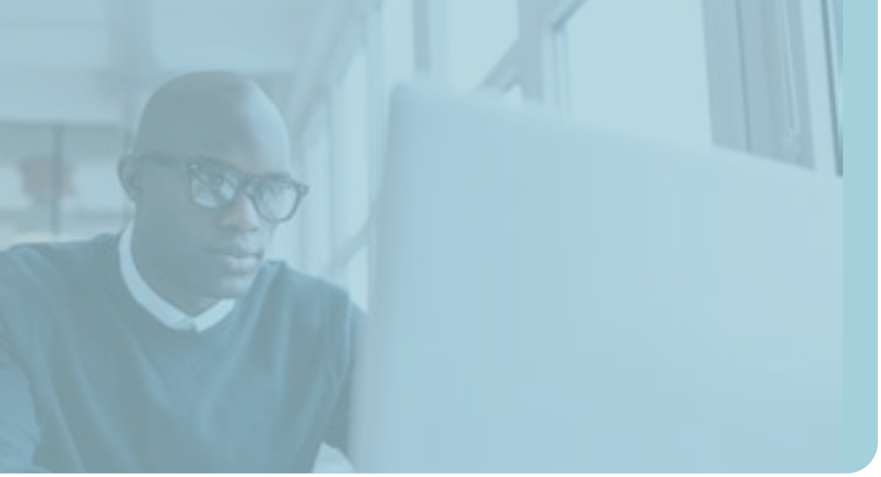

COMMON GROUND HEALTHCARE COOPERATIVE

SMALL GROUP UNDERWRITING GUIDE

888-870-4717• commongroundhealthcare.org

CGHC.EO.2357-2024-03

COMMON GROUND
HEALTHCARE COOPERATIVE

Thank you for choosing Common Ground Healthcare Cooperative

Our Commitment – As a Wisconsin-based, non-profit carrier with a mission of Putting Members First, Pursuing Better Healthcare, we continue to provide clients with access to some of the lowest-cost health insurance plans in eastern Wisconsin.

Our Support – We are local, and so is our team. We provide you and your clients with one-to-one, personalized experiences throughout the sales and onboarding processes with the help of our expert Small Group Account Specialists.

We Care – We partner with high-quality providers and strive to build a network where our members can receive the care they deserve.

About This Manual

This manual is intended for agents' training and reference. It contains important information you need to market Common Ground Healthcare Cooperative (CGHC) Small Group Health plans.

Agents are encouraged to read the manual in its entirety and to use it as a reference for answering questions and for servicing Common Ground Healthcare Cooperative business.

If you need information not found in this guide, please contact your Common Ground Healthcare Cooperative Small Group Account Manager at 888-870-4717.

While we make every effort to provide you with complete and current information about the enrollment and administration practices of our Small Group Health Plans, it's important to know this guide is subject to change. Active policies and procedures will take precedence over the information contained in this guide.

Please continue to work with your Common Ground Healthcare Cooperative Sales Team, to ensure you always have the most up-to-date version of this guide.

CGHC.EO.2357-2024-03

Table of Contents

Addendum Includes:

- Contact Information
- Helpful Resources
- Employer Application
- Employee Application
- Member Change Form

Eligibility Requirements

Small Group Employer Eligibility

A Small Group employer is an employer that meets eligibility requirements under the Affordable Care Act (ACA) and Wisconsin Small Group regulations and is eligible for guaranteed issue and guaranteed renewal coverage as a Small Group Health Plan.

When a Small Employer is Eligible for Coverage under a CGHC Group Health Plan:

- Under Wisconsin Small Group regulations, a Small Group employer is an employer that has had between 2-50 **total number** of employees (full-time, part-time, seasonal, temporary, etc.) on a monthly average over the last calendar year, including groups that are SHOP Eligible.
- Has employed at least 2 employees as of the preceding calendar year or preceding calendar quarter.
- If the employer's business was not in existence during the preceding calendar year, it is expected the employer will employ an average of at least two (2) but not more than 50 employees on business days during the current calendar year.
- Has and maintains business licensure and/or appropriate state filings, allowing the business to conduct business in Wisconsin.
- Must be headquartered in Wisconsin and domiciled within CGHC's service area.
- Must involve a bona fide employer-employee relationship.
- Meets CGHC's minimum employer contribution requirement of 50% of the lowest single plan employee-only monthly premium offered to each employee.
- Meets CGHC's minimum participation requirements (refer to "Participation Requirements" section)

