Large Employer Group Application

Health Tradition Health Plan
P.O. Box 21171
Eagan, MN 55121
877-832-1823
healthtradition.com

☐ New Group ☐ Renewal Group

Section 1 – General Information

Employer (legal name): ______________________________

Street Address:______________________________

City: ____________ **State:** ____________ **Zip Code:** __________ **County:** ______________

Mailing Address (if different than above): ______________________________

Phone Number: ____________ **Fax Number:** ____________ **Federal Tax ID Number:** ______________

Contact Person: ______________________ **Title:** ______________________

Phone Number: ____________ **Extension:** __________ **E-mail:** ______________________

Billing Contact Person: ______________ **Title:** ______________________

Phone Number: ____________ **Extension:** ____________ **E-mail:** ______________________

Employer is: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other ______________________

Description of Business: ______________________________

SIC Code: ______________________________

Name of Previous Carrier(s): ______________________ **Original Effective Date:** ____________

Employer Group Size Status: Provide the average number of employees working at your business during the entire previous calendar year. Please use the numbers reported on **last year's** Quarterly Contribution Reports (UCT-101) filed with the State of Wisconsin to calculate average number of employees.

Average Number of Employees: ____________

IMPORTANT: **If the average number of employees is 50 or less, STOP HERE.** You are a small employer. Please contact a Health Tradition Health Plan representative for information regarding a small group health plan option.

Is this group part of a controlled group connected through common ownership? ☐ No ☐ Yes

Number of employees in the controlled group, including all subsidiaries: ______________________

Do you want coverage for any subsidiaries? ☐ No ☐ Yes If yes, for each subsidiary provide the following information:

Legal name and Tax ID number: ______________________________

Address: ______________________________

Average employee count in previous calendar year :______________________________

For Medicare Coordination of Benefits. In the previous calendar year did you have:

100 or more employees on 50% of business days? ☐ No ☐ Yes

20 or more employees for each working day in each of 20 or more calendar weeks? ☐ No ☐ Yes

If yes, please indicate the date you had 20 or more employees for more than 20 weeks in the previous calendar year.

Date ______________________

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Section 2 – Health Plan Requested

1. **Requested Date of Health Plan Coverage:** ______________________________

   Note: The employer must attach a copy of the Premium Rate Sheet or Renewal Agreement Form showing the plan type, the monthly Premium for each Class of Coverage under the Benefit Plan, and any changes/renewal terms (if applicable), signed and dated by the employer, herein incorporated by reference.

2. **Renewal Date**: ______________________________

3. **Benefit Period:** (Deductible and Out-of-Pocket Accumulators):

   ☐ Calendar Year ☐ Plan Year: List Start Month: ______________________________

4. **Deductible Credit:** ☐ No ☐ Yes

5. **Type of Plan:**

   ☐ Standard HMO (attach Benefit Summary or SBC)

   ☐ Standard POS (attach Benefit Summary or SBC) (*Employers will execute a Master Contract and a POS Contract)*

   ☐ Care Plus HMO (attach Benefit Summary)

6. **Employer Contribution** (Indicate $ or %): **Single:** ____________________ **Family:** ____________________

   Note: Employer contribution must be at least 50% of the composite single rate.

Section 3 – Eligibility Information

Employee Information: Please complete the following using the **most recent** Quarterly Contribution Report (UCT-101) and supporting Quarterly Wage Report (UC-7823). Enclose a copy of each with this application or submit a census of all employees, such as a current, complete payroll.

a. Total number of employees: ____________________

b. Number of seasonal, temporary or part-time employees not eligible for coverage: ____________________

c. Number of eligible employees (all permanent employees working at least 30 hours per week must be eligible for coverage): ____________________

d. Number of eligible employees waiving coverage: ____________________

e. Number of eligible employees applying for coverage (should equal the number in "d" subtracted from the number in "c," and the number of applications submitted): ____________________

1. **Define Eligible Employees for Your Plan:** List your current eligibility criteria, including class(es) of employee(s) and minimum hours worked per week to be eligible for coverage. (Hourly requirement cannot exceed 30 hours.) If less than 30 hours, rate adjustment may apply.

