



2018 MINNESOTA 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

***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 MINNESOTA 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):	
<i>*(Delegate is the person who manages the online account with HealthPartners)</i>	
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 at least 20 hours per week each month during the calendar year:

- Include: Permanent employees, **owners** working at the company and employees for all Controlled Groups (as of the Controlled Group status effective date).
- Do **NOT** include: Contracted, temporary, seasonal employees, COBRA, retirees and union employees whose health coverage is determined by a collective bargaining agreement.

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) working a minimum of 20 hours/week 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 working a minimum of 20 hours/week?
- _____ 3. How many EEs reside outside of Minnesota? (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. What is the number of hours all eligible employees must work per week?
- _____ 2. Total number of eligible EEs?
- _____ 3. Total number of EEs that are taking medical coverage?
- _____ 4. Total number of EEs that are waiving coverage?
- _____ 5. Total number of new hires in their waiting period (application/waiver required and add their names to the wage report)?
- _____ 6. Number of individuals on COBRA (application required & indicate on bill)?
- _____ 7. What is the employer medical contribution? Must be a minimum of 50% of each employee's premium.
- YES NO 8. Are retirees eligible for coverage? If YES, please define _____
- YES NO 9. Do you have a rehire policy? If YES, please define _____
- YES NO 10. Does this organization intend to offer domestic partner coverage?
- YES NO 11. Do you exclude any class of employees from coverage? (other than seasonal, temporary and part time)
If Yes, provide job class and hours worked: _____
- Select One 12. Waiting Period for New Employees:
 First of the month following 30 days 90 days following hire date (maximum allowed)
 First of the month following 60 days 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)**

- Achieve may be offered alongside Open Access or Perform or stand alone. Open Access and Perform can't be offered together. CentraChoice can't be offered with another network.
- Achieve, Perform, and CentraChoice are only available in select counties. Refer to the service area maps for details.
- 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	Network				Plans		Metal Level	Network			
			Open Access	Perform	Achieve	Centra Choice				Open Access	Perform	Achieve	Centra Choice
Copay Copay/Deductible	25-95	Platinum					HSA Embedded	2800-100	Gold				
	500-20	Platinum						3600-100	Silver				
	500-40	Gold						4000-100	Silver				
	750-40	Gold						3000-80	Silver				
	1000-40	Gold						6500-100	Bronze				
	3500-60	Silver						5200-70	Bronze				
Three for Free	500-70	Gold						6000-70	Bronze				
	1000-70	Gold						HSA Rx Plus	2000-100	Gold			
	3000-70	Silver					2500-100		Gold				
HSA	2000-100	Gold					HSA Rx Plus Embedded	4000-100	Silver				
	2500-100	Gold						3000-80	Silver				
	3500-100	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?

DistinctionsSM Dental Plan Distinctions 1 Distinctions 3 Distinctions 5 Distinctions 2 Distinctions 4 Distinctions 6 Optional orthodontics add-on ¹		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 DistinctionsSM Dental Plan² Voluntary Distinctions 3 Voluntary Distinctions 4 Optional orthodontics add-on ¹		Voluntary Open Access Dental Plan² (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)		
Dental Options[®] Defined Contribution Plan Dental Options 1000 Dental Options 2000 Optional orthodontics add-on ¹		Voluntary Open Access Dental Plan w/Ortho¹ (select one benefit from each category) Annual maximum Deductible Coinsurance \$1000 \$25 100/80/50 \$1250 \$50 \$1500 \$75		
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)		Voluntary Open Access Dental Plan w/Ortho¹ (select one benefit from each category) Annual maximum Deductible Coinsurance \$1000 \$25 100/80/50 \$1250 \$50 \$1500 \$75		
Open Access Preventive-only Dental Plan Open Access Preventive Plus Dental Plan Open Access Preventive Plus Other _____ Voluntary Dental Plan ²				

¹Must have 10 or more employees **enrolled** to be eligible for orthodontic products.
²Must have 5 or more employees **enrolled** to be eligible for voluntary plans.

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
---	--------------	------

HealthPartners has used the flexibility offered under Minnesota Statute 62Q.188 to provide plans with benefits that vary from a typical HMO plan. These modifications are noted below. Employers are required by law to inform eligible employees of the benefit modifications.

Plans		Benefit Variation from Standard HMO Plan		
		“Benefits Administration Maintenance of Benefits”	“Benefit exclusions: acupuncture, infertility, bariatric surgery and orthognathic surgery”	“Rx Exclusions: infertility, erectile dysfunction, and non-sedating oral antihistamines for which there are over-the-counter alternatives”
“Copay Copay/Deductible”	25-95		X	X
	500-20		X	X
	500-40		X	X
	750-40		X	X
	1000-40		X	X
	3500-60		X	X
Three for Free	500-70		X	X
	1000-70		X	X
	3000-70		X	X
HSA	2000-100	X	X	X
	2500-100	X	X	X
	3500-100	X	X	X
HSA Embedded	2800-100	X	X	X
	3600-100	X	X	X
	4000-100	X	X	X
	3000-80	X	X	X
	6500-100	X	X	X
	5200-70	X	X	X
HSA Rx Plus	2000-100	X	X	X
	2500-100	X	X	X
HSA Rx Plus Embedded	4000-100	X	X	X
	3000-80	X	X	X
HRA Embedded	4000-100		X	X
	4750-100		X	X
	6000-100		X	X