Small Employer Group Application

COMMON GROUND
HEALTHCARE COOPERATIVE

Requested Effective Date: _____.

- **All required documents must be received by the 25th of the month prior to the requested effective date.**

Completed applications can be sent to:
Fax completed form to: (262) 754-9560 Attn: Sales
Email to: Sales@Commongroundhealthcare.org

Section 1- Group Information

Legal Name of Business			
Doing Business As (DBA)	**Legal Form of Business** ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Nonprofit ☐ Other: _____		
Business Address- street address (must be in the CGHC Service Area)			
City	**State**	**ZIP Code**	**County**
If billing address is different from the address listed above, please indicate it here.			
City	**State**	**ZIP Code**	**County**
Phone number	**Email address**		**Date Business Established**
Federal Tax ID Number (FEIN)	**Did the group offer healthcare coverage in the most recent calendar year?** If Yes, please provide a copy of your most recent invoice from your prior carrier. ☐ **YES** ☐ **NO**		

List names of ALL owners and their percentage of ownership in this company: _____

(1) Do any of the owners, either individually or in combination, own 50% or more of this company and 50% or more of any other company?
☐ YES ☐ NO

(2) Does the business above own any other companies or is the business above owned by any other company or legal entity?
☐ YES ☐ NO

If answered "Yes" to either (1) or (2) above, please provide the company details below.

Company Name	Company Address (Street, City, State and Zip Code)	Number of Employees	Does this company have a different FEIN than the company applying for coverage?	Will this company also be offered CGHC coverage?
			☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
			☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
			☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

Administrative Contact Name, Title, Phone Number and Email Address
Premium Billing Contact Name, Title, Phone Number and Email Address

NEED HELP COMPLETEING THIS APPLICATION? Contact your insurance agent or Common Ground Healthcare Cooperative representative with questions at 888.870.4717.

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Section II – Eligibility Information

In order to determine the employer group status of your business, what was the average number of employees working at your business during the most recent calendar year (January through December)? _____

- Small employer is defined as 2-50 employees. Use the numbers that are reported on your quarterly contribution report(s), including all owned businesses, for the most recent calendar year to determine this number.

Is your company enrolling through the Small Business Health Options Program (SHOP)? ☐ **YES** ☐ **NO**
More information can be found at www.healthcare.gov/small-businesses/choose-and-enroll/qualify-for-shop-marketplace

Current employee information:

a. _____ **Total number of permanent active employees currently on your payroll**
b. _____ **Number of permanent employees eligible for health insurance**
c. _____ **Number of permanent employees eligible for health insurance who reside outside of the CGHC Service Area**
d. _____ **Number of permanent employees NOT eligible for health insurance**
e. _____ **Number of employees who are seasonal or temporary**

Of the number of employees reported above in (b), list the number that are waiving CGHC due to other creditable health coverage. _____

Employer contribution percentage: Single:_____ Family:_____
Employers are required to contribute a minimum of 50% of the single premium for all employees.

Section III – Requested Plan Information

Do you want to offer benefits by class? ☐ **YES** ☐ **NO**
If "YES", please select which classes you have:

Class 1	☐ Hourly ☐ Salaried ☐ Part-Time ☐ Full-Time ☐ Management ☐ Non-Management ☐ Union ☐ Non-Union ☐ Executives ☐ Other:
Class 2	☐ Hourly ☐ Salaried ☐ Part-Time ☐ Full-Time ☐ Management ☐ Non-Management ☐ Union ☐ Non-Union ☐ Executives ☐ Other:
Class 3	☐ Hourly ☐ Salaried ☐ Part-Time ☐ Full-Time ☐ Management ☐ Non-Management ☐ Union ☐ Non-Union ☐ Executives ☐ Other:
Class 4	☐ Hourly ☐ Salaried ☐ Part-Time ☐ Full-Time ☐ Management ☐ Non-Management ☐ Union ☐ Non-Union ☐ Executives ☐ Other:

Are you requesting domestic partner coverage? ☐ **YES** ☐ **NO** (Domestic Partner Eligibility criteria applies)

Waiting period for new employees to obtain health insurance coverage *(cannot exceed 90 calendar days per the Affordable Care Act).*

PLEASE NOTE: Waiting periods for new employees may be changed only at renewal.

