ENROLLMENT REQUIREMENTS CHECKLIST

COMMON GROUND
HEALTHCARE COOPERATIVE

REMINDERS

The submission process will not begin until all required enrollment documents have been received.

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

SEND HERE

Fax to: (262) 754-9560 Attn: Sales

Email to: Sales@commongroundhealthcare.org

CHECKLIST

☐ **Small Group Employer Application**

- Only the employer may fill in, change, or modify the employer application.
- The employer application must be signed by the owner listed in the owner section of the employer application or an officer listed on the statement of information filed with the secretary of state of Wisconsin.
- The business address must be in the designated service area and cannot be a PO Box.
- The employer premium contribution must be in a percentage.

☐ **Employee Applications**

- All full-time employees must complete an Employee Application
- Employees waiving coverage only need to complete Page 1 of the application

☐ **Disclosure of Rating and Renewability Form**

☐ **Copy of Invoice from most recent carrier**

- Only if the group offered healthcare coverage in the most recent calendar year

☐ **Copy of most recent Quarterly Wage & Tax Report**

- Indicate the status of all employees listed: Full-time, Part-time, Seasonal, Temporary, COBRA, or Termed
- Employees not listed on the Quarterly Wage & Tax Report must be included on the Eligibility Certification Form
- If an owner is not on the Quarterly Wage & Tax Report, the group will also need to submit the following:
    - C-Corp: Form 1120 with Schedule 1125-E25-E
    - S-Corp: Form 2553 signed by all owners
    - LLC, LLP, or LP : Current schedule K-1F(Form 1065)
    - Nonprofit: Schedule SE or Form 4361 with IRS approval
    - Sole Proprietor: Eligibility Certification Form

☐ **Affidavit of Domestic Partnership Form**

- Only if domestic partner coverage was checked on the Employer Application and an employee is requesting domestic partnership coverage

☐ **Business and Ownership Documents (if applicable):**

- Affiliated Companies: Statement from CPA/tax attorney showing eligibility to file a combined tax return
- Controlled Groups: Official document(s) showing all individual Tax IDs, ownership percentage(s), and indication whether they are a parent-subsidiary controlled, brother-sister controlled or other arrangement.
- Nonprofit: Wisconsin Secretary of State active web confirmation, IIRS letter 501(c)(3), and IRS application for exempt status.
- Spin-off Group: A copy of the PEO client invoice billed to the worksite business and a signed Conditions of Enrollment/Start-Up Companies/PEO Spin-off Groups form.
- Sole Proprietor: Provide one of the following: Schedule C, Current WII business license, or Fictitious business name filing
- Startup: Conditions of Enrollment/Start-Up Companies/PEO Spin-off Groups form with all available Payroll records.

Small Group Employer Application

COMMON GROUND HEALTHCARE COOPERATIVE

Requested Effective Date: _____.

Did the group offer healthcare coverage in the most recent calendar year?

If Yes, please provide a copy of the most recent invoice from the prior carrier. ☐ **YES** ☐ **NO**

Section I – Group

Business Name	**Legal Name**		**DBA Name**	
Establishment	**Federal Tax ID Number (FEIN)**		**Date Business Established (MM/DD/YY)**	
Legal Form of Business	☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Non-profit ☐ Other:			
Business Address: (must be in the CGHC Service Area and cannot be a PO Box)	**Street Address**			
	City	**State** Wisconsin	**ZIP Code**	**County**
Mailing Address ☐ Check if same as business address	**Street Address**			
	City	**State**	**ZIP Code**	**County**
Business Contact Information	**Phone**		**Email**	
Administrative Contact:	**Name**		**Title**	
	Phone		**Email**	
Billing Contact:	**Name**		**Title**	
	Phone		**Email**	

Complete the remaining of Section I based on ALL owners in this company:

Owner 1	**Name**	**Percentage**	**Owner 3**	**Name**	**Percentage**
Owner 2	**Name**	**Percentage**	**Owner 4**	**Name**	**Percentage**

