HealthPartners®

2018 WISCONSIN NON-REFORM AND EZ EMPLOYER GROUP APPLICATION

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? ❑ YES ❑ NO If NO, please explain:

Owners and percentage of ownership for each:

Do owners work for the company? ❑ YES ❑ NO

Do owners meet eligibility criteria for coverage? ❑ YES ❑ 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 _____

For 2 and 3, please count all employees; including all controlled group employees (as of the Controlled Group status effective date), full time, part-time, temporary, seasonal, union, and owners employed in the company. Do not count contracted/leased employees, COBRA, or retirees.

_____ **2.** On average how many employees did this organization employ **throughout the preceding calendar year** (January through December)? 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 does this organization **currently** employ?

_____ **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 Wisconsin? *(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?)*

❑ YES ❑ NO **7.** Does this organization currently have any leased employees? If YES, please explain: _____

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.** **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.)*

❑ YES ❑ NO **4.** Are retirees eligible for coverage? If yes, define policy _____

5. Waiting Period for New Employees:

- ❑ Date of Hire
- ❑ First of the month following 30 days
- ❑ First of the month following 60 days
- ❑ 90 days following hire date (maximum allowed)
- ❑ Other _____

PARTICIPATION / EMPLOYEE ELIGIBILITY INFORMATION (cont.)

_____ **6.** Total number of eligible employees
_____ **7.** Total number of eligible employees that are applying for coverage
_____ **8.** Total number of employees that are waiving coverage
_____ **9.** Total number of employees in their waiting period (application or waiver required)
_____ **10.** 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 Wisconsin State Employer's Quarterly Wage and Detail 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.

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

Benefit Administration: ❑ Calendar Year ❑ Plan Year
(If offering more than one product, benefit administration must match.)

Select plan(s) and network

Plans		Network: Open Access	Network: Perform
Copay Copay/Deductible	25-100	❑	❑
	25-75	❑	❑
	500-25	❑	❑
	500-40	❑	❑
	1000-25	❑	❑
	1000-40	❑	❑
	1500-45	❑	❑
	2000-45	❑	❑
	2500-45	❑	❑
Three for Free	1000-75	❑	❑
	1500-75	❑	❑
	2000-75	❑	❑
	2500-75	❑	❑
HSA	1500-100	❑	❑
	2000-100	❑	❑
	2500-100	❑	❑
	3000-100	❑	❑
	3500-100	❑	❑

Plans		Network: Open Access	Network: Perform
HSA Embedded	2700-100	❑	❑
	3000-100	❑	❑
	3500-100	❑	❑
	4000-100	❑	❑
	4500-100	❑	❑
	5000-100	❑	❑
	6350-100	❑	❑
HSA Rx Plus	1500-100	❑	❑
	2000-100	❑	❑
	2500-100	❑	❑
	3000-100	❑	❑
	2000-80	❑	❑
HSA Rx Plus Embedded	2700-100	❑	❑
	3000-100	❑	❑
	3500-100	❑	❑
	2700-80	❑	❑
	3500-80	❑	❑

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

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[3] (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	❑ Voluntary2
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.
[3] Available to groups with 50–100 **eligible** employees

HealthPartners®

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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.