DELAWARE VALLEY HEALTH TRUST

Prospective Member Application

Entity Name:

Address:

County:

Contact Name & Title:

Email:

Phone Number:

Desired Effective Date:

Existing Plan Information

☐ Fully Insured ☐ Self-Insured

Renewal Date:

Current Carrier:

Years with Current Carrier:

Provisions in Place for termination of Coverage/Notification Period:

Interested Coverages

☐ Medical/RX ☐ Dental ☐ Vision

Total Full-time Employees:

Total Enrolled Employees:

Toal Employee Contribution Percentage Toward Premium

Employee Only:

Dependents:

Amount of Employer Funding of the Deductible (for High Deductive Plans with HSA or HRA only)

Please attach the following information to your application

☐ Most Recent Renewal

☐ Current Invoice

☐ Current Summary Plan Benefit (SPD)

☐ Current Employee Census

Signature

The undersigned Authorized Representative represents that to the best of his or her knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and may be relied upon by Delaware Valley Property and Liability Trust and its underwriting consultants, Insurance Buyers' Council, as the basis for offering membership in the Trust and providing coverage. The Applicant will notify the Trust of any material changes to the information provided.

Signature: _____ **Date:** _____