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

(2) Is this company affiliated with any other company? ☐ **YES** ☐ **NO**

If answered "Yes" to either of questions (1) or (2), please provide the other 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?	Do you want to offer coverage to this company?
			☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO

Small Group Employer Application

COMMON GROUND HEALTHCARE COOPERATIVE

Section II – Eligibility Information

Is your company enrolling through the Small Business Health Options Program (SHOP)? ☐ **YES** ☐ **NO**

If answered "**Yes**", please provide a copy of the confirmation of eligibility provided on CMS.gov

SHOP is a program offered through CMS. gov that may qualify a business for the Small Business Health Care Tax Credit or state premium assistance programs. To qualify for SHOP, the business must reside in Wisconsin, have at least 1 employee enrolling in coverage who is not the owner, business partner, or their spouse, have 1 - 50 full-time equivalent employees, and offer SHOP coverage to all full-time employees. Once eligible for SHOP, to qualify for the Small Business Health Care Tax Credit, the business must have fewer than 25 full-time equivalent employees, an average employee salary of $56,000 per year or less, contribute at least 50% of the employee premium, and offer coverage to all full-time employees. To learn more, go to Healthcare.gov/small-businesses/get-coverage/

Participation Requirements

What was the average number of employees by month that the group employed in the preceding calendar year? _____

Employees include full-time, part-time, seasonal and temporary.

List the count of how many current employees there are in each category. If any are not applicable, please put 0.

Full Time Permanent (30 or more hrs/week) _____

Part Time Permanent _____

Seasonal or Temporary _____

Total Number of Employees: _____

Of the number of Full Time Permanent Employees:

Enrolling and reside inside of the CGHC service area _____

Enrolling and reside outside of the CGHC Service Area _____

Waiving due to being enrolled in other creditable coverage _____

Waiving and not enrolled in other creditable coverage _____

Employer premium contribution percentage: Employees: _____ Dependents: _____

Employers are required to contribute a minimum of 50% of the premium for all employees. Contributions to dependent premiums are not required.

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

Section III – Requested Plan Information

Do you want to offer benefits by class? ☐ **YES** ☐ **NO**

If "NO", skip to section 'Waiting Period for New Employees.' If "YES", please select which classes you would like to offer:

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

Waiting Period for New Employees *Cannot exceed 90 calendar days per the Affordable Care Act and may only be changed at renewal.*

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** ☐ **N/A**

Will the waiting period apply to all classes of employees? ☐ **YES** ☐ **NO**

If "NO", skip to section 'Employee Waiting Period by Class' on the next page. If "YES", please check one of the boxes:

First of the Month Following

- ☐ 0 Days
- ☐ 30 Days
- ☐ 60 Days

OR

Immediately Following

- ☐ 0 Days
- ☐ 30 Days
- ☐ 60 Days
- ☐ 90 Days

Small Group Employer Application

COMMON GROUND
HEALTHCARE COOPERATIVE

Employee Waiting Period by Class

	First of the Month Following		Immediately Following
Class 1 Waiting Period:	☐ 0 Days ☐ 30 Days ☐ 60 Days	**OR**	☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days
Class 2 Waiting Period:	☐ 0 Days ☐ 30 Days ☐ 60 Days	**OR**	☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

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

Class Name	Waiting Period

Employee Termination

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

If "NO", skip to section 'Employee Termination by Class.' 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

Employee Termination by Class

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 Selection *Plans may only be changed at renewal.*

Groups who meet participation requirements can select Out of Service Area plans to accompany Service Area plans for employees that reside outside of the CGHC service area. Participation in Out of Service Area plans may not exceed 20% of enrolled employees.

Enrolled Subscribers Required	Service Area Plans	Out of Service Area Plans
2-4 Subscribers	1	0
5-10 Subscribers	2	1
11-19 Subscribers	2	2
20+ Subscribers	3	3

Benefit Plan Name(s): *Please list the full plan name exactly how it appears on the proposal. Example: Gold $800 Deductible/20% - Envision Network*

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

Small Group Employer Application

COMMON GROUND
HEALTHCARE COOPERATIVE

NEED HELP WITH THIS FORM? Contact your insurance agent or a Common Ground Healthcare Cooperative representative with questions at (262) 247-8050.

