

Wisconsin 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.

Proposal Predictions

- Group application completed by employer shall disclose all pertinent information.
- Group size is 2 to 50 employees
- Minimum Participation:

Number of Employees*	Participants
More than 10	70%
10	6
8 or 9	5
7	4
5 or 6	3
2 to 4	2

* Eligible employees who have other credible coverage, other than employees who have credible coverage under another health benefit plan sponsored by the employer, will not count against the minimum participation

- The employer must contribute a minimum of 50% toward the employee's monthly premium rate.

Please complete these forms and attach the following:

- Completed Small Group Employer Application.
- Wisconsin Quarterly Wage Report (from the most recent quarter); including the following:
 - Information regarding any NEW HIRES AND OWNERS not listed on the Wisconsin Quarterly Wage Report on page 2 of this form.
 - * **Note:** Indication of status of all employees; full-time, part-time, union, seasonal and terminated, including the number of hours per week worked by each.
- 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 _____

Tax ID Number _____ 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: _____

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.

2. Corporate headquarters location (City and State and/or County): _____

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

3. Number of years in business and group's Federal Tax ID number _____ Industry _____

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

5. On average, how many permanent employees did this organization employ (in all locations), regardless of hours, throughout the preceding calendar year (January through December)? _____

5a. How many permanent employees had a normal work week of 30 hours or more throughout the preceding calendar year (January through December)?* _____

5b. How many permanent employees currently employed (during this calendar year) have a normal work week of 30 hours or more?*
*Excluding seasonal, temporary and union employees covered under a collective bargaining agreement.

5c. 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? _____

6. How many employees reside outside of Wisconsin? (Submit Quarterly Wage Report for each state) _____

YES NO 7. Do you cover your employees under workers compensation?

YES NO 8. If you elect coverage, will you be offering a Medical Expense Reimbursement plan? (such as an HRA or similar arrangement)

YES NO 9. Does this organization currently have any leased employees? If YES, please explain: _____

YES NO 10. 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 11. Does this organization intend to offer domestic partner coverage? Same gender Opposite gender

Please refer to Domestic Partner Form on www.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 REPORT

Please use this space to account for Employees and Owners NOT included on the Wisconsin Quarterly Wage Report. 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 _____

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 law.

CEO/Owner/Authorized Company Representative _____ Printed Name _____ Date _____

PRODUCT SELECTION

MEDICAL PRODUCTS:

<p>NationalONE with Copayment options <input type="checkbox"/> 20-100% <input type="checkbox"/> 20-80% <input type="checkbox"/> 35-80%</p>	<p>NationalONE Deductible / Coinsurance Plans (Three For Free) <input type="checkbox"/> \$500-50% <input type="checkbox"/> \$750-50% <input type="checkbox"/> \$1000-50% <input type="checkbox"/> \$500-75% <input type="checkbox"/> \$750-75% <input type="checkbox"/> \$1000-75%</p>
<p>NationalONE Deductible / Copay Plans <input type="checkbox"/> \$250/20 <input type="checkbox"/> \$500/20 <input type="checkbox"/> \$750/20 <input type="checkbox"/> \$1000/20 <input type="checkbox"/> \$1500 40/60 <input type="checkbox"/> \$250/30 <input type="checkbox"/> \$500/30 <input type="checkbox"/> \$750/30 <input type="checkbox"/> \$1000/30 <input type="checkbox"/> \$2000/40 <input type="checkbox"/> \$250/40 <input type="checkbox"/> \$500/40 <input type="checkbox"/> \$750/40 <input type="checkbox"/> \$1000/40 <input type="checkbox"/> \$2500/40</p>	<p>Empower NationalONE (High Deductible Health Plans) <input type="checkbox"/> \$1150/100 <input type="checkbox"/> \$2300/100 <input type="checkbox"/> \$1500/80 <input type="checkbox"/> \$1500/100 <input type="checkbox"/> \$3000/100 <input type="checkbox"/> \$3000/80 <input type="checkbox"/> \$5600/100</p> <p>Embedded Deductible Plans <input type="checkbox"/> \$2300/100 <input type="checkbox"/> \$3000/100 <input type="checkbox"/> \$3000/80 <input type="checkbox"/> \$2500/80</p> <p>Benefit Administration: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year (If offering more than one product, benefit administration must match.)</p>

