HealthPartners®

2019 MINNESOTA FULLY INSURED SMALL EMPLOYER APPLICATION AND SUBMISSION CHECKLIST

Fully insured small employer groups (2-50)

HERE'S WHAT YOU NEED TO KNOW

Group submissions don't begin processing until all information in the checklist below is included.

Additional tax forms will be required for groups with one and two contracts.

DUE DATES

Initial submission should be submitted at least 30 days prior to the effective date to allow enough time for underwriting review.

Underwriting approval and a signed proposal acceptance page must be received by the 15th of the month prior to the effective date. Any groups not approved by Underwriting by the 15th will be moved to the next month. Please send completed forms to the following email address: **smallgrpsubmissions@healthpartners.com**.

USE THIS CHECKLIST

❑ **Small Group Employer Application**

- Please be sure all questions are answered before submitting this form, any questions left blank could delay the processing of your application
- The Group Contact should answer all questions and sign the application, this person should be an Owner, CEO or HR authorized administrative representative. The Group Contact can also be the Delegate or you can choose another contact for the Delegate role.
  - » The Delegate is accountable for the following:
    1) Using E-tools which includes access to E-billing, online enrollment, plan documents, reporting and the employee roster
    2) Managing user accounts which includes setting up new user accounts, account maintenance and giving your broker, if applicable, access to E-tools.
- P.O. Box address can't be accepted as the business address. If you use a PO Box for mail, you can list that in addition to the street address

❑ **State Employer's Quarterly Wage Detail Report**

- Minnesota groups: Form MDES-1D
- Wisconsin groups: Form UC-7823-E
- Indicate the status of all employees listed: full time, part time, union, seasonal, terminated
- List any employees that aren't on this report and provide status: new hire, owners (if eligible)

❑ **Copy of most recent bill from current health insurance carrier**

- Only needed if your company has coverage
- Be sure to identify COBRA individuals

❑ **Employee enrollment forms**

- There should be a form for each eligible employee, regardless if they're applying for or waiving coverage, including new hires in a waiting period
- Make sure each form is fully completed

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*__Tax filings__ must also be submitted for all one and two person groups, including the federal form signed by the CPA: (or as deemed necessary by underwriting)

- **Farmers:** dependent on the business situation – Federal 1040 Schedule F (Profit or Loss from Farming); Federal 1040 Schedule J (Income Averaging); or 4835 (Farm Rental Income and Expenses); 1120-C (Cooperative Associations)
- **Sole Proprietorship:** Federal 1040 Schedule C (Profit or Loss from Business)
- **Partnership:** Federal 1065 (Return of Partnership Income) and Schedule K-1 (for each partner)
- **S Corporation:** Federal 1120S and Schedule K-1 (for each owner) or W-2 as appropriate
- **C Corporation:** Federal 1120 (Corporation) and W-2 (Owners); some Corporations have ownership only through shareholders who aren't employed by the company

2019 MINNESOTA FULLY INSURED SMALL EMPLOYER APPLICATION

A. EMPLOYER INFORMATION

Today's Date:		Requested Eff. Date:	
Full Legal Group Name:		DBA (if applicable):	
Sales Rep Name:			
Business Address (No PO Box):			
City, State, Zip:		County:	
Phone:	Fax:	Industry Type:	
Federal Tax ID#:		**Corporate Headquarters (City, State):**	
Contact Person:		Title:	
Email (required):			
Delegate name:		Title:	
Delegate Email (required):			

◯ YES ◯ NO 1. Is contact person an eligible employee? If NO, please explain:

◯ YES ◯ NO 2. Is Delegate an eligible employee? If NO, please explain:

3. **List owners and percent of ownership for each:**

◯ YES ◯ NO 4. Do owners work for the company?

◯ YES ◯ NO 5. Do owners meet eligibility criteria for coverage? If NO, please explain:

◯ YES ◯ NO 6. 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 of the companies or have wholly or partially owned subsidiaries?
If YES, please provide the HealthPartners Controlled Group form, found on **healthpartners.com/employer**

◯ YES ◯ NO 7. Do you have any other locations or sites? If YES, list the state and/or country: _____

◯ YES ◯ NO 8. Are you a Government Group, public entity or public school?

◯ YES ◯ NO 9. Are you a church or religious group?

10. Please check your ERISA status: ◯ ERISA ◯ Non-ERISA

11. Select type of entity (we require ongoing payroll/wage and tax records for all W2 employees. Please see page 4 for Tax filing information):
◯ S Corporation ◯ C Corporation ◯ Sole Proprietorship ◯ Partnership ◯ Non-Profit

12. Number of years in business? _____

B. GROUP SIZE VERIFICATION INFORMATION

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

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												

_____ 1. On average, how many employees (including owner) working a minimum of 20 hours/week each month did this organization employ throughout the preceding calendar year? From January through December 2018

_____ 2. How many permanent employees (including owner) do you currently employ working a minimum of 20 hours/week?

_____ 3. How many employees reside outside of Minnesota? (Submit Quarterly Wage for each state)

_____ 4. What is the current total number of employees (full/part time for the entire family of companies) for your company? Based on the following definition:

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.

C. PARTICIPATION / EMPLOYEE ELIGIBILITY

_____ **1.** What is the number of hours all eligible employees must work per week?

_____ **2.** Total number of eligible employees?

_____ **3.** Total number of employees that are taking medical coverage?

_____ **4.** Total number of employees that are waiving coverage?

_____ **5.** Total number of new hires in their waiting period and/or those not on the wage & tax statement that meet the eligibility requirements. (application/waiver required and add their names to the wage report)?

