group health Cooperative of eau claire

Employer Application

The following is provided by the group for: ☐ A new application for benefits ☐ A revised application for benefits

Group Information

Group Name	
Requested Effective Date	Business Start Date (if started within the past year):

(DO NOT cancel your existing coverage until we notify you in writing of acceptance):

Contact Person and Title:		
Email:	Phone #:	Fax #:

Group Address

Street Address			
City	County	State	ZIP

Group Mailing Address for Billing and Correspondence: ☐ Check box if same as above

Street Address			
City	County	State	ZIP

Business Type: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other:

Nature of Business or SIC#:	Federal ID#

Do you have different business locations? ☐ Yes ☐ No

If yes, describe below how many employees at each location:

Location: (City, State)_____ Number of Employees: _____

Location: (City, State)_____ Number of Employees: _____

Subsidiaries included? ☐ Yes ☐ No *If yes, please provide legal name and address below:*

Legal Name: _____ Address: _____

Legal Name: _____ Address: _____

Workers' Compensation

Do you have Workers' Compensation coverage? ☐ Yes ☐ No If yes, please name the carrier:

Please list any eligible employees (including owners) not covered by Workers' Compensation below:

Name: _____ Job Classification: _____

Name: _____ Job Classification: _____

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Eligibility/Contribution Information

Employee Eligibility (include all locations)

How many total employees do you employ? *(full-time, part-time, seasonal and temporary)* _____

How many employees are eligible for health benefits? _____
(Eligible employees are active full-time employees who have a normal work week of 30 or more hours and receive a wage.)*

If you want to cover employees working less than 30 hours per week, please indicate hours: _____
(Must be approved by Underwriting) **Retirees, part-time, temporary, and seasonal employees are not eligible for coverage.*

How many eligible employees are: Enrolling? _____ Retirees? (requires Underwriting approval) _____

Covered under a spouse's plan or other qualified health plan and waiving coverage? _____

Waiving coverage for other reasons? _____

Eligibility Date is always the first day of the month following: ☐ 30 days ☐ 60 days

☐ Other (not to exceed 90 days): _____ ☐ Date of Hire: _____

☐ Waive Probationary Period for Initial Enrollment

Medicare Secondary Payer (MSP)

If you have fewer than 20 total employees, the following information is needed to ensure the proper administration of your benefits in compliance with the MSP laws. Medicare will be the primary payer to the extent permitted by law. Please list below those individuals (employees, spouses, dependents) who are eligible for or entitled to Medicare and covered under your group health plan. (If you need additional space, please attach a separate sheet.)

Individuals Eligible for or Entitled to Medicare					
Name of Medicare Eligible/Entitled Individual	Social Security Number	If Medicare Entitled:	Reason:	Relationship to Policyholder:	Employment Status:
		Medicare Effective Date	**A**-Over 65 **B**-Confirmed Disabled **C**-ESRD	01 - Policyholder 02 - Spouse 03 - Child 04 - Other	A - Active B - Retired

COBRA/State Continuation

Are any employees or dependents to be insured on COBRA/State Continuation? ☐ Yes ☐ No

If yes, please list all employees/dependents to be insured on continuation below. (Attach a separate sheet if more space is needed.)

Name	**Length of Time (18, 29, 36 months)**	**Reason**	**Start Date**

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Eligibility/Contribution Information (continued)

Premium Contributions

Group Health Cooperative of Eau Claire requires a minimum employer contribution equivalent to 50% of the single premium.

What percentage or amount of the monthly medical premium is paid by the employer?

Single: _____% Family: _____% **OR** Flat Dollar Amount: $_____ Other: _____

Existing Coverage Information

Are you replacing existing Group Medical Insurance? ☐ Yes ☐ No

If yes, please complete the section below and furnish a copy of your most recent billing statement, including an itemization of employees covered.

Name of current insurance company you are replacing:_____

Original effective date of this policy: _____

Will you be sponsoring any other health plans for your employees? ☐ Yes ☐ No

If yes, please indicate which type below:

☐ HMO ☐ POS ☐ PPO ☐ Fee for Service ☐ Individual ☐ Other: _____

Coordination of Benefits

The Insurer will coordinate benefits according to the coordination of benefits regulations adopted by the State of Wisconsin. The Insurer will investigate every twelve months when there is no record of other insurance on file.

Participation Requirements

These participation requirements must be observed and maintained for a Group to remain eligible for coverage. It is the Group's responsibility to maintain these requirements. The number of employees in medical coverage initially and when reviewed periodically thereafter determine the size of group for participation requirement purposes. Group Health Cooperative of Eau Claire may terminate coverage if participation falls below the minimum requirements.

Where the Cooperative is the exclusive carrier:	
Eligible Employees	Participation Required
2-4	2
5-6	3
7	4
8-9	5
10	6
11 and up	70%

Where the Cooperative is not the exclusive carrier:	
Eligible Employees	Participation Required
250+	40% with Underwriting approval and prior review of alternative plans offered.

Calculation of Participation:

1. Employees who waive coverage due to coverage under a health plan that constitutes "creditable coverage" for preexisting condition purposes (e.g. COBRA, spouse's group health coverage) will not be used to determine participation.
2. For Small Employers*, an employee who waives coverage because the employee's annual premium contribution exceeds 10% of the employee's annual gross earnings will not be used to determine participation.
3. For all groups, eligible employees who waive coverage because they are part of another health plan offered by the Group will be used to determine participation.

*Small Employer has the meaning given in Wis. Stat. s.635.02(7).

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Group Plan Selections

The applicable benefit options (deductible, coinsurance, copays, out-of-pocket limits, etc.) are as stated on the final quote and benefit summary issued by Group Health Cooperative of Eau Claire and signed by the Employer's Representative.

Quote Assumptions

Group Health Cooperative of Eau Claire's ("Insurer") rate quote is based on the Group's representations during the underwriting process. The rates shown in the quotation were developed based on the information provided by the Group and on the total enrollment used during the underwriting process. In the event that it is determined that the facts used to determine rates during the underwriting process are incorrect, even if the Group did not know they were incorrect, or the actual enrollment on the effective date varies from the total enrollment used during the underwriting process by 10% or more, the Insurer has the right, at its option, to rescind the quote or recalculate rates even after the effective date if any health coverage is issued. This application is subject to completion and approval of the underwriting department and acceptance of all enrollment requirements by the Insurer before coverage is effective.

Employer Agreement

You, the employer, understand, agree and represent:

- You have read this document, and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records.
- You have received and reviewed a proposal, including a description of the benefits.
- Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company.
- The first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application.
- You will collect any employee contribution toward premium.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting and participation requirements of the plan are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate or untimely information may void, reduce or increase past premium, or terminate an individual's coverage or the group's coverage.

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us. If this application is declined, we will return the premium deposit submitted with this application.

Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.

As an authorized representative of this Employer, I do hereby agree to the terms and conditions stated herein. I further attest and certify that all the statements included herein are true and correct to the best of my knowledge.

Signature of Employer Representative: _____ Date: _____

Name and Title (please print): _____ Signed at (City, State): _____

Agent Statement and Signature

I hereby certify that I have complied with the underwriting guidelines of the selected group insurance program and have explained to this Group, in detail, the coverage and provisions of the selected group insurance program.

Agent's Name (please print):	E-mail address:	
Agent's Signature:	License #:	Date:
Agency Name:	Agency Address:	