

**York Builders Insurance Trust  
Master Application  
Inter County Hospitalization/Health Plan, Inc.**

GHAI USE ONLY	
GROUP #	_____
PLANCODE	_____
CHECK \$	_____
ASSOCIATION	_____
MARKETING REP. INITIALS	_____



Y O R K B U I L D E R S  
**INSURANCE  
TRUST**

GROUP NAME: \_\_\_\_\_ BY: \_\_\_\_\_ TITLE: \_\_\_\_\_  
SIGNATURE

The above named Employer is eligible to participate in the above described Plan and is approved as a participant therein.

EFFECTIVE DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gettysburg Health Administrators By: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

GHAI FOR ADMINISTRATORS USE ONLY

The Insurance benefits, eligibility requirements and effective date of the insurance are requested herein. I certify, as the employer, that to the best of my knowledge and belief all statements and answers in this Application are true. I have read and understand the Notice Regarding Limitations on Health Coverage.

Administrator: Gettysburg Health Administrators, 404 Baltimore Street, P.O. Box 1060, Gettysburg, PA 17325-1060 (717-334-9247)

**Please Return all pages to York Builders Insurance Trust, PO Box 7684, York, PA 17404-0684**

PLAN OF COVERAGE

NAME OF FIRM \_\_\_\_\_ TAX ID # (E.I.N.) \_\_\_\_\_

CORRESPONDING PERSON & TITLE \_\_\_\_\_ TEL. # (\_\_\_\_) \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ FAX # (\_\_\_\_) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTY \_\_\_\_\_

(1) Effective Date: The requested effective date for this plan is \_\_\_\_\_, 20\_\_\_\_\_

(2) Type Of Business  Corporation  Partnership  Sole Proprietor

(3) Nature Of Business \_\_\_\_\_ SIC Code \_\_\_\_\_

(4) How long has this particular business been in operation? \_\_\_\_\_

(5) Subsidiary or affiliated companies to be covered (if trusteeship or association, list contributing employers or employer-members on a separate sheet and attach with this application):

Name & Address Relationship to Policyholder (Subsidiary or Affiliate)

a) Are any employees outside coverage area quoted by Gettysburg Health Administrators? # of employees \_\_\_\_\_ Location \_\_\_\_\_

(6) Total Number Of Employees: Full-Time \_\_\_\_\_ To Be Insured \_\_\_\_\_ Waivers \_\_\_\_\_ COBRA \_\_\_\_\_ (30 or more hours per week or 1560 hours per year)

a) List classes of employees to be covered: \_\_\_\_\_ All Employees \_\_\_\_\_

All full-time employees who devote a minimum of 30 hours each week to the service of the applicant at their regular and customary place of employment are considered eligible. It is agreed that the insurance applied for shall not become effective unless the number of persons insured is no less than the minimum number of lives required by law. It is also agreed that if contributions are required, at least 75% of the persons eligible for insurance make written request for the insurance. In addition to part-time and temporary employees, the following classes of employees or employees by name are NOT to be considered eligible: \_\_\_\_\_

b) Individuals to be covered receiving extended benefits under COBRA?  NO  YES Identify individuals, effective date and termination date of COBRA: \_\_\_\_\_

(7) Waiting Period For Eligible Full-Time Employees:

a) Initial employees employed ON or BEFORE effective date:  No Waiting Period 0 Months

b) Subsequent employees employed AFTER the effective date: \_\_\_\_\_ Months

c) New hire waiting period for current plan: \_\_\_\_\_ Months

d) Are any employees currently absent due to illness or injury or receiving disability benefits?  YES\*  NO

\*If YES, specify whom and provide explanation on separate sheet.

NOTE: Eligible employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to active work. If a dependent of an insured employee is hospital confined on the effective date, he or she shall be covered under this plan when discharged from the hospital.

(8) Does your company have a policy for Continuation of Coverage for disabled employees or those on leave of absence?  YES\*  NO

\*If YES, attach copy of policy.

