

Small Employer Group Application

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 <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Nonprofit <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
(2) Does the business above own any other companies or is the business above owned by any other company or legal entity? <input type="checkbox"/> YES <input type="checkbox"/> 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?
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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.

CGHC | 120 Bishop's Way, Suite 150, Brookfield, WI 53005-6271 | TOLL-FREE 1-877-450-8497 | FAX 262-754-9690 | www.CommonGroundHealthcare.org

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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:

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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

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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: