HEALTHEZ Employer Data Form

Employer Information

Full Legal Name:			
Address of Headquarters/Corporate Location:			
Tax ID Number:	Main Phone Number:	Fax Number:	Type of Organization: ☐ Assoication ☐ Public/Government ☐ Corporation ☐ Other: ____________
Nature of Business:			

Are there other subsidiaries or affiliated companies to include in the medical plan?
☐ Yes ☐ No

If yes, please provide:
Name: ______________________________ Address: ____
Name: ______________________________ Address: ____
Name: ______________________________ Address: ____
Name: ______________________________ Address: ____

Are there other locations to include in the medical plan? ☐Yes ☐No

If yes, please provide:
Name: ______________________________ Address: ____
Name: ______________________________ Address: ____
Name: ______________________________ Address: ____
Name: ______________________________ Address: ____

Prior Coverage Information

Is there prior coverage from a different carrier? ☐ Yes ☐ No

If yes, please provide:
Name of Carrier: ________________________________ Coverage Renewal Date: _____________
Prior coverage was: ☐ Fully Insured ☐ Self Funded

COBRA Information

Do you have a COBRA vendor? ☐ Yes ☐ No

If yes, please provide:
Name of Vendor: _______________________ Vendor Contact Name: _______________________
Vendor Contact Phone Number:_________ Vendor Contact Email: ______________________

If no, would you like information on HealthEZ's preferred vendor? ☐ Yes ☐ No

Employee Information

Total Number of Full Time Employees:	Total Number of Part Time Employees:
Are there employees currently in their waiting period? ☐ Yes ☐ No	
Are there employees currently covered under COBRA? ☐ Yes ☐ No	
Are there employees working remotley in locations not specified on page 1? ☐ Yes ☐ No *If yes*, where: ______________________________	

Coverage Information

Annual Open Enrollment Timeframe:
Full Time Requirements:
Waiting Period (*must not exceed 90 days total*): ☐ First of the month following ______days of employment ☐ _______ days after date of hire
Dependent Coverage: ☐ Children (*Required*) ☐ Spouses ☐ Grandchildren (*Who reside with and are financially dependent on the policy holder*) ☐ Common Law Spouse ☐ Domestic Partners
Deductible Year ☐ Plan Year ☐ Calendar Year

ID Cards

Cards fron initial eligibility load to be mailed to: ☐ Employee Homes ☐ Employer Office
Additional cards throughout the year mailed to: ☐ Employee Homes ☐ Employer Office
If mailed to the Employer Office, cards should be mailed to the attention of:

Additional Benefits

Would you like to offer virtual telemedicine visits? ☐ Yes ☐ No ☐ Interested
Would you like to offer a Medical and/or Dept. Care Flexible Spending Account (FSA)? ☐ Yes ☐ No ☐ Interested

Employer Contacts

*Review the different types of employer contacts that will work with HealthEZ, and complete the table below accordingly. Select all that apply for each seperate contact.

General Contact: General administative contacts.
These are typically CEO's, CFO's, HR, and similar personnel.

Agreement Signee: Eligible and responsible for signing contract agreements.

Eligibility/ID Cards Contact: Responsible for maintaining eligibility changes.
This is typically HR. This person must be HIPAA certified.

Reporting: Eligible to recieve monthly stop loss reporting (*member names not shown*).

Work Status: Responsible for confirming eligibility reqiurements are being met.
This is typically HR.

Full Name:		Title/Role:		
Email Address:		Phone Number:		
☐ General	☐ Agreement Signee	☐ Eligibility/ID Cards	☐ Reporting	☐ Work Status
Full Name:		Title/Role:		
Email Address:		Phone Number:		
☐ General	☐ Agreement Signee	☐ Eligibility/ID Cards	☐ Reporting	☐ Work Status
Full Name:		Title/Role:		
Email Address:		Phone Number:		
☐ General	☐ Agreement Signee	☐ Eligibility/ID Cards	☐ Reporting	☐ Work Status
Full Name:		Title/Role:		
Email Address:		Phone Number:		
☐ General	☐ Agreement Signee	☐ Eligibility/ID Cards	☐ Reporting	☐ Work Status
Full Name:		Title/Role:		
Email Address:		Phone Number:		
☐ General	☐ Agreement Signee	☐ Eligibility/ID Cards	☐ Reporting	☐ Work Status
Full Name:		Title/Role:		
Email Address:		Phone Number:		
☐ General	☐ Agreement Signee	☐ Eligibility/ID Cards	☐ Reporting	☐ Work Status