DENTAL PRODUCTS: *May also be purchased on a stand-alone basis.*

<p>Open Access – Employer sponsored (select one benefit from each category)</p> <table style="width:100%;"> <tr> <th style="text-align: left;">Annual maximum</th> <th style="text-align: left;">Deductible</th> <th style="text-align: left;">Coinsurance</th> </tr> <tr> <td><input type="checkbox"/> \$750</td> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> 100/50/0</td> </tr> <tr> <td><input type="checkbox"/> \$1,000</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/50/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,250</td> <td><input type="checkbox"/> \$50</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,500</td> <td><input type="checkbox"/> \$75</td> <td></td> </tr> </table> <p style="text-align: center;"><input type="checkbox"/> Optional orthodontics add-on¹</p>	Annual maximum	Deductible	Coinsurance	<input type="checkbox"/> \$750	<input type="checkbox"/> None	<input type="checkbox"/> 100/50/0	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/50/50	<input type="checkbox"/> \$1,250	<input type="checkbox"/> \$50	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$75		<p>Voluntary Open Access Dental Plan² (select one benefit from each category)</p> <table style="width:100%;"> <tr> <th style="text-align: left;">Annual maximum</th> <th style="text-align: left;">Deductible</th> <th style="text-align: left;">Coinsurance</th> </tr> <tr> <td><input type="checkbox"/> \$500</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/50/0</td> </tr> <tr> <td><input type="checkbox"/> \$750</td> <td><input type="checkbox"/> \$50</td> <td><input type="checkbox"/> 100/50/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,000</td> <td><input type="checkbox"/> \$75</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,250</td> <td></td> <td></td> </tr> </table> <table style="width:100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> \$1,000 (w/ortho)³</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,250 (w/ortho)³</td> <td><input type="checkbox"/> \$50</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> \$75</td> <td></td> </tr> </table>	Annual maximum	Deductible	Coinsurance	<input type="checkbox"/> \$500	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/50/0	<input type="checkbox"/> \$750	<input type="checkbox"/> \$50	<input type="checkbox"/> 100/50/50	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$75	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1,250			<input type="checkbox"/> \$1,000 (w/ortho) ³	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1,250 (w/ortho) ³	<input type="checkbox"/> \$50			<input type="checkbox"/> \$75	
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¹ Must have 10 or more employees **enrolled** to be eligible for orthodontic products.
² Must have 5 or more employees **enrolled** to be eligible for voluntary plans.
³ Available to groups with 50-100 **eligible** employees.

In compliance with state and federal small group disclosure requirements, HealthPartners is mandated to advise small employer group clients of the following general guidelines for coverage issued by HealthPartners to clients with 2 to 50 employees:

HealthPartners has established premium rates that do not vary from the base rate by more than plus or minus 30% for a client with similar case characteristics for the same or similar benefit design characteristics. HealthPartners may increase premium rates for a new rating period; however, the percentage increase is limited to the sum of the following:

- an adjustment for increase in the base rate
- an adjustment related to claims experience, health status, and duration of coverage which is limited to plus or minus 15%, pro-rated for periods less than a year
- an adjustment for changes in case characteristics or benefit design characteristics

Any contracts issued may not be cancelled by HealthPartners prior to the contract renewal date and guaranteed renewal of the contract is required, except for the following reasons:

- failure to pay a premium when due
- fraud or misrepresentation of material fact by the employer, by the insured individual
- there is no longer an actively engaged business enterprise
- Wisconsin small employer requirements are no longer met
- the employer fails to comply with the minimum contribution or participation requirements
- HealthPartners withdraws from the Wisconsin small group market

If your group size changes to less than 2 or more than 50 during the 12-month period prior to your renewal date, the Wisconsin Statutes Chapter 635, subchapters I and insurance Chapter 8, will not apply to your group contract. Employees may be subject to a 12-month (18-month for late entrants) pre-existing condition limitation period. During the limitation period, services for pre-existing conditions for which medical advice, diagnosis, treatment, or care was recommended or received within the 6 months prior to the effective date of the coverage will not be covered. Credit for prior continuous coverage will be applied to the limitation period.

Group Name _____
 Employer's Name _____ Date _____
 Agent's name _____ Date _____

HealthPartners will notify employees covered on HealthPartners plans of the special enrollment periods detailed in 29 CFR Sec. 2590.701-6. It is the responsibility of the employer to notify those employees who decline HealthPartners coverage of their special enrollment rights.



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 Minneapolis, MN 55440-1309
 Sales Metro Phone # 952-883-5200
 Non-Metro Phone # 800-298-4235

Fully-insured Wisconsin plans are underwritten and administered by HealthPartners Insurance Company.