



THE PERFECTHEALTH INSURANCE COMPANY

Request for Coverage

Firm Information

Group Number				Requested Effective Date			
Exact Legal Name of Firm							
Legal/Corporate Street Address of Firm							
City			State		Zip	County	
Mailing Address of Firm if Different than Above							
City			State		Zip	County	
Telephone		Fax			E-Mail		
Organization Type (Check one)	Corporation	Partnership	Sole Prop.	Association	Trustee	Other	
Federal Tax Identification Number				No. of Years in Business:			
Nature of Business					SIC Code		
Benefits Administrator					Title		
Telephone		Fax			E-Mail		

Firm Relationships (Please indicate any relationship with other Firms):

Firm Name	Address	Ownership Percentage	Electing Cov. Y/N

Eligibility

Total number employed at the firm all locations...		Total number waiving due to coverage through spouse....	
Total number working 30 or more hours a week.....		Total number waiving due to coverage through other.....	
Total number working less than 30 hours a week.....		Total number covered by Management-Labor contract....	
Total number of employees in waiting period.....		Total number not actively at work.....	
Total number covered by Taft-Hartley agreement.....		Total number covered under COBRA/State Continuance.	
		Total number of Retirees.....	
		Total number enrolling under PerfectHealth.....	
Class of Employees to be excluded: _____		Total number of Employees: _____	

Additional Information

Open Enrollment Period(s)	Scheduled from _____ to _____	Scheduled from _____ to _____
Employer Contributions	Employee \$ or %	
	Dependent \$ or %	

Additional Information Continued

Employment Waiting Period (Insurance becomes effective on the first of the month following the date of eligibility unless otherwise noted)		Applies to:
<input type="checkbox"/>	First of the month following date of hire	<input type="checkbox"/>
<input type="checkbox"/>	First of the month following 30 days from date of hire	<input type="checkbox"/>
<input type="checkbox"/>	First of the month following 60 days from date of hire	<input type="checkbox"/>
<input type="checkbox"/>	First of the month following 90 days from date of hire	<input type="checkbox"/>
<input type="checkbox"/>	First of the month following 6 months from date of hire	<input type="checkbox"/>
Is this Replacement Coverage? If it is...		
List your prior carrier and last date of coverage for the last (3) years		Term date:
<input type="text"/>		<input type="text"/>
Reason for Termination:		
<input type="text"/>		

Plan of Benefits

Choose your plan by signing the Proposal and attaching the signed Proposal to this Employer Request for Coverage.

By supplying the information requested in this application, the applicant applies for one or more of the group health benefit plans offered by The PerfectHealth Insurance Company ("PerfectHealth"). PerfectHealth shall not be bound by any term or provision herein. PerfectHealth shall not be obligated to issue any insurance coverage to applicant or any eligible person(s) until all required information is submitted. Such Information must be approved by PerfectHealth in writing by an authorized employee at its home office in Staten Island, New York.

Signature Agreement

No agent may set an effective date, make, modify or waive any term or provision of any contract or policy of insurance for PerfectHealth, or extend the time for premium payment without the written agreement of PerfectHealth. Such agreement must be signed by an officer or authorized employee of PerfectHealth at its home office in Staten Island, New York.

Attached is a check or money order in the amount of \$_____. This is advance payment of premium toward the coverage for which this application is made. If this application is accepted by PerfectHealth at its home office, and if the advance payment is more than the first premium due, the excess will be applied to the next premium due under the insurance policy. However, the applicant may opt to have the excess premium returned. If this application is not accepted by PerfectHealth, or if insurance coverage does not become effective, advanced payment will be returned to the applicant. If this application is accepted, coverage will begin on the date that all parts of this application are completed or, if the Requested Effective Date is subsequent to such date, on the Requested Effective Date. Cashing of advanced payment by PerfectHealth shall not constitute acceptance of this application. A completed copy of this application, signed by the agent, shall serve as evidence to PerfectHealth of advance payment. PerfectHealth reserves the right to set all premium rates for insurance coverage in accordance with its underwriting rules and other applicable requirements. The undersigned applicant hereby certifies, to the best of its knowledge, and belief, the information herein is true and complete.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

By _____	Date _____
Signature of Applicant	
Name of Agent / Broker (Please Print)	

By _____	Date _____
Signature of Agent / Broker	

Name of Agency: _____	General Agent: _____
Address: _____	_____
_____	_____
E-Mail Address: _____	_____
Telephone No.: _____	_____
FAX No.: _____	_____