# EMPLOYER APPLICATION

*For Health Plan Premium Subsidy*

*(Must be accompanied by Capital Health Plan Small Group Application and all required business documentation)*

**COMPANY INFORMATION**

Name of Company

*Mailing Address (if different)*

| | | | |
|---|---|---|---|
| Street Address | | Street Address | |
| City | | City | |
| State | | State | |
| Zip | | Zip | |
| Phone | | Fax | |
| Type of Business | | Number of Eligible Employees | |
| E-Mail | | | |

| | | |
|---|---|---|
| Is the company headquartered in Gadsden, Leon, Jefferson or Wakulla County? | Yes | No |
| Has the company been in existence for more than 12 months? | Yes | No |
| Has the company offered health insurance or HMO coverage to employees in the past 12 months? | Yes | No |
| Have all eligible employees for which this premium subsidy is sought not had employer sponsored health insurance or HMO coverage in the past 12 months? | Yes | No |
| Are the average wages paid by you for the eligible employees for which this premium is sought less than or equal to $12/hour? | Yes | No |

**EMPLOYER DECLARATIONS**

As a duly authorized agent of the Employer, signature to this application for Capital Health Partnership participation certifies and commits the employer

*a. To payment of at least 50% of the unsubsidized portion of the health plan coverage category selected by the employee.*

*b. I understand that Capital Health Partnership premium subsidies are available for two consecutive years of coverage for eligible employees and that the premium subsidies will terminate after 24 months.* ________ *(initial here).*

*c. That this application is true and accurate.*

**Signature:** ____________________ **Date:** ____________

*Authorized Agent of Employer*

Print Name / Title: ____________________

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