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?	❑ 100% ❑ 75% ❑ 50% ❑ 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. ❑ Yes ❑ No If yes, ____	
What is the employer contribution toward dependent premium?	❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 0% ❑ Other ________
What is the waiting period for new employees	**First Day of the Month Following**: ❑ Hire ❑ 30 days ❑ 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): _________________________