



EMPLOYER REQUEST FOR APPLICATION

Section 1: Employer Information (Complete all information)		
Company Name:		
Owner's Name:	Nature of Business:	
Contact Person:	Contact Person Phone Number:	
Good time to Contact?	Contact Person's Email:	
Fax Number:	Employer Federal Tax ID#:	
Requested Effective Date:		
Mailing Address		
City:	State:	Zip Code:
Section 2: Montana Medical Association Membership		
Please list MMA Members employed (attach list if necessary):		
Last Name	First Name	MMA Membership
Section 3: Participation		
What is the employer contribution toward employee premium?	<input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> Other _____ (Cannot be less than 50%)	
Is there a different criterion by class of employee? If so, identify what constitutes a class and how contribution is determined. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, _____		
What is the employer contribution toward dependent premium?	<input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> 25% <input type="checkbox"/> 0% <input type="checkbox"/> Other _____	
What is the waiting period for new employees	First Day of the Month Following: <input type="checkbox"/> Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days	
What are the work hour requirements for employees to be considered eligible for coverage?		
What is the total number of employees eligible for coverage under this plan? _____		
Signed by Employer/Employer's Authorized Representative: _____		
Print Name: _____ Title: _____		
Date: _____ At (City/State): _____		