COMMON GROUND
HEALTHCARE COOPERATIVE

Small Employer Group Application

Requested Effective Date: _____

Submit completed application to:
Common Ground Healthcare Cooperative
120 Bishop's Way, Suite 150
Brookfield, WI 53005-6271

Section I – Group Information

Legal Name of Business

Doing Business As (dba)

Legal Form of Business
❍ Sole Proprietor ❍ Partnership ❍ Corporation ❍ Nonprofit ❍ Other: _____

Street Address

City: State: ZIP Code: County:

If billing address is different from the address listed above, please indicate it here:

City: State: ZIP Code:

Telephone Number | Fax Number | Date Business Established

Federal Tax ID Number (FEIN)

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

(1) Do any of the owners, either individually or in combination, own 50% or more of this company and 50% or more of any other company? ❍ Yes ❍ No
(2) Does the business above own any other companies or is the business above owned by any other company or legal entity? ❍ Yes ❍ No

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

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

Administrative Contact Name, Title, Phone Number and Email Address

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

Section II – Eligibility Information

In order to determine the employer group status of your business, what was the average number of employees working at your business during the most recent calendar year (January through December)? _____ *(Small employer is defined as 2-50 total employees. Please use the numbers reported on your quarterly contribution report(s), including all commonly owned businesses, for the most recent calendar year to determine this number).*

Current employee information:

a. _____ Total number of permanent active employees currently on your payroll
b. _____ Number of permanent employees eligible for health insurance
c. _____ Number of permanent employees NOT eligible for health insurance
d. _____ Number of employees who are seasonal or temporary

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

Employer contribution percentage: Single: _____ Family: _____

Please note: Employers are required to contribute a minimum of 50% of the single premium for all employees.

Are you requesting domestic partner coverage? ❍ Yes ❍ No (Domestic Partner Eligibility Criteria must be followed.)

Section III – Requested Plan Information

Do you want to offer benefits by class? ❍ Yes ❍ No

If "Yes," please select which classes you have: ❍ Union ❍ Non-Union

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

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

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

Section VI - 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 application 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 employee not actively at work on his/her assigned effective date will not be eligible until he/she has returned to work on a full-time basis (with the exception of vacation time or medical leave/sick day).

f. 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 VII - 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 applicaiton to bind Common Ground Healthcare Cooperative by making any promise and/or representation, or to waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Common Ground Healthcare Cooperative.

Writing Agent's Signature: _____ Printed Name: _____ Date of Signature: _____

Writing Agent's NPN: _____ Agency Name: _____ Tax Identification Number: _____