_____ **6.** Number of individuals on COBRA (application required & indicate on bill)?

_____ **7.** What is the employer medical contribution? Must be a minimum of 50% of each employee's premium.

◯YES ◯NO **8.** Are retirees eligible for coverage? If YES, please define _____

◯YES ◯NO **9.** Does this organization intend to offer domestic partner coverage?

◯YES ◯NO **10.** Do you exclude any class of employees from coverage? (other than seasonal, temporary and part time)
If Yes, provide job class and hours worked: _____

Select One **11.** Waiting Period for New Employees:
◯ First of the month following 30 days ◯ 90 days following hire date (maximum allowed)
◯ First of the month following 60 days ◯ Date of hire

◯YES ◯NO **12.** Do you have a waiting period for rehires? If YES, please define _____

D. CURRENT CARRIER

1. Type of coverage: ◯ Group ◯ Individual

2. Current MEDICAL Carrier: _____ Medical renewal date: _____

3. Current DENTAL Carrier: _____ Dental renewal date: _____

E. MEDICAL PRODUCT SELECTION

Products effective 1/1/2018-12/31/2019

1. Benefit Administration: ◯Plan Year ◯Calendar Year
(If offering more than one product, benefit administration must match.)
All HealthPartners small employer medical plans include an ACA compliant embedded pediatric dental benefit.

2. Select plan(s) and network(s)

- Achieve may be offered alongside Open Access or Perform or stand alone. Open Access and Perform can't be offered together. CentraChoice can't be offered with another network.
- Achieve, Perform, and CentraChoice are only available in select counties. Refer to the service area maps for details.
- Platinum plans can't be paired with Bronze plans.
- Small groups with 1-9 enrolled employees may offer one plan. Groups with 10-24 enrolled employees may offer up to two plans. Groups with 25 or more enrolled employees may offer up to three plans.

Plans		Metal Level	Network: Open Access	Perform SE	Achieve SE	Centra Choice SE
Copay Copay/ Deductible	25-95	Platinum	☐	☐	☐	☐
	500-20	Platinum	☐	☐	☐	☐
	500-40	Gold	☐	☐	☐	☐
	750-40	Gold	☐	☐	☐	☐
	1000-40	Gold	☐	☐	☐	☐
	2000-50	Gold	☐	☐	☐	☐
	30-60 P/S	Gold	☐	☐	☐	☐
	45-90 P/S	Gold	☐	☐	☐	☐
	4000-60	Silver	☐	☐	☐	☐
Three for Free	500-70	Gold	☐	☐	☐	☐
	1000-70	Gold	☐	☐	☐	☐
	2000-70	Gold	☐	☐	☐	☐
	3500-70	Silver	☐	☐	☐	☐
	5000-70	Silver	☐	☐	☐	☐
HSA	2000-100	Gold	☐	☐	☐	☐
	2500-100	Gold	☐	☐	☐	☐
	3600-100	Silver	☐	☐	☐	☐

Plans		Metal Level	Network: Open Access	Perform SE	Achieve SE	Centra Choice SE
HSA Embedded	3000-100	Gold	☐	☐	☐	☐
	3850-100	Silver	☐	☐	☐	☐
	4000-100	Silver	☐	☐	☐	☐
	4500-100	Silver	☐	☐	☐	☐
	3000-80	Silver	☐	☐	☐	☐
	6500-100	Bronze	☐	☐	☐	☐
	5500-70	Bronze	☐	☐	☐	☐
	6000-70	Bronze	☐	☐	☐	☐
HSA Rx Plus	2000-100	Gold	☐	☐	☐	☐
	2500-100	Gold	☐	☐	☐	☐
HSA Rx Plus Embedded	3000-100	Gold	☐	☐	☐	☐
	4250-100	Silver	☐	☐	☐	☐
	5000-100	Silver	☐	☐	☐	☐
	3000-80	Silver	☐	☐	☐	☐
HRA Embedded	4000-100	Silver	☐	☐	☐	☐
	5000-100	Silver	☐	☐	☐	☐
	6500-100	Bronze	☐	☐	☐	☐

F. DENTAL PRODUCT SELECTION (May also be purchased on a stand-alone basis.)

◯ YES ◯ NO **1.** Would you like to receive a dental quote?

_____ **2.** What is the employer dental contribution? Must be a minimum of 50% of each employee's premium.

_____ **3.** Total number of employees that are taking dental coverage?

Distinctions℠ Dental Plan
◯ Distinctions 1 ◯ Distinctions 3 ◯ Distinctions 5
◯ Distinctions 2 ◯ Distinctions 4 ◯ Distinctions 6

☐ Optional orthodontics add-on[1]

Voluntary Distinctions℠ Dental Plan[2]
◯ Voluntary Distinctions 3 ◯ Voluntary Distinctions 4

☐ Optional orthodontics add-on[1]

Dental Options® Defined Contribution Plan
◯ Dental Options 1000 ◯ Dental Options 2000

☐ Optional orthodontics add-on[1]

Open Access Advantage (select one benefit from each category)
◯ Employer sponsored ◯ Voluntary[2]

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 Dental Plan
☐ Open Access Preventive Plus Voluntary Dental Plan[2] ☐ 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.

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[1] (select one benefit from each category)

Annual maximum	Deductible	Coinsurance
◯ $1000	◯ $25	◯ 100/80/50
◯ $1250	◯ $50	
◯ $1500	◯ $75	

AGENT INFORMATION

Agent Name:	Broker Number:
Additional Contact and Email:	
Firm Name:	
Address:	Phone:
City, State, Zip:	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. I understand that I may be required to pay all outstanding premium due for any prior employer sponsored HealthPartners coverage received for the 12-month period preceding the effective date of any new coverage.

CEO/Owner/Authorized Company Representative | Printed Name | Date