

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, 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, 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, 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 (If LLC, check 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, 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 30 hours or more 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 employees who work on a part-time, temporary or substitute basis, or COBRA and retirees.

Month	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Total EEs												

- _____ 2. On average, how many employees did this organization employ working a minimum of 30 hours per week **throughout the preceding calendar year** (January through December)? _____
- _____ 3. 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, contact your broker or sales representative.*
- _____ 4. How many employees reside outside of North Dakota? *Submit Quarterly Wage Report for each state.*
- YES NO 5. 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? *Refer to the Domestic Partner Form on healthpartners.com/employer for eligibility.*
- YES NO 2. Do you have a rehire policy? If YES, define policy: _____
- _____ 3. Number of hours all eligible employees must work per week
- YES NO 4. Do you exclude any class of employees from coverage (other than seasonal, temporary and part time)? If YES, provide job class and hours worked: _____
- 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
- _____ 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 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). Please print and sign. _____ 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. Please print and sign. _____ Printed Name _____ Date _____

*Employee's social security number is used for IRS tax reporting regarding the health plan. It does not have any impact on the application or enrollment.

PRODUCT SELECTION

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

Select plan(s) and network

- An embedded high deductible health plan can't be offered next to a non-embedded high deductible health plan.
- Groups may select up to four plans.

Plans		Network
		Open Access
Copay-Deductible	2000-45	<input type="checkbox"/>
	2500-45	<input type="checkbox"/>
Three for Free	2000-80	<input type="checkbox"/>
	2500-80	<input type="checkbox"/>
HRA Embedded Deductible	2500-100	<input type="checkbox"/>
	5000-100	<input type="checkbox"/>

Plans		Network
		Open Access
HSA Non-Embedded (Contract) Deductible	2500-100	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>
HSA Embedded Deductible	2700-100	<input type="checkbox"/>
	4000-100	<input type="checkbox"/>
	6350-100	<input type="checkbox"/>
HSA Rx Plus Non-Embedded (Contract) Deductible	3000-100	<input type="checkbox"/>
	2000-80	<input type="checkbox"/>
HSA Rx Plus Embedded Deductible	2700-100	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>
	3500-80	<input type="checkbox"/>



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.