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PREMIUM ASSISTANCE PROGRAM
Employer Application & Certification Form

1. Answer each question or enter "N/A" 2. Please PRINT all answers.

Section I: EMPLOYER INFORMATION

Employer/Business Name	Federal Tax ID	Business Start Date	Number of Full Time Employees*	Number of Part-Time Employees

Name of Company Owner(s) (Last, First, MI)	Nature of Business / SIC Code

Employer Business Address	City	County	Zip

Mailing Address (If different from Business Address above)	Company Contact Person

Contact Phone # (Required)	Contact Fax #	Contact E-mail Address (Required)

Health Insurance Company:	Effective Date of Plan:

Section II: QUALIFYING INFORMATION

Does your business pay part of the health insurance premium or provide a stipend to its employees?
Yes ☐ No ☐ Premium ☐ Stipend ☐
In the past 6 months, have you offered your employees, or have your employees been covered under any company-sponsored group health plan or association or union health benefits plan? Yes ☐ No ☐
If prior coverage, was it with TexHealth? Yes ☐ No ☐

Section III: PAYMENT METHODOLOGY

Employers enrolled in the TexHealth Central Texas Program may be eligible for premium assistance for qualified employees' monthly health insurance premiums depending on the employee's income. I agree to provide the latest quarterly state Wage & Tax Statement or other documentation required by TexHealth for eligibility determination.

Section IV: EMPLOYER CERTIFICATION

I certify, by my signature below, that:

1. The information submitted in this Employer Application and Enrollment Form is accurate and complete and I verify that I understand and meet the TexHealth Central Texas Program eligibility requirements as further set forth in the separate Employer Agreement between Employer and TexHealth Central Texas.
2. I understand that the TexHealth Central Texas Program is based on a monthly cycle and can only become effective on the first day of the month following enrollment certification.
3. I represent and warrant that I have obtained verification of immigration status of all eligible employees as required by law.
4. I understand and agree that my business is enrolled in the TexHealth Central Texas Premium Assistance Program for one year or until the next open enrollment period, whichever comes first.
5. I understand TexHealth Central Texas is not an insurer, plan sponsor/administrator/fiduciary and cannot be held responsible for any errors or omissions on the part of my health insurance company or insurance agent.

Employer or authorized representative signature_ _____

Printed Name/Title_____

Witness _____

Date signed_____

* Full-time is defined as 30 hours per week.