

EMPLOYER ELIGIBILITY INFORMATION

Today's Date:	Requested Eff. Date:	HealthPartners Sales Executive:
Full Legal Group Name:	DBA (if applicable):	
Address:		
City, State, Zip:	County:	
Phone:	Fax:	
Federal Tax ID#:	Corporate Headquarters (City, State):	
Contact Person:		
Contact Title:	Contact Email:	
Is contact person an eligible employee? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, please explain:		
Owners and percentage of ownership for each:		
Do owners work for the company? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Do owners meet eligibility criteria for coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, please explain:		

- YES NO 1. 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 other companies or have wholly or partially owned subsidiaries? **If YES, please provide the HealthPartners Controlled Group form, found on HealthPartners.com/employer**
- YES NO 2. Do you have any other locations or sites? If YES, list the state and/or country: _____
3. Type of Entity: S Corporation C Corporation Sole Proprietorship Partnership Non-Profit
 LLC (circle one: C Corporation Sole Proprietorship Partnership)
4. Are you a Government Group, public entity or public school? YES NO Erisa or Non-Erisa
5. Are you a church or religious group? YES NO Erisa or Non-Erisa (If YES and Non-Erisa, please provide DOL certification letter)

GROUP SIZE VERIFICATION INFORMATION

_____ 1. Number of years in business. Industry _____

Using the table below, enter the total number of employees (EEs) who worked at least 20 hours per week each month during the prior 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 and retirees and those union employees whose health coverage is determined by a collective bargaining agreement.

_____ 2. On average, how many employees did this organization employ **throughout the preceding calendar year** (January through December 2017)? Please complete the table below.

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												

_____ 3. How many employees do you currently employ working a minimum of 20 hours per week?

_____ 4. 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. **Based on this definition**, what is the current total number of employees (full/part time for the entire family of companies) for your company? *If you have questions on this rule, please contact your broker or sales representative.*

_____ 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, 105 or any underlying plan?)

PARTICIPATION / EMPLOYEE ELIGIBILITY INFORMATION

- YES NO 1. Does this organization intend to offer domestic partner coverage?
Please refer to Domestic Partner Form on healthpartners.com/employer for eligibility.
- YES NO 2. Do you have a rehire policy? **If YES, please define** _____
- _____ 3. **Number of hours all eligible employees must work per week**
4. Classification(s) of Employees **Excluded** from Coverage:
 Union covered by a collective bargaining agreement Part-time Hourly
 Union not covered by a collective bargaining agreement Salaried Owners
 Other (explain): _____
- YES NO 5. Are retirees eligible for coverage? If yes, define policy _____
6. Waiting Period for New Employees:
 Date of Hire 90 days following hire date (maximum allowed)
 First of the month following 30 days Other _____
 First of the month following 60 days

PARTICIPATION / EMPLOYEE ELIGIBILITY INFORMATION (cont.)

- _____ 7. Total number of eligible employees
- _____ 8. Total number of eligible employees that are applying for coverage
- _____ 9. Total number of employees that are waiving coverage
- _____ 10. Total number of employees in their waiting period (application or waiver required)
- _____ 11. Number of former employees on COBRA continuation (application required) see below

Employer Contribution: Minimum 50% of single coverage, or **Medical:** _____ Single _____ Family **Dental:** _____ Single _____ Family

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.

Former Employee Name	Social Security Number	Notification Date	COBRA Termination Date

CURRENT CARRIER INFORMATION

Current MEDICAL Carrier: _____ Type of coverage Group Individual

Current DENTAL Carrier: _____ Renewal Date: _____

AGENT/BROKER INFORMATION

Agent Name: _____ Phone: _____

Address: _____ Fax: _____

City, State, Zip: _____ Broker Number: _____

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 _____

PRODUCT SELECTION

Select plan(s) and network(s)

- Distinctions plans can't be offered with other plans or networks.
- An embedded high deductible health plan can't be offered next to a non-embedded high deductible health plan.
- Up to four plans may be offered.