   Coverage Classes (Examples include Class 1: Active Employees; Class 2: Retirees with 15 years of service etc.):

   ☐ ______________________________
   ☐ ______________________________
   ☐ ______________________________
   ☐ ______________________________
   ☐ ______________________________

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2. **If more than one health plan option is offered, are all plan options available to all eligible employee classes?**

   ☐ No ☐ Yes If no, please specify employee class(es) eligible for each: ____

   ____

3. **Do you have an orientation period that new employees must satisfy before they enter their waiting period for coverage?**

   ☐ No ☐ Yes If Yes, how long is it (may not exceed one month)? ____

4. **Effective Date or Waiting Period for New Hires** (waiting period may not exceed 90 days):

   ☐ First of the month following _____ days after the first day worked.

   ☐ Date of Hire.

   ☐ Immediately following _____ days after first day worked *(Premium is pro-rated).*

5. **Do you have a waiting period for rehires, return from layoff, or return from leave of absence (non-Family and Medical Leave Act) that is different than for new hires?** ☐ No ☐ Yes

   If Yes, you must elect the Eligibility Rider for Laid Off/Rehired Employees and Leave of Absence (non-FMLA) in Section 4 and specify a waiting period: ____

6. **Employee Termination Policy:**

   ☐ End of the month following date of termination. *The full Premium is due through the end of the coverage month.*

   ☐ Date of termination/last day employed (requires Termination Date rider – see Section 4). *Premium is pro-rated based on the date of termination.*

   ☐ Another date approved by Health Tradition Health Plan.

7. **Do you offer annual open enrollment in accordance with the Affordable Care Act (ACA)?** ☐ No ☐ Yes

   If YES, please specify below when open enrollment will be held each year.

   Open Enrollment Period: Month ____________ Day ____________ to Month ____________ Day ____________
   (Cannot exceed 31 days and must end prior to coverage effective date noted below)

   Coverage Effective Date Month ____________ Day ____________

8. **Do you continue coverage for employees on an approved paid leave of absence?** ☐ No ☐ Yes

   If YES, for how long? ☐ Until Accumulated Leave Exhausted ☐ Other: ____________________________________

Note: Coverage may only continue during a paid leave of absence as long as the individual is considered to be an employee of the employer and the employer does not discriminate for or against any eligible employee.

Individuals Not Currently At Work (please list below):

Name	Last Work Day	Expected Return to Work or Coverage End Date	Reason (i.e., COBRA/continuation, laid off, medical leave, paid non- medical leave, unpaid non-medical leave, retiree)

HEALTH TRADITION

9. **Do you cover retirees, and if so, how many are currently enrolled?** ☐ No ☐ Yes **# of retirees:** ________________________

10. **List dependents over age 26 covered under your current group plan due to disability.** Health Tradition will determine if they are eligible for coverage under the Health Tradition plan. ____
____

Section 4 – Optional Riders

1.	**Domestic Partner**	☐ No	☐ Yes	
2.	**Eligibility for Laid Off/Rehired Employees and Leave of Absence (non-FMLA)**	☐ No	☐ Yes	
3.	**Termination Date**	☐ No	☐ Yes	
4.	**Surviving Dependent Continuation**	☐ No	☐ Ongoing	☐ Limited Duration
5.	**Disabled Employee Continuation**	☐ No	☐ Ongoing	☐ Limited Duration
6.	**Retired Employee Continuation**	☐ No	☐ Ongoing	☐ Limited Duration
7.	**Retired Employee Spousal Continuation**	☐ No	☐ Yes	
8.	**Retired Employee Continuation – Consecutive COBRA**	☐ No	☐ Yes	
9.	**Drug Plan Coverage for Medicare Part D Eligible Individuals**	☐ No	☐ Yes	
10.	**Preventive Health Services (available for POS Only)**	☐ No	☐ Yes	
11.	**Out of Area Coverage (available for POS Only)**	☐ No	☐ Yes	

If YES, all Medicare-eligible individuals covered under the Disabled Employee, Surviving Dependent, and all three Retiree Continuation Riders (group or direct bill) will receive drug plan coverage.