Some groups that do not meet eligibility requirements for coverage:

- Groups formed for the sole purpose of obtaining health insurance.
- Groups that do not have at least one (1) common law employee enrolling in coverage.
    - For example: –
        - Sole proprietors with no common law employees.
        - Owner-only groups with no common law employees. (For purposes of underwriting, an owner is not considered a common law employee.)
- A two-person group comprised of the business owner and their spouse/partner.
- A group where only the owners are applying for coverage and common-law employee(s) are waiving coverage.

New Group Enrollment Requirements

Submission Requirement:

- Completed Small Group Employer Application.
- A copy of the company's most recently submitted Quarterly Wage & Tax Report and includes the employees' current employment status (full-time, part-time, temporary, seasonal, COBRA/Continuation or termed and quarterly wages of all employees listed)
    - Employees not listed on Wage & Tax will require Payroll documentation.
- Completed Eligibility Certification Form for employees not listed on the Quarterly Wage & Tax Report
- Employee Applications or Waivers for every eligible employee (including terminated employees who are within their COBRA / Continuation with the group's current carrier)
- Affidavit of Domestic Partnership Form
    - This form is only required if the group wants to offer domestic partnership coverage.
- A copy of the last month's group billing invoice from the group's prior carrier with the status of all listed employees, unless the employer did not have prior coverage.
- Depending on the type of Group, the additional documents noted below are also required.

"C" Corporations	"S" Corporations	Partnerships
• Articles of incorporation • Wage & Tax or Recent Payroll • Form 1120 with Schedule 1125E	• Articles of incorporation • Wage & Tax or Recent Payroll • Form 2553 signed by all officers.	• Partnership Agreement • Wage & Tax or Recent Payroll • Form 1065
Sole Proprietors	**Limited Liability Companies (LLC)/ Limited Partnerships**	**Nonprofit Organizations and Corporations**
• Business License • Wage & Tax or Recent Payroll • Form 1040/Schedule C Note: Single owners and spouses or domestic partners of officers or partners do not constitute the qualifying W-2 employee.	• Schedule K-1 (Form 1065) or LLC Agreement and either Articles of Incorporation or Partnership Agreement • Wage & Tax or Recent Payroll Note: Single owners and spouses or domestic partners of officers or partners do not constitute the qualifying W-2 employee.	• Payroll • IRS letter 501(c)(3) • IRS application for exempt status Members of the clergy

Continued on the next page

Optional document:

- Completed Electronic Funds Transfer (EFT) form.
    - If submitted, ETF will not begin until after the initial, first month's premium is received and processed by CGHC.

Notes:

- CGHC requires all submission documents to be returned no later than the 25th of the month or the next business day of the prior month, to have coverage effective on the 1st of the following month.
- 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.
- Whenever an individual has a language barrier and requires assistance to properly complete the application, the application must be submitted with a signed CGHC Statement of Accountability / Translator Statement from the group or the agent.
- No alterations to preprinted materials will be accepted.
- Annual open enrollment period: Once a year, employers must allow employees to change plans or add dependents not previously enrolled. Employees and/or dependents who do not enroll when first eligible must wait until the annual open enrollment period to enroll.
    - However, employees may be eligible to enroll themselves and their dependents before the next open enrollment period if a qualifying life event, such as losing other coverage, occurs.

Startup Companies

A startup group could be considered for a CGHC Small Group Health Plan. CGHC considers a startup group as an employer that has been in business for less than a calendar quarter and has at least two or more eligible common-law employees.

If a group enrolls or renews during the 11/15 - 12/15 Open Enrollment Period, participation requirements will be waived for as long as they have an active policy with us.

Required documents:

- Conditions of Enrollment/Start-Up Companies/PEO Spin-Off Groups form.
    - All available payroll records.
- First 30 days of payroll within 45 days of the requested coverage effective date.

