# ENROLLMENT REQUIREMENTS CHECKLIST

## SMALL GROUP

- ☐ Completed Employer Application
- ☐ Completed Employee Applications – Including Waivers
- ☐ Disclosure of Rating and Renewability Form
- ☐ Copy of Invoice from most recent carrier
- ☐ Copy of Sold Quote
- ☐ Copy of most recent Wage & Tax Form – Full-time and Part-Time employees noted
- ☐ Affidavit of Domestic Partnership Form – only if Domestic Partner Coverage was checked on Employer Application

**All documentation MUST be submitted by the 10th of the month or the next business day in order to have coverage effective on the 1st of the following month.**

If you have any questions,
please give us a call at: 855.494.2667

# Small Employer Group Application

COMMON GROUND
HEALTHCARE COOPERATIVE

Requested Effective Date: __________________.

- **All required documents must be received by the 10th of the month prior to the requested effective date.**

**Completed applications can be sent to:**
**Fax completed form to:** (262) 754-9560 Attn: Sales
**Email to:** Sales@Commongroundhealthcare.org

## Section 1- Group Information

**Legal Name of Business**

| **Doing Business As (DBA)** | **Legal Form of Business**<br>☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Nonprofit ☐ Other: ___________ |
|---|---|

**Business Address- street address (must be in the CGHC Service Area)**

| **City** | **State** | **ZIP Code** | **County** |
|---|---|---|---|

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

| **City** | **State** | **ZIP Code** | **County** |
|---|---|---|---|

| **Phone number** | **Email address** | **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 and 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**

**NEED HELP COMPLETEING THIS APPLICATION?** Contact your insurance agent or Common Ground Healthcare Cooperative representative with questions at 888.870.4717.

# Small Employer Group Application

COMMON GROUND
HEALTHCARE COOPERATIVE

## 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 employees. Use the numbers that are reported on your quarterly contribution report(s), including all owned businesses, for the most recent calendar year to determine this number.

Is your company enrolling through the Small Business Health Options Program (SHOP)? ☐ **YES** ☐ **NO**
*More information can be found at www.healthcare.gov/small-businesses/choose-and-enroll/qualify-for-shop-marketplace*

**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 eligible for health insurance who reside outside of the CGHC Service Area**
d. ______________________________________ **Number of permanent employees NOT eligible for health insurance**
e. ______________________________________ **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:__________________________
*Employers are required to contribute a minimum of 50% of the single premium for all employees.*

## 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**

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

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

**PLEASE NOTE**: Waiting periods for new employees may be changed only at renewal.

- First of the month following: ☐ 0 Days ☐ 30 Days ☐ 60 Days
- Immediately following: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

**Does the waiting period apply to all classes of employees?** ☐ **YES** ☐ **NO**
If "No", please list each class and their probationary period requirements. ______________________________________________

**Employee termination is effective:** ☐ End of day the employee terminates ☐ End of the month the employee terminates

- Does this termination requirement apply to all classes of employees? YES NO
- If "No", please list each class and their termination requirement.

**Benefit Plan** *Plans may only be changed at renewal.*

**CGHC Benefit Plan Name(s):** *Please list the plan name exactly how it appears on the rate sheet*

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

# Small Employer Group Application

COMMON GROUND
HEALTHCARE COOPERATIVE

**NEED HELP WITH THIS FORM?** Contact your insurance agent or Common Ground Healthcare Cooperative representative with questions at 888.870.4717.

## 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.***

## Section V - Employer Certification

# Small Employer Group Application

COMMON GROUND HEALTHCARE COOPERATIVE

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: | Tax Identification Number: |

# Small Group Employee Application

COMMON GROUND
HEALTHCARE COOPERATIVE

**IMPORTANT - PLEASE READ CAREFULLY**

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

**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.
- Please provide Social Security numbers to match your enrollment information to your assigned Member ID number for administrative purposes.

**To submit your application:**

- Please review all information for completeness and accuracy.
- Be sure to sign and date the application.
- Submit the application to your employer or as instructed by your employer.

## Section I-Enrollment Information

- **Event Status:** ☐ New Group ☐ New Hire ☐ Other: _________ ☐ Special Enrollment Period (Describe):
- **Employee Status:** ☐ Active Employee ☐ New Hire ☐ Waiver ☐ Cobra/Continuation

| Name of Employer | Group Number | Effective Date |
|---|---|---|
| | | |

## Section II-Employee Information

| First Name | M.I. | Last Name | HRS Worked per wk. | Hire Date |
|---|---|---|---|---|
| | | | | |

| Home Address- street address |
|---|
| |

| City | State | ZIP Code | County | Email Address |
|---|---|---|---|---|
| | | | | |

| Primary phone (include area code) | Secondary phone (include area code) | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Windowed ☐ Domestic Partner |
|---|---|---|
| | | |

## Section III- Plan Selection

**Please indicate the CGHC Plan that you are enrolling in:** ________________________________

**I am applying for coverage for: (check all that apply)**

☐ Myself
☐ My spouse
☐ My dependent child(ren)
☐ Domestic partner (if coverage is offered by your employer.) Must complete Domestic Partnership attestation.

## Section IV- Other Insurance Information

| **Will you or any family members covered by this policy have other health insurance coverage when this policy becomes effective?** | ☐ **YES** ☐ **NO** |
|---|---|

# Small Group Employee Application

## 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 SELF | Sex (M/F) |
|---|---|---|---|---|---|

**DEPENDENTS: (Indicate last name ONLY if different than employee)**

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

| Employee Signature: | Date of Signature: |
|---|---|

**Complete the waiver on page 3 if waiving/declining group coverage.**

# Small Group Employee Application

COMMON GROUND HEALTHCARE COOPERATIVE

## Section VII – Waiver of Coverage

**I am declining group health coverage for:** ☐ Myself ☐ Myself and all eligible dependents ☐ My eligible dependents listed below

**Complete the following for all dependents waiving coverage:**

| Name (First, M.I., Last) | Relationship to Employee | Date of Birth | Sex |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Please check the reason(s) why you and/or your dependents are waiving coverage.**

- ☐ Persons listed above have other group coverage. **Please complete section below*.**
- ☐ Persons listed above are covered by Medicare or Medicaid (Badger Care). **Please complete section below*.**
- ☐ Persons listed above have other individual coverage. **Please complete section below*.**
- ☐ I am, and my dependents are, in good health.

***Complete this section if you or your dependents have other insurance coverage.**

| Name of Carrier | Phone Number of Carrier | Policy Number | Name of Policyholder |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I also understand that if I apply for coverage in the future, I and/or my eligible dependents will be considered a Late Enrollee(s) 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 below.

Further, I certify that I and/or my eligible dependents have not been influenced in any way to waive coverage through CGHC by my employer, agent, or Common Ground Healthcare Cooperative.

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

## NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself and/or your dependents (including spouse) because of other 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.

**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 line

CGHC.FO.1002-2020

# AFFIDAVIT OF DOMESTIC PARTNERSHIP FOR DOMESTIC PARTNER BENEFITS

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 |