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.

Small Group Employer Application

COMMON GROUND
HEALTHCARE COOPERATIVE

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:**	**Agency Tax Identification Number:**

Small Group Employee Application

COMMON GROUND HEALTHCARE COOPERATIVE

Information provided on this application is solely for the purpose of administering the Common Ground Healthcare Cooperative (CGHC) plan(s) offered through your employer.

Hire Date: ________________.

Average Hours Worked Per Week: ____________.

Coverage Effective Date: ________________.

Section I – Enrollment Information

Event Status: ☐ New Group ☐ New Hire ☐ Special Enrollment Period:

Name of Employer

Section II – Employee Information

First Name	M.I.	Last Name

Home Address

City	State	ZIP Code	County

Phone	Email	Marital Status
		☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Employee status, select all that apply:

☐ Hourly ☐ Salaried ☐ Management ☐ Non-Management ☐ Union ☐ Non-Union ☐ Executives

☐ Other: ____________________

Section III – Waiver of Coverage

Complete the following for all waiving coverage:

Name (First, M.I., Last)	Relationship to Employee	Reason for Waiving	Carrier (if other coverage)
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	
		☐ Other Group Coverage ☐ Individual Coverage ☐ Medicare or Medicaid ☐ No Coverage	

I also understand that if I apply for coverage in the future, I and/or my eligible dependents will be considered a Late Enrollee and must wait for the group's renewal/anniversary date to enroll provided I and/or my eligible dependents are still eligible for coverage and are not entitled to a special enrollment period as described in the Notice of Special Enrollment Rights on Page 2.

Waiving Employee Signature:	Date of Signature:

Small Group Employee Application

COMMON GROUND HEALTHCARE COOPERATIVE

Section IV – Application for Coverage

I am applying for coverage for (select all that apply):

- ☐ Myself
- ☐ My spouse
- ☐ My dependent child(ren)
- ☐ Domestic partner (if coverage is offered by your employer)

Please list the full name of the benefit plan you are selecting:
Example: Gold $800 Deductible/20% - Envision Network ______________________________.

Will any enrolling members have other health insurance coverage when this policy becomes effective? ☐ YES ☐ NO

Section V – Applicant Information- List all family members to be covered.

EMPLOYEE:

EMPLOYEE	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex (M/F)
				SELF	

DEPENDENTS:

Name (First, MI, Last)	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex (M/F)
Name (First, MI, Last)	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex (M/F)
Name (First, MI, Last)	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex (M/F)
Name (First, MI, Last)	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex (M/F)
Name (First, MI, Last)	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex (M/F)
Name (First, MI, Last)	Social Security Number	Are you disabled? (Y/N)	Date of Birth (MM/DD/YYYY)	Relationship	Sex (M/F)

Section VI – Employee's Authorization and Representation

Read this section carefully, sign and date the application.

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby represent all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers, and subsequent information I provide are the basis for my coverage.

I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified of the Effective Date.

I hereby authorize Common Ground Healthcare Cooperative(CGHC) to obtain from providers of services and hospitals, including those providers with whom CGHC contracts for service, the medical records, including those which relate to mental health and chemical dependency treatment, relating to me and my family members to the extent that those records are necessary for the administration of the CGHC contract, including for purposes of claims payment, case management, fraud investigation and quality of care review. A photocopy of this authorization shall be as valid as the original and remains in effect as long as continually insured by CGHC or until revoked.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION TO COMMON GROUND HEALTHCARE COOPERATIVE IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE.

Applying Employee Signature: **Date of Signature:**

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself and/or your dependents because of other qualified health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after the qualifying event. In addition, if you have a new dependent as a result of marriage or birth you may be able to enroll yourself and/or your dependents, provided that you request enrollment within the qualifying Special Enrollment Period.