Note: Single owners and spouses or domestic partners of officers or partners do not constitute the qualifying W-2 employee.

Buyout / Acquisition / Mergers

As a small group health plan provider, it is important to understand and have processes in place to manage when changes occur in the structure of a business that is currently insured by CGHC or applying for group coverage through CGHC. Historically known as buyouts, acquisitions, or mergers, it is necessary to understand key scenarios that will require change within CGHC systems in order to maintain and/or set up within CGHC systems.

Name change (the business still has the same owner, Tax ID, and employees)
Process: Change the name of the group in The Agent Portal.

Name change and new Tax ID (the business still has the same owner and employees)
Process: A new group needs to be set up

- A New Small Group Employer Application is required.
- All enrolled members need to be moved from the original group to the new group.
    - New employee applications are **not** required.
- Accumulators for enrolled will need to be moved from old records to the new records.

Name change (or same name), new Tax ID and new owner (business still has the same employees)
Process: A new group needs to be set up.

- A copy of the purchase agreement is required.
- A new Small Employer Group Application is required.
- All enrolled members need to be moved from the original group to the new group.
    - New employee applications are **not** required.
- Accumulators for enrolled members will need to be moved from old records to the new records.

Name change, new Tax ID, new owner, and new employees.
Process: A new group needs to be set up

- A copy of the purchase agreement is required.
- A new Small Employer Group Application is required.
- All enrolled members need to be moved from the original group to the new group.
    - New employee applications are **not** required.
- Accumulators for enrolled members will need to be moved from old records to the new records.
- Employee Applications or Waivers for new members are required.
- Refer to the “Prior Deductible Credit / Annual Out-of-Pocket Maximum” section to determine if applicable.

Continued on the next page

An existing group with the same name and Tax ID that acquires another business and that business' employees.

Process: A new group does **not** need to be set up

- A copy of the acquisition agreement is required.
- An Eligibility Certification Form with all new members listed is required.
    - Employee Applications or Waivers for new members listed are required.
        - Refer to the "Prior Deductible Credit / Annual Out-of-Pocket Maximum" section to determine if applicable.

Employee Eligibility

An eligible employee is:

Employed by the Small Group employer and has a status of "Active" at work meaning they have completed their waiting period required by the group, and are:

- Permanent full-time employee who conducts business for the small employer, with a normal workweek of an average of 30 hours per week for a month, at the employer's regular place of business,
- Sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis (average of 30 hours per week for a month) in the employer's small business and included as employees under a healthcare service plan contract of a small employer.
- A terminated employee that is within their COBRA/Continuation period and enrolled with the group's current health insurance carrier. Employees must complete a waiver and prove the end date of COBRA eligibility.

An ineligible employee is:

- A part-time employee working less than an average of 30 hours per week.
- Seasonal, temporary, and substitute employees, defined as an employee hired with a planned future termination date.
- Contract employees (1099) or employees compensated on a 1099 basis.
- Employees who reside outside of the 48 contiguous states, Washington, D.C., Alaska, Hawaii, Puerto Rico, or the United States Virgin Islands.
- Other ineligible classifications include but not limited to: private households, domestic help, members of organizations

Rehired Employee Eligibility

The group is responsible for notifying us immediately if an employee is rehired and will be continuing coverage. Eligible employee rehire scenarios:

- An enrollee rehired within 31 days of termination.
    - Coverage will resume with no lapse upon receipt of the required written notification from the employer.

Continued on the next page

- An employee rehired more than 31 days from termination but no more than 91 days from the termination date.
    - Coverage will restart and become effective as of the employee's rehire date.
        - The employee will not be subject to applicable group-imposed orientation and/or waiting periods.
        - A new Employee Application is required.
- An employee rehired more than 91 days (13 weeks) from the termination date.
    - The employee is considered a new employee and will be subject to applicable employer-imposed orientation, probationary period, and/or waiting periods.
        - A new Employee Application is required.

