affordable Care Act requires that to purchase a medical plan without pediatric dental, the group must provide a Qualified Health Plan Stand-Alone Pediatric Dental Plan to your employees.

Name of Group/Plan Sponsor: _____

NOTE: If offering more than two (2) options, this form may be copied as needed. Multiple plan options may be offered only if the same type — all POS or all PPO.

Point of Service (POS) Plan

Option 1	Option 2
<input type="checkbox"/> Initial Selection Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>	<input type="checkbox"/> Initial Selection Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>
<input type="checkbox"/> Renewal <input type="checkbox"/> Renewal "As Is" <input type="checkbox"/> Changing Plan to: Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>	<input type="checkbox"/> Renewal <input type="checkbox"/> Renewal "As Is" <input type="checkbox"/> Changing Plan to: Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>
Option 1 Rates	Option 2 Rates
Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____	Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____
Enter monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups:\$ _____	Enter monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups:\$ _____

Preferred Provider (PPO) Plan

Option 1	Option 2
<input type="checkbox"/> Initial Selection Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>	<input type="checkbox"/> Initial Selection Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>
<input type="checkbox"/> Renewal <input type="checkbox"/> Renewal "As Is" <input type="checkbox"/> Changing Plan to: Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>	<input type="checkbox"/> Renewal <input type="checkbox"/> Renewal "As Is" <input type="checkbox"/> Changing Plan to: Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>
Option 1 Rates	Option 2 Rates
Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____	Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____
Enter monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups:\$ _____	Enter monthly premium below from the Medical Quote and attach <i>Underwriting Rate Table</i> . Monthly Premium for Age Rated Groups:\$ _____

Medical Optional Benefit Riders <i>You must elect or reject each rider.</i> <i>By electing any of the following benefit riders, premiums will be adjusted accordingly.</i>		Mandated Offer	Elect	Reject
POS and PPO Plans	Mental Health and Substance Use Disorder <i>IMPORTANT: Plan Sponsors with more than 50 eligible employees do not need to answer this question. You receive Mental Health and Substance Abuse Disorder benefits consistent with the Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Temporomandibular Joint (TMJ) Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO Plans	Hearing Aids and Hearing Instruments Benefit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Non-Grandfathered Small or Large Group: Non-Metallic Plans

Not available for purchase with ACA Metallic plans

Name of Group/Plan Sponsor: _____

NOTE: If offering more than 2 options, this form may be copied as needed. Multiple plan options may be offered only if the same type — all POS or all PPO.

Point of Service (POS) Plan

Option 1	Option 2
<input type="checkbox"/> PreferredChoice <input type="checkbox"/> FlexChoice <input type="checkbox"/> RightChoice Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>	<input type="checkbox"/> PreferredChoice <input type="checkbox"/> FlexChoice <input type="checkbox"/> RightChoice Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>
Option 1 Rates – 10+ eligible employees	Option 2 Rates – 10+ eligible employees
Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____	Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____
Option 1 Rates – 2-9 eligible employees	Option 2 Rates – 2-9 eligible employees
Enter the monthly premium below from the Medical Quote and attach Underwriting Rate Table. Monthly Premium for Age Rated Groups: \$ _____	Enter the monthly premium below from the Medical Quote and attach Underwriting Rate Table. Monthly Premium for Age Rated Groups: \$ _____

Preferred Provider (PPO) Plan

Option 1	Option 2
<input type="checkbox"/> PPO Performance <input type="checkbox"/> PPO Complete Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>	<input type="checkbox"/> PPO Performance <input type="checkbox"/> PPO Complete Medical Plan ID _____ Rx Plan _____ <small>Example P2000A Example: \$10/30/50/100</small>
Select a formulary: <input type="checkbox"/> Enhanced <input type="checkbox"/> Basic	Select a formulary: <input type="checkbox"/> Enhanced <input type="checkbox"/> Basic
Option 1 Rates — 10+ eligible employees	Option 2 Rates — 10+ eligible employees
Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____	Sold Premiums/Composite Rated Groups Employee Only \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____
Option 1 Rates — 2-9 eligible employees	Option 2 Rates — 2-9 eligible employees
Enter the monthly premium below from the Medical Quote and attach Underwriting Rate Table. Monthly Premium for Age Rated Groups: \$ _____	Enter the monthly premium below from the Medical Quote and attach Underwriting Rate Table. Monthly Premium for Age Rated Groups: \$ _____

Medical Optional Benefit Riders. You must elect or reject each rider. By electing any of the following benefit riders, premiums will be adjusted accordingly.		Mandated Offer	Elect	Reject
POS and PPO Plans	Temporomandibular Joint (TMJ) Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO Plans	Hearing Aids and Hearing Instrument Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>