		Network		
Plans		Open Access	Perform	Achieve
Copay Copay/Deductible	25-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	25-75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	500-25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	500-40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1000-25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1000-40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1500-45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2000-45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2500-45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Three for Free	1000-75	<input type="checkbox"/>	<input type="checkbox"/>
1500-75		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2000-75		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2500-75		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HSA	1500-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2000-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2500-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3000-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Network		
Plans		Open Access	Perform	Achieve
HSA Embedded	2700-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3000-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4000-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4500-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	5000-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	6350-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HSA Rx Plus	1500-100	<input type="checkbox"/>	<input type="checkbox"/>
2000-100		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2500-100		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3000-100		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HSA Rx Plus Embedded	2000-80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2700-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3000-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2700-80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3500-80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Network	
Plans		Distinctions II	
Distinctions Tiered Embedded	1000-25/50 80/70	<input type="checkbox"/>	
	HSA 3000-100/75	<input type="checkbox"/>	

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

<p>DistinctionsSM Dental Plan</p> <p><input type="checkbox"/> Distinctions 1 <input type="checkbox"/> Distinctions 3 <input type="checkbox"/> Distinctions 5</p> <p><input type="checkbox"/> Distinctions 2 <input type="checkbox"/> Distinctions 4 <input type="checkbox"/> Distinctions 6</p> <p><input type="checkbox"/> Optional orthodontics add-on¹</p>	<p>Open Access – Employer sponsored (select one benefit from each category)</p> <table border="0"> <tr> <td>Annual maximum</td> <td>Deductible</td> <td>Coinsurance</td> </tr> <tr> <td><input type="checkbox"/> \$1000</td> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> 100/50/50</td> </tr> <tr> <td><input type="checkbox"/> \$1250</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1500</td> <td><input type="checkbox"/> \$50</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$2000 (avail. with 100/80/50 coinsurance only)</td> <td><input type="checkbox"/> \$75</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$2500 (avail. with 100/80/50 coinsurance only)</td> <td></td> <td></td> </tr> </table> <p><input type="checkbox"/> Optional orthodontics add-on¹</p>	Annual maximum	Deductible	Coinsurance	<input type="checkbox"/> \$1000	<input type="checkbox"/> None	<input type="checkbox"/> 100/50/50	<input type="checkbox"/> \$1250	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1500	<input type="checkbox"/> \$50		<input type="checkbox"/> \$2000 (avail. with 100/80/50 coinsurance only)	<input type="checkbox"/> \$75		<input type="checkbox"/> \$2500 (avail. with 100/80/50 coinsurance only)		
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<p>Voluntary DistinctionsSM Dental Plan</p> <p><input type="checkbox"/> Voluntary Distinctions 3 <input type="checkbox"/> Voluntary Distinctions 4</p> <p><input type="checkbox"/> Optional orthodontics add-on¹</p>	<p>Voluntary Open Access Dental Plan² (select one benefit from each category)</p> <table border="0"> <tr> <td>Annual maximum</td> <td>Deductible</td> <td>Coinsurance</td> </tr> <tr> <td><input type="checkbox"/> \$750</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/50/50</td> </tr> <tr> <td><input type="checkbox"/> \$1000</td> <td><input type="checkbox"/> \$50</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1250</td> <td><input type="checkbox"/> \$75</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$1500 (avail. with 100/80/50 coinsurance only)</td> <td></td> <td></td> </tr> </table>	Annual maximum	Deductible	Coinsurance	<input type="checkbox"/> \$750	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/50/50	<input type="checkbox"/> \$1000	<input type="checkbox"/> \$50	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1250	<input type="checkbox"/> \$75		<input type="checkbox"/> \$1500 (avail. with 100/80/50 coinsurance only)					
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<p>Dental Options[®] Defined Contribution Plan</p> <p><input type="checkbox"/> Dental Options 1000 <input type="checkbox"/> Dental Options 2000</p> <p><input type="checkbox"/> Optional orthodontics add-on¹</p>	<p>Voluntary Open Access Dental Plan w/Ortho³ (select one benefit from each category)</p> <table border="0"> <tr> <td>Annual maximum</td> <td>Deductible</td> <td>Coinsurance</td> </tr> <tr> <td><input type="checkbox"/> \$1000</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1250</td> <td><input type="checkbox"/> \$50</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$1500</td> <td><input type="checkbox"/> \$75</td> <td></td> </tr> </table>	Annual maximum	Deductible	Coinsurance	<input type="checkbox"/> \$1000	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1250	<input type="checkbox"/> \$50		<input type="checkbox"/> \$1500	<input type="checkbox"/> \$75							
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<p>¹ Must have 10 or more employees enrolled to be eligible for orthodontic products.</p> <p>² Must have 5 or more employees enrolled to be eligible for voluntary plans.</p> <p>³ Available to groups with 50–100 eligible employees</p>																			



HealthPartners[®]

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 Sales Metro Phone # 952-883-5200
 Non-Metro Phone # 800-298-4235

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