Domestic Partnership Eligibility

CGHC allows for eligible domestic partner coverage when:

- Domestic Partner coverage is requested on the Small Group Employer Application.
- A Domestic Partnership attestation is completed and submitted with the employee application for enrollment and;
- The Employee meets the following domestic partnership qualifications:
    - Each individual is at least 18 years of age and capable of consenting to the domestic partnership.
    - They have lived together for at least six months before enrollment in the health insurance plan.
    - Neither individual is married to, or in a domestic partnership, with another individual.
    - Individuals are not related by blood, closer than allowed under the marriage laws of the State of Wisconsin.
    - The individuals are in a relationship and living together as a couple.
    - The individuals intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner.
    - If requested, the individuals can provide at least two of the types of documentation listed here:
    - Documentation showing the joint purchase and ownership of a home.
    - A notarized copy of a lease for a residence that identifies both the Subscriber and his/her Domestic Partner as responsible for payment of rent.
    - Documentation showing a joint checking/savings account that has been in effect and valid for at least six months.
    - A title and registration for a car showing joint ownership.
    - Documentation of joint use and liability for credit cards.
    - A certified copy of a policy declaration page specifying that the Domestic Partner is the beneficiary under a policy of life insurance issued to the Subscriber, or vice versa.

Continued on the next page

- Evidence that the Domestic Partner is the beneficiary of the Subscriber's deferred compensation or other retirement plan.
- Evidence of durable powers of attorney for property which satisfies ss. 243.07 and/or 243.10, Wis. Stats., or for health which satisfies ss. 155.05 and 155.10, Wis. Stats.
- The Subscriber's last will and testament which specifies that his/her Domestic Partner is the major recipient of the Subscriber's financial and real property assets; and/or
- Other forms of documentary evidence that depict significant joint financial interdependency between the Subscriber and his/her Domestic Partner.

Dependent Eligibility

CGHC considers a qualified dependent to be:

- Lawful spouse.
- Registered domestic partner IF domestic partner eligibility is chosen by the group.
- Disabled dependent child, who at the time of becoming age 26, is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition, and is chiefly dependent on the subscriber for support and maintenance. The employee will be required to submit physician certification of the child's condition. If the Subscriber does not provide proof of the child's disability and dependency within 30 days of our request as described above, coverage for that child will end.
- An employee's, their spouses or registered domestic partner's child under age 26:
    - Natural child
    - Newborn child
    - Stepchild
    - Legally adopted child
    - Ward of legal guardian
- In the case of birth, adoption, or placement for adoption, the child will be covered for the first 60 days from the date of birth, adoption, or placement for adoption. To continue the plan beyond the 60 days, CGHC must receive an application for coverage of a dependent child within 60 days of the child's eligibility. Coverage will be effective beginning on the date of birth or adoption or placement for adoption following our receipt of the completed Employee Enrollment Application.
- A child will be deemed adopted either from the moment of placement in a group member's home or from the date of an order granting custody of the child to the group member, whichever is earlier. The child's adopted status remains in effect unless the child is removed from the member's home before the issuance of a legal decree of adoption.
- If both parents are covered subscribers through the same employer, their children may be covered as dependents of either, but not both, of the subscribers.
- New spouses and/or domestic partners have 60 days from the date of marriage or affidavit of domestic partnership.

Employee Enrollment Requirements

Each Eligible Employee / Owner

Please note, CGHC is required by the IRS and Centers for Medicare & Medicaid Services (CMS) regulations to collect Social Security Numbers applicants.

Required documents:

- Completed Employee Application or Waiver (waivers must include the reason for waiving coverage)
- Valid Social Security Numbers are required for all enrolling members including dependents to enroll. If an applicant does not have a valid Social Security number, they are not eligible for coverage.

Note: Only the employee may fill in, change, or modify the employee application.

Participation Requirements

When determining participation, "eligible employees" do not include those with other full coverage health insurance, unless those employees are enrolled in qualified health insurance coverage through this group and those with group continuation coverage.

Minimum participation requirements are as follows:

Number of Eligible Employees	Enrolled Subscribers Required
2-4	*2 Subscribers
5-6	3 Subscribers
7	4 Subscribers
8-9	5 Subscribers
10	6 Subscribers
11-50	70% of eligible employees

*The Small Group Special Enrollment Period (SEP) takes place annually from November 15 to December 15 for coverage that starts on January 1. During this one-month period, the normal participation and contribution minimums do not apply.