(9) Does your company provide health benefits for laid off employees?  NO  YES, # of Days: " 30 " 60 " 90 " 90

(10) Does your company provide health benefits for dependents to age 30 (PA Act 4 of 2009)?  NO  YES

(11) Are all employees and owner/partners covered by Workers' Compensation?  YES  NO Name of Carrier \_\_\_\_\_

Name of owner/employee not covered by Workers' Compensation: \_\_\_\_\_

(12) Is HMO currently offered?  YES\*  NO \*Specify HMO: \_\_\_\_\_

\*Specify HMO Enrollment Period: \_\_\_\_\_

(13) Insurance coverage hereby applied for is to replace insurance in force as stated below: **(Attach copy of previous carrier's bill.)**

a) Coverage applied for  is  is not in addition to coverage below:

TYPE OF INSURANCE	DATE DISCONTINUED	INSURANCE COMPANY	YEARS WITH CURRENT CARRIER
_____	_____	_____	_____

(14) EMPLOYEE CONTRIBUTIONS:  Insurance is non-contributory  Insurance is contributory  
 The Applicant Employer agrees to make the payroll deduction authorized in writing by each employee.

**EMPLOYEE'S CONTRIBUTION TOWARD COST**

MEDICAL	LIFE/LIFE & SHORT TERM DISABILITY
%/ %	%
Employee/Dependent	Employee

**COVERAGES REQUESTED**

**MEDICAL COVERAGE REQUESTED:** (Select 1 if 24 or less employees are applying; or Select 1 or 2 if 25 or more employees are applying)

Plan A \_\_\_\_\_ Plan B \_\_\_\_\_ Plan C \_\_\_\_\_ Plan C-100% \_\_\_\_\_  
 Plan D \_\_\_\_\_ Plan D-100% \_\_\_\_\_  
 Plan E w/ \$500/\$1000 ded. Rx \_\_\_\_\_ Plan F w/ HSA compliant Rx \_\_\_\_\_ Plan G w/ \$500/\$1000 ded.Rx \_\_\_\_\_

**DRUG CARD (for plans A-D ; excludes Plans E, F, and G):**

\$100 deductible then \$20 Generic / \$35 Brand / \$60 Non-Formulary ; Mail Order = 2x copay

**MINMAX** \_\_\_\_\_ **MINMAX DEDUCTIBLE** \$5,000 \_\_\_\_\_ \$7,500 \_\_\_\_\_ \$10,000 \_\_\_\_\_ \$12,500 \_\_\_\_\_ \$15,000 \_\_\_\_\_

**MATERNITY COVERAGE:** Normal Delivery Included

**LIFETIME MAXIMUM:** \$2,000,000

**OTHER COVERAGES- YORK COUNTY BUILDERS ASSOCIATION INSURANCE TRUST:**

LIFE INS/LIFE INS SHORT-TERM DISABILITY – **THE HARTFORD LIFE** –  
 (Selection of One Plan is Mandatory when selecting medical coverage – See Blue Brochure)

Plan 1 \_\_\_\_\_ Plan 2 \_\_\_\_\_ Plan 3 \_\_\_\_\_

LONG TERM DISABILITY – **THE HARTFORD** (Optional-any number may participate)  
 Yes \_\_\_\_\_ No \_\_\_\_\_

DENTAL COVERAGE – **UNITED CONCORDIA, HIGHMARK DENTAL COMPANY** (Optional - 75% company participation required)

High Option \_\_\_\_\_ Low Option \_\_\_\_\_

**NOTICE REGARDING LIMITATIONS ON HEALTH INSURANCE COVERAGE**

While we believe that the insurance coverage you are purchasing is among the finest obtainable, you should be aware of certain limitations in the coverage being offered. In particular, please note the following:

- There may be a "waiting period" which would delay the insurance coverage effective date (see page 2 of this form);
- Certain exclusions from coverage are contained in the policy (see the policy);
- Some "pre-existing conditions" may not be covered for up to 12 months (see the policy);
- The policy discusses the various optional coverages and limitations upon some of these benefits.