Small Group Master Application

PARAMOUNT

Business Name: _____ Requested Effective Date: _____

Address: _____ City: _____ Zip: _____

Phone Number: (_____) _____ Fax: (_____) _____

SIC/Primary Business Activity: _____

Years in Business: _____TIN: _____

Contact Person: _____

Email address of Contact Person: _____

Please provide the following information relating to your current and previous health insurers:

Current Carrier: _____ Number of years with current carrier: _____

Plan Type (deductible/coinsurance): _____

Attach a copy of your most recent billing.

Has your health insurance ever been cancelled? If so, please describe the circumstances: _____

_____

What percentage of your employees' health care premiums are funded by the company (min. of 50% required)?

_____

Are you aware of any short-term disability or workers compensation claims within the past 12 months? _____

If so, please explain: _____

Paramount Selections:

Plan Design Selected: _____*Alliance, if applicable:* _____

Non-Grandfathered: ☐ Grandfathered: ☐

Probationary Period for New Hires (not to exceed 90 days in Ohio / 60 days in Michigan): _____

How many employees work at least 30 or more hours/week? _____

How many new hires in the past 12 months? _____Number of Cobra employees:_____

This group Questionnaire is part of the application for coverage. Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against Paramount, submits an application or files a claim containing a false or deceptive statement, is guilty of Insurance Fraud under Ohio and/or Michigan criminal law.

Company Signature: _____ Date: _____

Broker/Agent Name/Signature: _____ Date: _____

Agency Name/Number/TIN: _____

Broker/Agent Address:_____

Broker/Agent Phone, Fax & e-mail:_____

Paramount Approval:_____ Date: _____Group Number:_____

Contracts: _____ Members: _____

**Per Superior Vision requirements, additional broker/agency information is required.*

Rev. 7/2015