



Healthy Communities Cooperative

PO Box 888 East Troy, WI 53120

MEMBERSHIP APPLICATION (with Enrollment in Insurance plan)

Organization Name: _____

Parent Company Name (if applicable): _____

Number of employees: (Locally) _____ (Nationally) _____

Number of employees currently enrolled in organizations health insurance plan: _____

Street Address: _____

Mailing Address: _____

City, State, Zip : _____ County _____

CEO name, title: _____ CEO e-mail: _____

Company representative name/title: _____

Address (if different from above): _____

Phone: _____ Mobile Phone: _____

E-Mail: _____ Web Address: _____

Name of health insurance agent and agency: _____

Application Fee attached (One-time fee):

- 1 – 10 Eligible local employees: \$150
- 11 – 25 Eligible local employees \$250
- 26 – 49 Eligible local employees: \$500
- 50 – 99 Eligible local employees: \$750
- 100+ Eligible local employees: \$1,000

- Signed Insurance Agreement Attached
- Member of Participating Chamber _____ (Please attach a certificate of Chamber membership)

By the authorized signature below, member applicant:

1. Agrees to support a consumer-driven and wellness-based approach to health insurance and thereby cause each adult insured pursuant to a cooperative sponsored health insurance plan to participate in a Health Risk Assessment (HRA) within 90 days of the HRA being made available. Failure to do so may result in termination of coverage at the sole discretion of the cooperative, and
2. Agrees to have \$12 per applicant per month or \$12 per covered employee per month added to the monthly insurance premium for monthly cooperative membership dues (such dues shall be non-refundable and subject to adjustment from time to time)
3. Agrees to remain a member in good standing of a participating Chamber of Commerce. If membership in a participating chamber lapses it will result in the loss of the HCC Insurance benefit and will be subject to the penalties as outlined in the three-year insurance agreement.

Signature: _____ Title: _____

Print Name: _____ Date: _____

This application is valid for 180 days from date signed.