PREMIUM ASSISTANCE PROGRAM

Employer Application & Certification Form

1. Answer each question or enter "N/A" 2. ELECTRONIC SUBMISSION ONLY

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?_____

County Business located in?

◯Bastrop ◯Bell ◯Burnet ◯Hays ◯Harris ◯McLennan ◯Milam ◯Travis ◯Williamson county

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 Certification Form is accurate and complete and I agree that I understand and meet the TexHealth Program eligibility requirements as further set forth in the separate Employer Agreement between Employer and TexHealth.
2. I understand there is a 3 month qualifying period. Employees pay their full share of premiums until first subsidy is received.
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 Premium Assistance Program for 12 months and automatically renews.
5. I understand TexHealth 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 theTexHealth Program(s) may cease at anytime and is not guaranteed in any way.

Employer or authorized representative signature

Printed Name/Title _____

Witness _____

Date signed _____

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