HealthPartners
UnityPoint Health

2019 IOWA EMPLOYER APPLICATION – HEALTH HISTORY

EMPLOYER ELIGIBILITY INFORMATION

Today's Date:	Requested Eff. Date:	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 UnityPoint Health 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 permanent full-time employees (EEs) who worked at least 30 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 employees working 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 **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 Iowa? *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, please define: _____

_____ **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
- ❑ 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.)

_____ **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 Iowa Withholding Tax Quarterly Return (44-095). 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

*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(s)

- 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. All four plans may be offered on two networks.

Plans		Networks	
		Open Access	Bridges
All-Copay	30/60 -5500	❑	❑
	45/90 -7900	❑	❑
Copay-Coinsurance	25-100	❑	❑
	25-80	❑	❑
Copay-Deductible	500-25	❑	❑
	500-40	❑	❑
	1000-25	❑	❑
	1000-40	❑	❑
	1500-45	❑	❑
	2000-45	❑	❑
	2500-45	❑	❑
Primary-Specialty	500-30/60	❑	❑
	1000-45-90	❑	❑
	1500-45/90	❑	❑
Three for Free	1000-80	❑	❑
	1500-80	❑	❑
	2000-80	❑	❑
	2500-80	❑	❑
HRA Embedded Deductible	2500-100	❑	❑
	5000-100	❑	❑
	2500-80	❑	❑
	4000-80	❑	❑

Plans		Networks	
		Open Access	Bridges
HSA Non-Embedded (Contract) Deductible	1500-100	❑	❑
	2000-100	❑	❑
	2500-100	❑	❑
	3000-100	❑	❑
	3500-100	❑	❑
HSA Embedded Deductible	2700-100	❑	❑
	3000-100	❑	❑
	3500-100	❑	❑
	4000-100	❑	❑
	4500-100	❑	❑
	5000-100	❑	❑
	6350-100	❑	❑
HSA Rx Plus Non-Embedded (Contract) Deductible	1500-100	❑	❑
	2000-100	❑	❑
	2500-100	❑	❑
	3000-100	❑	❑
	2000-80	❑	❑
HSA Rx Plus Embedded Deductible	2700-100	❑	❑
	3000-100	❑	❑
	3500-100	❑	❑
	2700-80	❑	❑
	3500-80	❑	❑

HealthPartners
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HealthPartners UnityPoint Health (HPUPH) will notify employees covered on HPUPH plans of the special enrollment periods detailed in 29 CFR Sec. 2590.701-6. It is the responsibility of the employer to notify those employees who decline HPUPH coverage of their special enrollment rights.