

Friday Health Plans
Benefit Contract for Employer Groups
SIGNATURE SHEET

Anniversary Date: _____ Group No: _____ AE: _____
Benefit & Premium Modification Date: _____ Broker: _____

This Agreement, consisting of the Benefit Schedule(s) and other related documents, as supplemented by this Signature Sheet and attachments, has been entered between Friday Health Plans, Inc. (formerly Colorado Choice) and the Employer Group named below, in order to provide eligible Employers and eligible Dependents electing to enroll hereunder with health care benefits as specified in the Benefit Schedule(s) and related documents. This Agreement may be amended pursuant to the Benefit Schedule(s) and related documents of at any time by mutual written consent between the Employer Group and Friday Health Plans.

1. Name and Address of Employer Group:

Employer Tax I.D. No: _____
Administrator: _____
Title: _____

2. Eligibility: Standard 1st of month following ___ days. Other 1st of month following ___ days.

Full time employees must work at least ___ hours per week (must be at least 24 hours per week).

Employer contribution: Employee _____ Dependents _____

3. Monthly Prepayment Schedule (premium): The rates are in effect for coverage through: _____

See attached for Employer Group rates. It is the Employer Group's responsibility to prepay for healthcare coverage prior to the month of coverage (for example, payment for February coverage must be received by Friday Health Plans in January) to maintain coverage. **Friday Health Plans has no responsibility to extend coverage beyond the month for which premiums have been received or to send Employer Group billings or statements for any period of coverage.**

4. Contract Type Rate Tier Structure:

Age-Rated Composite Rates

5. Plan Selection

Bronze

- Value Choice
- Simple HSA
- Bronze Basic

Silver

- HSA
- Silver Value
- Silver Basic

Gold

- Gold Value
- Gold Basic

I wish to offer all plans in my Employer Group

6. Optional Benefits – VSP Vision

- Exam Plus (included on all plans at no additional cost)
- Exam + \$75 material allowance
- Exam + \$100 material allowance

Executed at: _____, Colorado

Effective Date: _____

Employer Group: _____

Friday Health Plans

Signature: _____

Signature: _____

Print Name & Title: _____

Cynthia Palmer, CEO

Date: _____

Date: _____

Friday Health Plans
700 Main Street, Suite 100, Alamosa, CO 81101 * 719-589-3696 or 1-800-475-8466
SIGNATURE SHEET

Group Name: _____

1. We wish to enroll our firm as a group account with Friday Health Plans, Inc.
2. We understand the eligibility rules applicable to employee enrollment and the prepayment requirements of Friday Health Plans.
3. Participating requirements for specific coverage(s) have been explained in detail, and we fully understand that they must be met and maintained in order for the group to remain eligible for coverage.
4. The group herewith tenders the amount of \$ _____; and in consideration of approval of the application by the Plan, it promises to pay the Plan, as appropriate, any balance necessary to constitute the full initial payment for group benefits herein identified in the application. It is understood that the Plan has the right to accept or reject this application, and coverage will not commence until the application has been accepted.

This Agreement, consisting of the Evidence of Coverage (EOC) and Benefit Schedule(s), as supplemented by this Group Application and Signature Sheet, has been entered into between Friday Health Plans, Inc. and the Employer Group named above, in order to provide eligible Employers and eligible Dependents electing to enroll here under with health care benefits as specified in the Benefit Schedule(s). This Agreement may be amended with mutual written consent between the Employer Group and Friday Health Plans, Inc. at any time.

Executed at: _____, Colorado

Effective Date: _____
Friday Health Plans

Employer Group: _____

Date: _____

Date: _____

Signature: _____

Signature: _____

Print Name: _____

Print Name: Cynthia Palmer

Title: _____
Authorized Representative

Title: CEO
Authorized Representative

PRODUCER STATEMENT

Name: _____

Production Split: _____

Address: _____

Make Check Payable to: _____

Telephone: _____

Fax #: _____

Federal Tax I.D. #: _____

Producer #: _____

I certify that all the information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm is a bona fide business establishment.
2. All participation requirements have been met.
3. Coverage's, enrollment provisions, eligibility requirements, limitations, exclusions, the effect of misrepresentations and termination provisions have been fully explained and understood by the employer. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be coverage.

Dated this _____

day of: _____, 2018

Print Name of Producer: _____

Producer Signature: _____

Any change to this Producer statement does not constitute an amendment to the Group Application and Signature Sheet.

FRIDAY HEALTH PLANS
Certification of Completed Group Application/Renewal

Please complete the following

I hereby certify that the following required documentation has been submitted to Friday Health Plans as part of this group Application/Renewal.

The documentation requested below may be required each year at renewal.

REQUESTED EMPLOYER INFORMATION IS ATTACHED.

Please provide the most recent quarterly UTR (Unemployment Income Tax Report), or a similar payroll report verifying employment status of eligible employees.

YES I have provided the necessary documentation.

Please provide copies of each employee signed waiver for eligible employees **NOT** participating in the group health plan.

YES I have provided the required waivers.

NOTE: This page is required for all new and renewal groups. IF there are no plan changes at renewal, this page will act as renewal confirmation.

GROUP BENEFITS ADMINISTRATOR

Name: _____ Title: _____
Address: _____
Telephone: _____ Fax #: _____

BILLING CONTACT PERSON

Name: Same as above _____ Title: _____
Address: _____
Telephone: _____ Fax #: _____

Signed: _____
Printed Name: _____
Date: _____
Business Name: _____