If NO, Medicare-eligible individuals covered under the Disabled Employee, Surviving Dependent, and all three Retiree Continuation Riders (group or direct bill) must obtain other drug plan coverage when the become eligible for Medicare Part D.

Section 5 – HRA/HSA and Group Billing Information

1. **Does your plan include an HRA or HSA:** ☐ No ☐ Yes If YES, indicate type of account: ☐ HRA ☐ HSA
2. **If HRA, complete the following: HRA Vendor:** ____
3. **HRA Covers:** ☐ Deductible ☐ Copayment ☐ Coinsurance
4. **Class of Employees Eligible for HRA Reimbursement:** ____

   If you provide continued coverage for retired employees, are these individuals eligible for the HRA? ☐ No ☐ Yes
5. **Deductible Amount:** Single: $ _______________ Family: $ _______________
6. **Funding Amount:** Single: $ _______________ Family: $ _______________
7. **Employee Responsibility:** Single: $ _______________ Family: $ _______________
8. **Claims Submission:** ☐ Electronic (DBS or EBC) ☐ Paper (member sends claims to HRA vendor for reimbursement)

Monthly Billing Method: Each monthly contract charge is calculated based on the plan's enrollment records based off the premium rates in effect as listed on the Premium Rate Sheet. The employer should pay the contract charge as listed on the billing and not make any adjustments to the amount billed. Retroactivity due to member additions, terminations, or changes to coverage will be adjusted by the plan and show up on the invoice following the receipt of member change forms.

Payment Method: The Employer will send the Plan a Premium payment that equals the amount shown on each monthly billing. This payment is due on the 1st business day of the coverage month.

Section 6—Employer's Certification

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HEALTH TRADITION

As an official representative for my organization, I understand and agree that:

- Application is hereby made to Health Tradition Health Plan for issuance of a Master Contract. This Large Employer Group Application provides the specifics for the administration of the Master Contract and is to be reviewed annually.
- To the best of my knowledge and belief, all statements are true and accurate.
- Health Tradition Health Plan (Health Tradition) may request, and this organization must provide, additional information and documentation it deems necessary to administer coverage.
- Health Tradition may void or delay the implementation of coverage due to incomplete, inaccurate, or untimely information.
- An employee not actively at work on the assigned effective date will not be eligible until they have returned to work on a full-time basis, with the exception of vacation time, sick leave, or absence due to their own illness, medical condition or disability.
- I may not require employees to work more than 30 hours per week to be eligible for health coverage.
- I understand that no agent or other person has the authority to alter, bind Health Tradition, waive or change any terms, conditions, and/or provisions of the plan or any other requirement imposed by Health Tradition. Any alterations will invalidate this contract.
- This application is submitted to participate in the group health plan underwritten by Health Tradition.
- I have enclosed a copy of our most recent Quarterly Contribution Report (UCT-101) and supporting Quarterly Wage Report (UC-7823), or a current, complete employee census.

Employer Signature	**Date**
Print Name	

Section 7—Agent's Certification

I certify that I have been designated by this employer as the Agent of Record and have secured the proper documentation of this designation from the employer and provided it to Health Tradition. I further acknowledge that I have fully explained Health Tradition plan/coverage information. I have participated in the active solicitation and placement of this insurance and verify that I have witnessed the employer's signature. I understand that I have no authority to alter this application, and that any alterations will invalidate this contract. I have no authority to bind Health Tradition, by making any promises and/or representation, or to waive or change terms, conditions, and/or provisions of the plan or any requirement imposed by Health Tradition.

Agency Name	**Agent Name (print)**	
Agent Signature	**Agent License Number**	**Date** (MM/DD/YYYY)

Section 8 – Health Tradition's Certification (if no Agent of Record)

I have participated in the solicitation and placement of this health insurance.

Health Tradition Representative Signature	**Date** (MM/DD/YYYY)