

# Small Employer Group Application

Health Tradition Health Plan  
P.O. Box 21171  
Eagan, MN 55121  
877-832-1823  
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Application is hereby made to Health Tradition Health Plan for issuance of a Master Contract. This Small Employer Group Application provides the specifics for the administration of the Master Contract and is to be reviewed annually.

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 average number of employees is over 50, STOP HERE.** Please contact a Health Tradition Health Plan representative for information regarding a large 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, give legal name, Tax ID number, address, and average employee count in previous calendar year for each.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

100 or more employees during 50% of the business days?  No  Yes

20 or more employees during 20 or more weeks?  No  Yes

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

Date \_\_\_\_\_

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## Section 2—Health Plan Requested

- 1. Requested Date of Health Plan Coverage:** \_\_\_\_\_  
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:** \_\_\_\_\_  
**Benefit Period** Deductible and Out-of-Pocket accumulate based on the Calendar Year.
- 3. Type of Plan:**
  - HMO (attach Summary of Benefits and Coverage)
  - POS (attach Summary of Benefits and Coverage) *Employers electing the POS option will execute a Master Contract and a POS Contract.*
- 4. Employer Contribution (Indicate \$ or %):** **Single:** \_\_\_\_\_ **Family:** \_\_\_\_\_

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

## Section 3—Eligibility Information

- 1. 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.
  - Total number of employees: \_\_\_\_\_
  - Number of seasonal, temporary, or part-time employees not eligible for coverage: \_\_\_\_\_
  - Number of eligible employees (all permanent employees working at least 30 hours per week must be eligible for coverage): \_\_\_\_\_
  - Number of eligible employees waiving coverage: \_\_\_\_\_
  - 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): \_\_\_\_\_
- 2. 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.  
**Classes of Coverage** (examples, Class 1-Active Employees, Class 2-Retirees with 15 years of service):
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- 3. 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 \_\_\_\_\_
- 4. 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)? \_\_\_\_\_

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**5. Effective Date and Waiting Period for New Hires (waiting period may not exceed 90 days)**

First of the month following \_\_\_\_\_ days after first day worked (0, 30, or 60).

**Termination Policy:** end of the month following the date of termination; the full premium is due through the end of coverage month.

**6. 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:** From: \_\_\_\_\_ To: \_\_\_\_\_  
(cannot exceed 31 days and must end prior to coverage effective date noted below)

**Coverage Effective Date:** \_\_\_\_\_

**7. Do you cover a retiree class?**  No  Yes **If yes how many are covered?** \_\_\_\_\_

**8. Individuals Not Currently At Work but covered under plan (please list below):**

Name	Last Work Day	Coverage End Date	Reason (i.e., COBRA/Continuation, FMLA ,Retiree)

## Section 4—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 following receipt of member change forms.

**Rates are calculated per person covered under the contract. Family contracts are charged for each dependent child age 21 to 25. For dependents under age of 21, you only pay for the three oldest.**

**Payment Method:**

The Employer or Subscriber will send the Plan a Premium payment that equals the amount shown on each monthly billing. This payment is due on the 1<sup>st</sup> business day of the coverage month.

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## Section 5—Employer’s Certification

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

- To the best of my knowledge and belief, all statements are true and accurate.
- The Health Tradition Health Plan (Health Tradition) may request further information if it deems necessary.
- 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.

<b>Employer Signature</b>	<b>Date (MM/DD/YYYY)</b>
<b>Print Name</b>	

## Section 6—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.

<b>Agency Name</b>	<b>Agent Name (print)</b>	
<b>Agent Signature</b>	<b>Agent License Number</b>	<b>Date (MM/DD/YYYY)</b>

## Section 7—Health Tradition’s Certification (if no Agent of Record)

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

<b>Health Tradition Representative Signature</b>	<b>Date (MM/DD/YYYY)</b>
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