To calculate participation, the following are considered valid waivers if included on the Waiver form, such as:

- Employer-sponsored group coverage through another employer
- Medicaid
- Medicare
- United States military coverage
- Individual coverage on and off the exchange

Note: An owner of multiple entities will not be considered a valid waiver if the owner is declining due to coverage under another entity in which they hold ownership. Dual coverage by the same employer would not be considered a valid waiver.

Prior Deductible Credit / Annual Out-of-Pocket Maximum

For new group submissions, CGHC provides credit for in-network deductibles met under prior takeover group medical coverage if proof of the actual dollar amount is submitted with the first claim.

- This provision does not apply to new hires.
- Credit for a pharmacy deductible is not available, except when the member's prior takeover group coverage was an aggregate plan (such as an HSA).
- A Deductible Report from the previous carrier must be received within 90 days post-enrollment.
- Credit is not applied to maximum out-of-pocket.

Small Group Plan Options

Depending on the number of eligible employees, Small Group employers

- may choose up to three (3) different standard medical/pharmacy plan options within the EPO product lines.
- They must choose either Envision or Rise network, they cannot offer both Envision and Rise networks to their members.
- To qualify for the Rise network, employers must be domiciled in rating areas 1, 9, or 12 (Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties).
- EPO Plus plans are available to accommodate subscribers who reside outside of the CGHC service area.

Envision Network Plans

Subscriber Resides in One of the Following	Service Area Description	Plan Options
Wisconsin: CGHC Service Area	CGHC 24 county service area	Employees can only enroll in an Envision Network plan.
Wisconsin: CGHC Service Area Border County	Adams, Columbia, Dane, Dickinson, Iron, Florence, Forest, Lake, Langlade, Marathon, Marquette, McHenry, Menominee, Portage, and Rock County	Employees may choose an Envision Network plan or EPO Plus plan.
Wisconsin: Outside of Service Area	County within Wisconsin but not in the CGHC service area and not a border county.	Employees can only enroll in an EPO Plus* plan.
Illinois: CGHC Service Area Border County	Boone, Lake, and McHenry County	Employees may choose an Envision Network plan or EPO Plus* plan.
Michigan: CGHC Service Area Border County	Iron, Dickinson, and Menominee	Employees may choose an Envision Network plan or EPO Plus* plan.
Outside of Wisconsin: Outside of CGHC Service Area Border County	The county is outside of WI and is not an IL or MI border county.	Employees can only enroll in an EPO Plus *plan.

*Group must meet participation requirements for the EPO Plus plan

Rise Network Plans: *(To be able to offer the Rise network, employers must be domiciled in rating areas 1, 9, or 12)*

Subscriber Resides in One of the Following	Service Area Description	Plan Options
Wisconsin: Rating areas 1, 9 & 12	Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha	Employees can only enroll in a Rise Network plan.
Wisconsin: Other CGHC rating areas	The other 18 CGHC counties	Employees can only enroll in a Rise Network plan.
Wisconsin: Outside of Service Area	County within Wisconsin but not in the CGHC service area and not a border county.	Employees can only enroll in an EPO Plus* plan.
Illinois: CGHC Service Area Border County	Boone, Lake, and McHenry County	Employees may choose a Rise Network plan or EPO Plus* plan.
Michigan: CGHC Service Area Border County	Iron, Dickinson, and Menominee	Employees may choose a Rise Network plan or EPO Plus* plan
Outside of Wisconsin: Outside of CGHC Service Area Border County	The county is outside of WI and is not an IL or MI border county.	Employees can only enroll in an EPO Plus plan*

*Group must meet participation requirements for the EPO Plus plan

EPO Plus Plans

Groups who meet participation requirements can elect up to three (3) Envision EPO Plus plans to accompany Envision or Rise EPO plans for employees that reside outside of the CGHC service area. Participation 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

Status Changes / Special Enrollment Periods (SEPs)

Adding an Employee and/or Dependent

- **New Hires -** New hires and their dependents must enroll within 30 days of becoming eligible for health benefits.
- **Special Enrollment Periods** - An applicant who experiences a qualifying life event (QLE) status change may qualify for a special enrollment period and will be eligible to enroll within 30 days of the qualifying life event. The group has 60 days to report. The table below includes guidelines and form requirements for the most common qualifying life events. The group decides if part-time employees who move to full-time status have a waiting period.

