HealthPartners®

2018 WISCONSIN FULLY INSURED SMALL EMPLOYER APPLICATION AND SUBMISSION CHECKLIST

Fully insured small employer groups (1-50)

HERE'S WHAT YOU NEED TO KNOW

Group submissions don't begin processing until all information in the checklist below is included.

Additional tax forms will be required for groups with one and two contracts.

DUE DATES

Initial submission should be submitted at least 30 days prior to the effective date to allow enough time for underwriting review.

Underwriting approval and a signed proposal acceptance page must be received by the 15th of the month prior to the effective date. Any groups not approved by Underwriting by the 15th will be moved to the next month.

USE THIS CHECKLIST

- ❑ **Small Group Employer Application**
  - Be sure to answer all questions
  - Group contact needs to complete and sign
  - P.O. Box address can't be accepted as company address
- ❑ **State Employer's Quarterly Wage Detail Report**
  - Minnesota groups: Form MDES-1D
  - Wisconsin groups: Form UC-7823-E
  - Indicate the status of all employees listed: full time, part time, union, seasonal, terminated
  - List any employees that aren't on this report and provide status: new hire, owners (if eligible)
- ❑ **Copy of most recent bill from current health insurance carrier**
  - Only needed if your company has coverage
  - Be sure to identify COBRA individuals
- ❑ **Employee enrollment forms**
  - There should be a form for each eligible employee, regardless if they're applying for or waiving coverage, including new hires in a waiting period
  - Make sure each form is fully completed

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*__Tax filings__ must also be submitted for all one and two person groups, including the federal form signed by the CPA: (or as deemed necessary by underwriting)

- **Farmers:** dependent on the business situation – Federal 1040 Schedule F (Profit or Loss from Farming); Federal 1040 Schedule J (Income Averaging); or 4835 (Farm Rental Income and Expenses); 1120-C (Cooperative Associations)
- **Sole Proprietorship:** Federal 1040 Schedule C (Profit or Loss from Business)
- **Partnership:** Federal 1065 (Return of Partnership Income) and Schedule K-1 (for each partner)
- **S Corporation:** Federal 1120S and Schedule K-1 (for each owner) or W-2 as appropriate
- **C Corporation:** Federal 1120 (Corporation) and W-2 (Owners); some Corporations have ownership only through shareholders who aren't employed by the company

2018 WISCONSIN FULLY INSURED SMALL EMPLOYER APPLICATION

A. EMPLOYER INFORMATION

Today's Date: Requested Eff. Date:

Full Legal Group Name: DBA (if applicable):

Business Address (No PO Box):

City, State, Zip: County:

Phone: Industry Type:

Federal Tax ID#: **Corporate Headquarters (City, State):**

Contact Person: Title:

Email (required):

Delegate* name: Title:

Email (required):

**(Delegate is the person who manages the online account with HealthPartners)*

YES NO 1. Is contact person an eligible employee? If NO, please explain:

YES NO 2. Is Delegate an eligible employee? If NO, please explain:

YES NO 3. Do owners work for the company?

YES NO 4. Do owners meet eligibility criteria for coverage? If NO, please explain:

5. List owners and percent of ownership for each:

YES NO 6. Is this organization in any way related to other companies (such as national corporation) as a wholly or partially owned subsidiary, or does this organization own any of the companies or have wholly or partially owned subsidiaries? If YES, please provide the HealthPartners Controlled Group form, found on **HealthPartners.com/employer**

YES NO 7. Do you have any other locations or sites? If YES, list the state and/or country: ___________________________________

YES NO 8. Are you a Government Group, public entity or public school?

YES NO 9. Are you a church or religious group?

10. Please check your Erisa status: Erisa Non- Erisa

11. Select type of Entity (we require ongoing payroll/wage and tax records for all W2 employees. Please see page 4 for Tax filing information):
S Corporation C Corporation Sole Proprietorship Partnership Non-Profit

12. Number of years in business? _______________

13. Industry Type? ____________________________

B. GROUP SIZE VERIFICATION INFORMATION

Using the table, enter the total number of employees (EEs) who worked each month during the calendar year:

- Include: **Owners** working at the company, temporary, seasonal, union, full- and part- time employees, and employees for all Controlled Groups (as of the Controlled Group status effective date).
- Do **NOT** include: Contracted, temporary, COBRA, and retirees.

Month	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Total EEs												

______________ 1. On average, how many EEs (including owner) each month did this organization employ throughout the preceding calendar year? From January through December 2017

______________ 2. How many permanent employees (including owner) do you currently employ?

______________ 3. How many EEs reside outside of Wisconsin? (Submit Quarterly Wage for each state)

______________ 4. What is the current total number of employees (full/part time for the entire family of companies) for your company? Based on the following definition:

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.

