



## Minnesota Group Application - Small Employer

### Submission Information

Group submissions do not begin processing until all the information in the checklist below is included. Submissions received after the 10th of the month cannot be guaranteed an effective date of the first of the following month. HealthPartners will request additional information as deemed necessary.

Please complete these forms and attach the following:

- Completed Small Group Employer Application.
  - Information regarding any NEW HIRES AND OWNERS not listed on the Minnesota Quarterly Wage Report on page 2 of this form.
- Minnesota Quarterly Wage Report (from the most recent quarter which should list each employee and the hours they worked); including the following:
  - Indication of status of all employees; full time, part-time, union, seasonal and terminated.
- Copy of most recent bill from current HEALTH insurance carrier
- All completed employee enrollment forms. Enrollment forms **MUST** be completed in their entirety.
- All eligible employees must be accounted for with an application or waiver.

## EMPLOYER ELIGIBILITY INFORMATION

Today's Date \_\_\_\_\_ Requested Eff. Date \_\_\_\_\_ HealthPartners Sales Executive \_\_\_\_\_

Full Legal Group Name \_\_\_\_\_ DBA (if applicable) \_\_\_\_\_

Address \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Fax \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_ email \_\_\_\_\_

Is Contact Person an eligible employee?  YES  NO If NO, please explain: \_\_\_\_\_

Owners and percentage of ownership for each \_\_\_\_\_

Are they eligible for coverage?  YES  NO If NO, please explain: \_\_\_\_\_

Tax ID Number \_\_\_\_\_ Corporate headquarters location (City and State and/or County): \_\_\_\_\_

YES  NO 1. Is this organization in any way related to other companies (such as a national corporation) as a wholly or partially owned subsidiary, or does this organization own any other companies or have wholly or partially owned subsidiaries?  
If YES, please provide the HealthPartners Controlled Group form, found on [healthpartners.com](http://healthpartners.com).

YES  NO Do you have any other locations or sites? If yes, list the State and/or County: \_\_\_\_\_

\_\_\_\_\_ 2. Number of years in business \_\_\_\_\_ Industry \_\_\_\_\_

3. TYPE OF ENTITY:  S Corporation  C Corporation  Sole Proprietorship  Partnership  Non-Profit  
 LLC (circle one to the right: C Corporation Sole Proprietorship Partnership)

**For 4a and 4b exclude seasonal, temporary and union employees covered under a collective bargaining agreement.**

\_\_\_\_\_ 4a. On average, how many individuals did this organization employ (in all locations), working a normal work week of 20 or more hours throughout the preceding calendar year (January through December)?\*

\_\_\_\_\_ 4b. Currently, how many employees have a normal work week of 20 hours or more?\*

\_\_\_\_\_ 4c. What is the total number of employees (full/part time for entire family of companies) for your company? Medicare Secondary Payer rules apply to employer group health plans with 20 or more employees for each working day in at least 20 weeks in either the current or the preceding calendar year. If you have questions on this rule, please contact your broker or sales representative.

Some employees who do not work a full twelve months may be covered under their employers plan. These employees must work a minimum of nine months in a calendar year. If providing coverage for these employees, the employer must complete the Small Employer Contribution Agreement Form. Contact your HealthPartners Sales Representative for details.

If you are going to cover employees working for a minimum of 9 months, how many will you be covering? \_\_\_\_\_

\_\_\_\_\_ 5. How many employees reside outside of Minnesota? (Submit Quarterly Wage Report for each state)

YES  NO 6. If you elect coverage, will you be offering a Medical Expense Reimbursement plan? (such as an HRA or similar arrangement)

YES  NO 7. Does this organization currently have any leased employees? If YES, please explain: \_\_\_\_\_

YES  NO 8. Does this organization currently have, intend to have, or ever had a Professional Employer Organization (PEO) agreement?  
If YES, please provide a copy of the agreement

Please provide the name and termination date of the PEO agreement: \_\_\_\_\_

YES  NO 9. Does this organization intend to offer domestic partner coverage? Same gender  Same **and** opposite gender   
Please refer to Domestic Partner Form on [healthpartners.com](http://healthpartners.com) for eligibility.

## PARTICIPATION/EMPLOYEE ELIGIBILITY INFORMATION

\_\_\_\_\_ Number of hours all eligible employees must work per week

\_\_\_\_\_ Classification(s) of Employees Excluded from Coverage:  Union covered by a collective bargaining agreement  Part-time  
 Union not covered by a collective bargaining agreement  Salaried  
 Other (explain): \_\_\_\_\_  Hourly  
 Owners

YES  NO Are retirees eligible for coverage? If yes, define policy \_\_\_\_\_

Waiting Period for New Employees:  Date of Hire **OR**

First of the month following:  30 days  60 days  90 days  Other, explain: \_\_\_\_\_

\_\_\_\_\_ Total number of eligible employees

\_\_\_\_\_ Total number of eligible employees that are applying for coverage

\_\_\_\_\_ Total number of employees that are waiving coverage

\_\_\_\_\_ Total number of employees in their waiting period (application or waiver required) See page 2.

\_\_\_\_\_ Number of former employees on COBRA continuation (application required for all COBRA participants)

**Employer Contribution:** Minimum 50% of single coverage, or **Medical:** \_\_\_ Single \_\_\_ Family **Dental:** \_\_\_ Single \_\_\_ Family (if applicable)

## EMPLOYEES AND OWNERS NOT ACCOUNTED FOR ON QUARTERLY WAGE AND DETAIL REPORT

Please use this space to account for Employees and Owners NOT included on the Minnesota State Employer's Quarterly Wage and Detail Report (Form MDES-1D). Additional documentation may be required regarding owners.

EMPLOYEE / OWNER NAME	SOCIAL SECURITY NUMBER	HIRE DATE	TERMINATION DATE	# OF HOURS WORKED

## FORMER EMPLOYEES ENROLLED WITH COBRA COVERAGE

Please use this space to account for former employees covered by COBRA continuation. Indicate either the notification date if the individual is currently under COBRA or the cancellation date if an individual's COBRA coverage is terminating. **Employers must also complete the Small Employer Verification of Terminated Employees form (HP490016), found on healthpartners.com.**

FORMER EMPLOYEE NAME	SOCIAL SECURITY NUMBER	NOTIFICATION DATE	COBRA TERMINATION DATE

## CURRENT CARRIER INFORMATION

Current **MEDICAL Insurance Carrier** \_\_\_\_\_ Type of Coverage (circle one)    **GROUP**    **INDIVIDUAL**

Please list ALL medical carriers for the previous 5 years (if needed, attach additional pages):

NAME OF CARRIER	RENEWAL DATE	DATES OF COVERAGE	REASON FOR TERMINATION

Renewal Rates: \_\_\_\_\_ Single \_\_\_\_\_ Family    **Renewal Plan (product) Name:** \_\_\_\_\_

Current **DENTAL Insurance Carrier** \_\_\_\_\_ **Renewal Date** \_\_\_\_\_

## AGENT / BROKER INFORMATION

Agent Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Fax \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_ Broker Number \_\_\_\_\_  
 email Address \_\_\_\_\_

**x**  
 Agent of Record signature \_\_\_\_\_ Printed Name and Company \_\_\_\_\_ Date \_\_\_\_\_  
 (if applicable)

## EMPLOYER SIGNATURE

I hereby certify that the information provided in this document, and any additional information submitted to support this application, is accurate and complete.

I understand that errors or omissions regarding this information may result in premium adjustments and/or termination of the contract as permitted by Minnesota law.

**x**  
 CEO/Owner/Authorized Company Representative \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

