

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, 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, 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 each month during the prior calendar year:
- Include 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** include contracted/leased employees, COBRA, or 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 Wisconsin? *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)?
- YES NO 6. Does this organization currently have any leased employees? If YES, explain: _____

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

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 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). 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(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	Perform
All-Copay	30/60 -5500	<input type="checkbox"/>	<input type="checkbox"/>
	45/90 -7900	<input type="checkbox"/>	<input type="checkbox"/>
Copay-Coinsurance	25-100	<input type="checkbox"/>	<input type="checkbox"/>
	25-75	<input type="checkbox"/>	<input type="checkbox"/>
Copay-Deductible	500-25	<input type="checkbox"/>	<input type="checkbox"/>
	500-40	<input type="checkbox"/>	<input type="checkbox"/>
	1000-25	<input type="checkbox"/>	<input type="checkbox"/>
	1000-40	<input type="checkbox"/>	<input type="checkbox"/>
	1500-45	<input type="checkbox"/>	<input type="checkbox"/>
	2000-45	<input type="checkbox"/>	<input type="checkbox"/>
Primary-Specialty	500-30/60	<input type="checkbox"/>	<input type="checkbox"/>
	1000-45-90	<input type="checkbox"/>	<input type="checkbox"/>
	1500-45/90	<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"/>
	2000-75	<input type="checkbox"/>	<input type="checkbox"/>
	2500-75	<input type="checkbox"/>	<input type="checkbox"/>
HRA Embedded Deductible	2500-100	<input type="checkbox"/>	<input type="checkbox"/>
	5000-100	<input type="checkbox"/>	<input type="checkbox"/>
	2500-75	<input type="checkbox"/>	<input type="checkbox"/>
	4000-75	<input type="checkbox"/>	<input type="checkbox"/>

Plans		Networks	
		Open Access	Perform
HSA Non-Embedded (Contract) Deductible	1500-100	<input type="checkbox"/>	<input type="checkbox"/>
	2000-100	<input type="checkbox"/>	<input type="checkbox"/>
	2500-100	<input type="checkbox"/>	<input type="checkbox"/>
	3000-100	<input type="checkbox"/>	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>	<input type="checkbox"/>
HSA Embedded Deductible	2700-100	<input type="checkbox"/>	<input type="checkbox"/>
	3000-100	<input type="checkbox"/>	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>	<input type="checkbox"/>
	4000-100	<input type="checkbox"/>	<input type="checkbox"/>
	4500-100	<input type="checkbox"/>	<input type="checkbox"/>
	5000-100	<input type="checkbox"/>	<input type="checkbox"/>
	6350-100	<input type="checkbox"/>	<input type="checkbox"/>
HSA Rx Plus Non-Embedded (Contract) Deductible	1500-100	<input type="checkbox"/>	<input type="checkbox"/>
	2000-100	<input type="checkbox"/>	<input type="checkbox"/>
	2500-100	<input type="checkbox"/>	<input type="checkbox"/>
	3000-100	<input type="checkbox"/>	<input type="checkbox"/>
	2000-80	<input type="checkbox"/>	<input type="checkbox"/>
HSA Rx Plus Embedded Deductible	2700-100	<input type="checkbox"/>	<input type="checkbox"/>
	3000-100	<input type="checkbox"/>	<input type="checkbox"/>
	3500-100	<input type="checkbox"/>	<input type="checkbox"/>
	2700-80	<input type="checkbox"/>	<input type="checkbox"/>
	3500-80	<input type="checkbox"/>	<input type="checkbox"/>

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 |
|--|-------------------------------|------------------------------------|
| <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) | | |
| <input type="checkbox"/> Optional orthodontics add-on ¹ | | |

Voluntary Open Access Dental Plan² (select one benefit from each category)

- | 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) | | |

Voluntary Open Access Dental Plan w/Ortho³ (select one benefit from each category)

- | 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 | |

Open Access Advantage (select one benefit from each category)

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Employer sponsored | <input type="checkbox"/> Voluntary2 |
| Annual maximum | Out-of-Network |
| <input type="checkbox"/> \$1000 | <input type="checkbox"/> Option 1 |
| <input type="checkbox"/> \$1500 | <input type="checkbox"/> Option 2 |
| <input type="checkbox"/> Optional orthodontics add-on ¹ (employer-sponsored plans only) | |

- | | |
|---|--|
| <input type="checkbox"/> Open Access Preventive-only Dental Plan | <input type="checkbox"/> Open Access Preventive Plus Dental Plan |
| <input type="checkbox"/> Open Access Preventive Plus Voluntary Dental Plan ² | <input type="checkbox"/> 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



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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.