COMMON GROUND
HEALTHCARE COOPERATIVE

Disclosure of Rating and Renewability for Employers with 2-50 Employees

Section 635.11 Wis. Stat., and section Ins 8.48, Wis. Adm. Code require the following information be disclosed to Small Employers prior to group enrollment.

1. Premium rates on your effective date are developed using the following rating factors:
    - Individual or family;
    - Geographic area;
    - Age; and,
    - The benefit plan selected for your group.

2. Premium rates are guaranteed for one year from your effective/anniversary date.

3. If the Employee Participation review at renewal determines your group employed less than two or more than 50 eligible employees during at least 50% of the number of weeks in any previous 12 month period, you may no longer be considered a small employer.

4. The benefits and premiums for all health insurance plans available to you will be provided upon request.

5. Common Ground Healthcare Cooperative (CGHC) is required to renew or continue your coverage annually unless:
    - Premiums are not paid
    - You committed fraud or misrepresented the eligibility of an employee, or misrepresented group information
    - The minimum contribution and/or participation requirements are not met
    - Your business is no longer open or no longer has status as an independent legal entity
    - Your business is no longer located in the CGHC Service Area
    - CGHC no longer offers coverage in the small group insurance market in the State of Wisconsin. Notice would be sent to you at least 180 days before the date on which your groups coverage would end.

By signing below, you certify that the rating factors and renewability provisions were disclosed prior to enrollment.

_____
Agent/Salesperson

_____ _____
Signature Date

_____
Group Administrator

_____ _____
Signature Date

_____
Employer Group Name

120 Bishop's Way, Suite 150, Brookfield, WI 53005 | P: 877.450.8497 | F: 262.754.9690 | www.CommonGroundHealthcare.org

AFFIDAVIT OF DOMESTIC PARTNERSHIP FOR DOMESTIC PARTNER BENEFITS

COMMON GROUND
HEALTHCARE COOPERATIVE

Your employer offers health care benefits to domestic partners of its employees through Common Ground Healthcare Cooperative (CGHC). Domestic partners must complete the affidavit below in order to be eligible for these benefits.

We, the undersigned, declare that all of the following are true and correct:

1. We are both at least 18 years of age;
2. We are both mentally competent to consent to a contract;
3. We are not legally married to, nor the domestic partner of, any other person under statutory or common law;
4. We are in a mutually exclusive relationship that is similar to marriage of at least six months, and we intend to remain in that relationship indefinitely;
5. We have entered into the domestic partner relationship voluntarily, willingly and without reservation;
6. We are not related by blood to a degree of closeness that would prohibit marriage in the state of Wisconsin;
7. We share a permanent residence, and have done so for at least six months, prior to coverage;
8. We are financially interdependent as demonstrated by at least three of the following:
   (a) Joint ownership or common leasehold in a residence;
   (b) Joint ownership of motor vehicle;
   (c) Joint bank, checking or investment account;
   (d) Joint credit account;
   (e) A will, retirement plan, or life insurance policy that names the other as a primary beneficiary;
9. We have not entered into this relationship for the purpose of obtaining healthcare.
10. We understand and agree that the representations that we make in this Affidavit of Domestic Partnership are made to induce the employer to extend domestic partner benefits to the undersigned domestic partner;
11. We understand that the employer is relying on the representations made in the Affidavit of Domestic Partnership in order to determine whether to extend domestic partner benefits to the undersigned domestic partner;
12. We agree to notify the employer of any change in circumstances which we have attested to in this affidavit within 30 days of any such change;
13. We the undersigned understand that misrepresentation of domestic partner status is grounds for retroactive termination of coverage;

Agreed and confirmed:

Employee Information:	**Domestic Partner Information:**	
Print Employee Name	**Print Domestic Partner Name**	
Employee Signature	**Domestic Partner Signature**	
Date	**Date**	
Employer Information:		
Employer Name	**Group #**	
Authorized Signature	**Title**	**Date**