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)	Number of Eligible Employees:	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 ☐ Premium - _____%? ☐ Stipend - Amount?_____

Is your business headquarters located in Bastrop, Burnet, Hays, Harris, Milam, Travis or Williamson County? 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 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 verification.
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, and automatically renews.
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.
6. I understand funding for the TexHealth Program(s) may cease at anytime and not guaranteed in anyway.

Employer or authorized representative signature_____

Printed Name/Title_____

Witness _____

Date signed_____

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