2022 WISCONSIN FULLY INSURED SMALL EMPLOYER APPLICATION AND SUBMISSION CHECKLIST

Fully insured small employer groups

HERE'S WHAT YOU NEED TO KNOW

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

DUE DATES

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

All required documents must be received by the 20th of the month prior to the requested effective date. Any groups not complete by the 20th will be moved to the next month. Please send completed forms to the following email address: **smallgrpsubmissions@healthpartners.com.**

USE THIS CHECKLIST

❑ **Small 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 Owner, CEO or HR authorized administrative representative should answer all questions and sign the application.
  - » The Primary HR/Administrative Contact (Delegate) is accountable for the following:
    1. All health plan related functions including E-tools which includes access to E-billing, online enrollment, plan documents, **plan renewals,** reporting and the employee roster
    2. Managing user accounts which includes setting up and adding 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**

- 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

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

2022 WISCONSIN FULLY INSURED SMALL EMPLOYER APPLICATION

A. EMPLOYER INFORMATION

Today's Date:	Requested Effective 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):**
Primary HR/Administrative Contact (Delegate):	Title:
Email (required):	
Secondary Contact name:	Title:
Secondary Contact Email (required):	

◯ YES ◯ NO 1. Is the Primary HR/Administrative contact an eligible employee? If NO, please explain:

◯ YES ◯ NO 2. Is the Secondary Contact 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. Do you have ownership in multiple corporations or are you a part of a wholly owned or partially owned subsidiary under the provisions of the federal tax code regarding Controlled Groups (Title 26, Section 414)?
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 1 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 below, enter the total number of employees (EEs) who worked each month during the calendar year. Complete as many months as able, starting with January. Follow these guidelines:

- Include owners working at the company, temporary, seasonal, union, full-time and part-time employees, including furloughed employees if the employer maintained contributions during the furlough
- Include employees for all Controlled Groups (as of the Controlled Group status effective date)
- Do NOT include contracted, COBRA or retirees

Month	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021
Total EEs												

_____ 1. On average, how many employees did this Organization employ from January through December 2021 (Total employees/number of months)?

_____ 2. Using the same guidelines as above, how many permanent employees (including owners) do you **currently** employ?

_____ 3. How many employees reside outside of Wisconsin? (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. How many hours must an employee work to be eligible for coverage? (Employers must apply the same hourly requirement for all permanent employees. Employers must offer coverage to all permanent employees working at least 30 hours per week as well as their dependents)

_____ 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?

Select One 10. 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 11. Is the waiting period waived for rehires? If yes, the rehire waiting period is:

◯ Date of hire ◯ Other*: _____

*(ie: first of the month following date of rehire, one month following date of rehire)

D. CURRENT CARRIER

1. Type of coverage: ◯ Group ◯ Individual
2. Current MEDICAL Carrier: _____ Medical renewal date: _____
3. Current DENTAL Carrier: _____ Dental renewal date: _____

E. ROBIN WITH HEALTHPARTNERS MEDICAL PRODUCT SELECTION

Products effective 1/1/2022-12/31/2022

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)

- Small groups with 2-5 enrolled employees may offer one plan. Groups with 6-9 enrolled employees may offer up to two plans. Groups with 10-50 enrolled employees may offer up to three plans.
- Platinum plans cannot be offered next to Bronze plans.
- If offering more than one plan option, all plans must be paired with the same network.
- Embedded and non-embedded HSA plans may be offered alongside each other. This includes HSA Plus plans.

Plans		Metal Level	Focused	Broad
All Copay	30-60 P-S	Gold	☐	☐
Deductible-Copay Primary-Specialty	500-30/50	Platinum	☐	☐
	1000-30/50	Gold	☐	☐
	2000-30/50	Gold	☐	☐
	3000-30/50	Gold	☐	☐
	4000-30/50	Gold	☐	☐
	5000-45/90	Silver	☐	☐
Three for Free	500-70	Gold	☐	☐
	1000-70	Gold	☐	☐
	2000-70	Gold	☐	☐
	3500-70	Silver	☐	☐
	4000-70	Silver	☐	☐
	5000-70	Silver	☐	☐
HSA Copay	2000-100 30/60	Gold	☐	☐
HSA Copay Embedded	3000-100 30/60	Silver	☐	☐
	5000-100 30/60	Silver	☐	☐
	6250-100 30/60	Bronze	☐	☐
HSA	2300-100	Gold	☐	☐
	2500-100	Gold	☐	☐

Plans		Metal Level	Focused	Broad
HSA Embedded	3000-100	Gold	☐	☐
	4200-100	Silver	☐	☐
	5000-100	Silver	☐	☐
	6000-100	Silver	☐	☐
	6850-100	Bronze	☐	☐
	3000-70	Silver	☐	☐
	6500-70	Bronze	☐	☐
HSA Plus	2500-100	Gold	☐	☐
HSA Plus Embedded	3000-100	Gold	☐	☐
	4550-100	Silver	☐	☐
	5500-100	Silver	☐	☐
HRA Embedded	6900-100	Bronze	☐	☐

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

If you're adding a HealthPartners dental plan, please complete the information below. If you'd like to add a dental plan, please contact your broker or account manager for a quote.

_____ 1. What is the employer dental contribution? No minumum contribution for Voluntary plans. All others require a minimum of 50% of the Single employee premium.

_____ 2. Total number of employees that are taking the dental coverage?

Open Access Advantage (select one benefit from each category)

◯ Employer sponsored ◯ Voluntary[2]

Annual maximum
◯ $1000
◯ $1500

Out-of-Network
◯ Option 1
◯ Option 2

☐ Optional orthodontics add-on[1] (employer-sponsored plans only)

Preventive Dental Plans

☐ 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
◯ $1000
◯ $1250
◯ $1500
◯ $2000 (avail. with 100/80/50 coinsurance only)
◯ $2500 (avail. with 100/80/50 coinsurance only)

Deductible
◯ None
◯ $25
◯ $50
◯ $75

Coinsurance
◯ 100/50/50
◯ 100/80/50

☐ Optional orthodontics add-on[1]

Voluntary Open Access Dental Plan[2] (select one benefit from each category)

Annual maximum
◯ $750
◯ $1000
◯ $1250
◯ $1500 (avail. with 100/80/50 coinsurance only)

Deductible
◯ $25
◯ $50
◯ $75

Coinsurance
◯ 100/50/50
◯ 100/80/50

Voluntary Open Access Dental Plan w/Ortho[1] (select one benefit from each category)

Annual maximum
◯ $1000
◯ $1250
◯ $1500

Deductible
◯ $25
◯ $50
◯ $75

Coinsurance
◯ 100/80/50

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