



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 <input type="checkbox"/> Premium <input type="checkbox"/> Stipend No				
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 Prior TexHealth				
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.