C. PARTICIPATION / EMPLOYEE ELIGIBILITY

_______________ **1.** Total number of permanent employees working a minimum of 30 hours per week? (Employers must offer coverage to all permanent employees working at least 30 hours per week as well as their dependents.)

_______________ **2.** Total number of EEs that are taking medical coverage?

_______________ **3.** Total number of EEs that are waiving coverage?

_______________ **4.** Total number of new hires in their waiting period (application/waiver required and add their names to the wage report)?

_______________ **5.** Number of individuals on COBRA (application required & indicate on bill)?

_______________ **6.** What is the employer medical contribution? Must be a minimum of 50% of each employee's premium.

YES NO **7.** Are retirees eligible for coverage? If YES, please define _______________

YES NO **8.** Do you have a rehire policy? If YES, please define _______________

YES NO **9.** Does this organization intend to offer domestic partner coverage?

Select One **10.** Waiting Period for New Employees:

First of the month following 30 days
First of the month following 60 days
90 days following hire date (maximum allowed)
Date of hire

D. CURRENT CARRIER

1. Type of coverage: Group Individual

2. Current MEDICAL Carrier: _______________ Medical renewal date: _______________

3. Current DENTAL Carrier: _______________ Dental renewal date: _______________

E. MEDICAL PRODUCT SELECTION

Products effective 1/1/2018-12/31/2018

1. Benefit Administration: Plan Year Calendar Year
(If offering more than one product, benefit administration must match.)
All HealthPartners small employer medical plans include an ACA compliant embedded pediatric dental benefit.

2. Select plan(s) and network(s)
- Platinum plans can't be paired with bronze plans.
- Small groups with 1-9 enrolled employees may offer one plan. Groups with 10-24 enrolled employees may offer up to two plans. Groups with 25 or more enrolled employees may offer up to three plans.

Plans		Metal Level	Select Plan
Copay Copay/Deductible	25-95	Platinum	
	500-20	Platinum	
	500-40	Gold	
	750-40	Gold	
	1000-40	Gold	
	3500-60	Silver	
Three for Free	500-70	Gold	
	1000-70	Gold	
	3000-70	Silver	
HSA	2000-100	Gold	
	2500-100	Gold	

Plans		Metal Level	Select Plan
HSA Embedded	2800-100	Gold	
	3600-100	Silver	
	4000-100	Silver	
	3000-80	Silver	
	6400-100	Bronze	
	5200-70	Bronze	
	6000-70	Bronze	
HSA Rx Plus	2000-100	Gold	
	2500-100	Gold	
HSA Rx Plus Embedded	4000-100	Silver	
	3000-80	Silver	
HRA Embedded	4000-100	Silver	
	4750-100	Silver	
	6000-100	Bronze	

F. DENTAL PRODUCT SELECTION (May also be purchased on a stand-alone basis.)

YES NO **1.** Would you like to receive a dental quote?

_______________ **2.** What is the employer dental contribution? Must be a minimum of 50% of each employee's premium.

_______________ **3.** Total number of EEs that are taking dental coverage?

Open Access Advantage (select one benefit from each category)

Employer sponsored Voluntary[2]

Annual maximum	Out-of-Network
$1000	Option 1
$1500	Option 2

Optional orthodontics add-on[1] (employer-sponsored plans only)

Open Access Preventive-only Dental Plan
Open Access Preventive Plus Voluntary Dental Plan[2]
Open Access Preventive Plus Dental Plan
Other_______________________

[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.

Open Access – Employer sponsored (select one benefit from each category)

Annual maximum	Deductible	Coinsurance
$1000	None	100/50/50
$1250	$25	100/80/50
$1500	$50	
$2000 (avail. with 100/80/50 coinsurance only)	$75	
$2500 (avail. with 100/80/50 coinsurance only)		

Optional orthodontics add-on[1]

Voluntary Open Access Dental Plan[2] (select one benefit from each category)

Annual maximum	Deductible	Coinsurance
$750	$25	100/50/50
$1000	$50	100/80/50
$1250	$75	
$1500 (avail. with 100/80/50 coinsurance only)		

Voluntary Open Access Dental Plan w/Ortho[1] (select one benefit from each category)

Annual maximum	Deductible	Coinsurance
$1000	$25	100/80/50
$1250	$50	
$1500	$75	

AGENT INFORMATION

Agent Name: Broker Number:

Firm Name:

Address: Phone:

City, State, Zip: Email:

Agent of Record Signature (if applicable) Printed Name and Company Date

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

The HealthPartners family of health plans is underwritten and/or administered by HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company or HealthPartners Administrators, Inc.
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