Does the waiting period apply to all classes of employees? ☐ **YES** ☐ **NO**
If "YES", please check one of the boxes below:

First of the month following: ☐ 0 Days ☐ 30 Days ☐ 60 Days

Immediately following: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

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If "NO", please select the waiting periods below:

Class 1 Waiting Period:

First of the month following: ☐ 0 Days ☐ 30 Days ☐ 60 Days

Immediately following: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Class 2 Waiting Period:

First of the month following: ☐ 0 Days ☐ 30 Days ☐ 60 Days

Immediately following: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

If more than 2 classes, list class and their waiting period below:

Class Name	Waiting Period

Do you want new employees currently in their waiting period to be eligible for benefits as of the date CGHC starts administering this plan? ☐ **YES** ☐ **NO**

Employee Termination

Does the termination requirement apply to all classes of employees? ☐ **YES** ☐ **NO**

If "YES", please check one of the boxes below:

Employee termination is effective: ☐ End of day the employee terminates ☐ End of the month the employee terminates

If "NO", please select termination requirements below:

Class 1 Termination is effective: ☐ End of day the employee terminates ☐ End of the month the employee terminates

Class 2 Termination is effective: ☐ End of day the employee terminates ☐ End of the month the employee terminates

If more than 2 classes, list class and their termination requirement below:

Class Name	Termination Requirement

Benefit Plan *Plans may only be changed at renewal.*

CGHC Benefit Plan Name(s): *Please list the plan name exactly how it appears on the rate sheet.*

Plan #1:	**Plan #2:**
Plan #3:	**Plan #4:**

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NEED HELP WITH THIS FORM? Contact your insurance agent or Common Ground Healthcare Cooperative representative with questions at 888.870.4717.

Section IV – Medicare Reporting

In accordance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, we are required to report group size to the Centers of Medicare and Medicaid Services (CMS).
Below is a questionnaire to provide us with the necessary data to report Medicare Secondary Payer information to CMS.

1. Enter the average number of full, part-time, and seasonal employees employed during the preceding calendar year (include all locations): _____

2. Did you have 20 or more full-time and / or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc.

   ☐ Yes ☐ No

3. Medicare Secondary Payer disability provisions have a different rule for reporting group size for disabled employees. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc. Did you employ 100 or more full-time and part-time employees on 50% or more of your regular business days during the previous calendar year?

   ☐ Yes ☐ No

   You must notify us when you have had an increase to a size of 20 or more full-time and part-time employees for 20 or more weeks during the current calendar year.

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Section V - Employer Certification

If any application information changes during Common Ground Healthcare Cooperative's review of this application, please contact Common Ground Healthcare Cooperative for approval.

All Employers: By signing this form I understand and agree that:

a. All statements and answers I give are complete and true to the best of my knowledge and belief.
b. Common Ground Healthcare Cooperative will rely in part on the information recorded on this application as the basis for their decision on whether to approve this application and issue coverage.
c. Common Ground Healthcare Cooperative may delay/void this request for coverage due to incomplete, inaccurate, or untimely information.
d. Coverage is not in effect until the final approval is given by Common Ground Healthcare Cooperative. I should not cancel my current coverage until I have received such approval, in writing, from Common Ground Healthcare Cooperative.
e. An agent, agency, or broker, acting in any capacity, has no authority to:
    (i) alter this application to bind Common Ground Healthcare Cooperative by making any promise and/or representation, or
    (ii) waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Common Ground Healthcare Cooperative.

Employer Representative's Signature:	**Date of Signature:**
Title of Employer Representative:	

Section VI – Agent's Certification

I, as writing agent, certify that I have actively participated in the solicitation and placement of this insurance. I understand that I have no authority to alter this application to bind Common Ground Healthcare Cooperative by making any promise and/or representation, or to waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Common Ground Healthcare Cooperative.

Writing Agent's Signature:	**Printed Name:**	**Date of Signature:**
Writing Agent's NPN:	**Agency Name:**	**Tax Identification Number:**