Qualifying Event	Guidelines	Effective Date	Form(s) Needed
Loss of other coverage (Involuntary)	• Applications must be received within 30 days of other coverage termination. • Examples include exhaustion of COBRA; Loss of coverage on parent's plan; Loss of Medicaid, Divorce of Spouse.	Date following other coverage termination	• Employee Application • SEP Proof • Letter from the previous carrier stating loss and reason for loss
Marriage	• Employee, spouse, and newly acquired dependents may apply or employee may add spouse and newly acquired dependents. • CGHC must receive the application after the marriage date but within 30 days of marriage.	Date of Marriage	• If the employee is a new enrollee in the plan, the Small Group Employee Application must be completed. • SEP Proof - proof of marriage and marriage license • If adding a spouse, the Member Change form, and marriage license are required

Qualifying Event	Guidelines	Effective Date	Form(s) Needed
Birth	• Employee, spouse, qualified dependent, and newborn may apply, or employee may add spouse and/or newborn. • Application to add a newborn should be received within 60 days of the birth. • Applications received from day 61 to day 365 will be billed premiums back to the newborn's date of birth and interest may be applied. • Other dependents added at this time may be considered late enrollees. • Application to add other dependents must be received within 31 days of the birth. • Children from an adult-dependent are ineligible for coverage under the family policy.	Date of birth of newborn child	• If an employee is a new enrollee in the plan, a Small Group Employee Application must be completed. • If adding a dependent, a Member Change Form is required.
Adoption	• Application to add an adopted child must be received within 60 days of adoption/placement. • Employee, spouse, and new dependent may apply, or employee may add spouse and/or new dependent.	Date of order for legal adoption or placement	• If Employee is a new enrollee in the plan, a Small Group Employee Application must be completed. • If adding a dependent, a Member Change Form is required. • SEP Proof • Adoption papers

Addendum:

- Contacts & Quick Links
- Employer Application
- Employee Application
- Member Change Form

Contacts and Quick Links

Agent & Broker Services Line: 888.870.4717
sales@commongroundhealthcare.org

Quotes to quotes@commongroundhealthcare.org

Small Group Plan Administration for Employers and Plan Administrators
262.247.8050
sales@commongroundhealthcare.org

Member Services for Individuals and Employer Plan Members:
877.514.2442
8 am -5 pm CST Mon-Fri

Prescription Questions:
(OptumRx)
855.577.6545

Agent Resources
https://commongroundhealthcare.org/agent-resources-and-training/

- General Forms
- Enrollment Forms
- Payment Forms
- Rx Forms
- Marketing & Product Training

Visit https://commongroundhealthcare.org/ for additional Plan, Coverage, and Prescription Information.

Agent Portal
https://healthplans.commongroundhealthcare.org/formConsumerLogin.aspx

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 2 employee enrolling in coverage who is not the owner, business partner, or their spouse, have 2 - 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	**OR**	**Immediately Following**
☐ 0 Days		☐ 0 Days
☐ 30 Days		☐ 30 Days
☐ 60 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:

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

DEPENDENTS:

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

Member Change Form

Submit Completed Form to:
Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630

MEMBER ID # _____ GROUP NUMBER _____

I. Applicant Information

FIRST NAME	M.I.	LAST NAME	COUNTY YOU LIVE IN	DATE OF BIRTH

HOME ADDRESS – STREET	CITY	STATE	ZIP CODE

PRIMARY PHONE (include area code)	SECONDARY PHONE (include area code)	EMAIL ADDRESS

II. Reason for Application

A. UPDATE PERSONAL DATA - Choose all that apply.

- ❍ Name Change - Indicate former name: _____
- ❍ Address Change - Indicate updated address in Section I.
- ❍ Telephone Number Change - Indicate updated number in Section I.
- ❍ Date of Birth Correction - Change date to (mm/dd/yyyy) _____ for (Name) _____
- ❍ Social Security Number Correction - Change SSN to _____ for (Name) _____

B. ADD DEPENDENT(S) - Update Section III below. Date of Event: _____

❍ Birth ❍ Marriage ❍ Loss of Coverage (Please attach proof of loss.)
❍ Adoption ❍ Domestic Partner (if provided by employer) ❍ Other: _____

C. REMOVE DEPENDENT(S) - Update Section III below. Date of Event: _____

❍ Death ❍ Dependent no longer eligible ❍ Grandchild's parent turns 18
❍ Divorce ❍ Domestic Partnership Terminated (if provided by employer) ❍ Other: _____

D. CHANGE BENEFIT PLAN DESIGN - Indicate current health plan, choose one and indicate the effective date. Update Section III below.

Current Benefit Plan Design: _____
New Benefit Plan Design: _____ Effective Date: _____

E. CANCEL COVERAGE

❍ Cancel my Current Coverage Reason: _____
Effective Date of Cancellation: _____

III. Dependent Information *- List all dpendents to be added or deleted.*

DEPENDENTS (Indicate last name ONLY if different than applicant.):

NAME (FIRST, MI, LAST)	SOCIAL SECURITY NUMBER	DISABILITY (Y/N)	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP	SEX (M/F)	TOBACCO USE* (Y/N)

*Not applicable if an employer group.

PO Box 1630 | Brookfield, WI 53008-1630 **TOLL-FREE** 877.514.2442 **FAX** 262-754-9690 **WEB** www.CommonGroundHealthcare.org

IV. Applicant'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.

SIGNATURE OF MEMBER **DATE SIGNED**

IMPORTANT - PLEASE READ CAREFULLY

Information provided on this application is solely for the purpose of administering the CGHC plan(s).

To enroll in Common Ground Healthcare Cooperative Plan:

- Answer every question, providing complete information about yourself and family members you want to cover. If information is missing or incomplete, your enrollment may be delayed and/or your coverage may be limited.

To submit your application:

- Please review all information for completeness and accuracy.
- Be sure to sign and date the application.

COMMON GROUND
HEALTHCARE COOPERATIVE

NOTICE OF NON-DISCRIMINATION AND AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

Common Ground Healthcare Cooperative (CGHC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). This means that CGHC does not exclude people or treat them differently because of race, color, national origin (including limited English proficiency and primary language), age, disability, sex (including pregnancy, sexual orientation, gender identity, and sex characteristics).

CGHC provides free aids and services to people with disabilities so they may communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, and other formats)

CGHC provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please contact the CGHC Civil Rights Coordinator.

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). You can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone.

CGHC Civil Rights Coordinator
Phone Number: 414.269.4684 (TTY: 711)
Fax Number: 262.754.9690
Email: CivilRights@CommonGroundHealthcare.org
Mail: PO Box 1630
Brookfield, WI 53008-1630

U.S. Department of Health and Human Services
Phone: 1.800.368.1019 (TDD: 1.800.537.7697)
Mail: 200 Independence Avenue SW,
Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1.877.514.2442 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.514.2442 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.514.2442 (TTY/TDD: 711)
Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.514.2442 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.514.2442 (TTY/TDD: 711)	**Arabic** ةغلا ركذا ثدحتت تنك اذإ :ةظوحلم قيوغلا ةدعاسملا تامدخ نإف (TTY/TDD: 711) 1.877.514.2442 مقرب لصتا .ناجملاب كل رفاوتت
Pennsylvania Dutch Wann du [Deitsch] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.514.2442 (TTY/TDD: 711)	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.514.2442 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.514.2442 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.514.2442 (TTY/TDD: 711).	**Thai** ี ยน: ถา้ คุณพดภาษาไทยคุณสามารถใชบ้ รการชาว่ ยเหลอื ทางภาษาไดฟ้ ร โทร 1.877.514.2442 (TTY/TDD: 711).	**Laotian** ໂປດຊາບ: ຖ້າ ່ ວ ່ າ ທ ່ ່ ານ ◌ ◌ ◌