Employer Group Application

Employer Data

Group # **Requested Effective Date:** ____________

1. **Corporate Name** of Employer: ____________
2. Address: ____________
   Street City State Zip
3. DBA: ____________
   Address: ____________
   Street City State Zip
4. Employer Tax ID Number: ____________
5. Billing Address: ____________
   Street City State Zip
6. Executive Contact Name: ____________ Title: ____________
   Address: ____________
   Phone: ( ) ____________ Fax: ( ) ____________
   Email Address: ____________
7. Administrative Contact: ____________
   Address:
   Phone: ( ) ____________ Fax: ( ) ____________
   Email Address: ____________
8. Type of Ownership: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Limited Liability Corp.
9. Nature of Business: ____________ # years in business: ____________
10. Name of Worker's Compensation Carrier: ____________ S.I.C. # ____________
11. List names of any owners/officers/partners who are not legally required to be covered by Worker's Compensation, and need on-the-job medical coverage with Network Health Plan (NHP) or Network Health Insurance Corporation (NHIC):
    ____________ ____________ ____________ ____________
12. Will this coverage replace your current group health coverage? ☐ Yes ☐ No
    If yes, list your current health insurance carrier: ____________ Initial effective date: ____________
13. Will your employees have access to another medical plan due to their employment with you? ☐ Yes ☐ No
    If yes, name of carrier(s): ____________
14. COBRA – are any present or former employees or their dependents, including eligible owners, currently on or eligible to elect COBRA/State Continuation? ☐Yes ☐ No If Yes, complete the following:

Name	**COBRA / State Cont. Start Date**	**Expiration Date**	**Qualifying Event / Date (i.e. termination, divorce, etc.)**

15. Employer contribution** Single: ______ % EE & Child(ren): ______ %
    Family: ______ % EE / Spouse: ______ %

****NHP and NHIC have a minimum employer contribution requirement of 50% of the single premium of the lowest cost plan offer.**

HMO plans underwritten by Network Health Plan.
POS plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Plan.

ELIGIBILITY

All employees working a minimum of 30 hours per week are eligible. If requested in writing and approved by NHP, employees working less than 30 but not less than 20 hours per week may be eligible.

1. Hourly requirement (cannot be greater than 30): ____________________
2. Total number of employees: ____________________
3. Total number of eligible employees: ____________________
4. Total number of eligible employees enrolling: ____________________
5. Total number of eligible employees waiving due to other coverage: ____________________
6. Dependent eligibility requirement unless otherwise noted:
   - Network Health Plan adheres to Wisconsin statute s. 632.885 for all dependent eligibility requirements.

Employees must apply within thirty-one (31) days of becoming eligible, or they will be considered a late applicant.

7 Employee waiting period: ☐ None ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

8 Employee effective date: ☐ first of month after waiting period ☐ Immediately after waiting period

9 Do you want new employees currently in their waiting period to be eligible as of the group's plan effective date?
☐ Yes ☐ No

10 Rehires: ☐ Treat as a new employee
☐ Waive waiting period if rehired within ________ days ________ months

11 Employee ceases to be eligible: ☐ Immediately ☐ End of month

12 Are any employees or dependents totally disabled, confined to a nursing facility, or hospitalized at the current time?
☐ Yes ☐ No
If Yes, give names, ages, date of disability:

____________________ ____________________

____________________ ____________________

13 If large group offers medical benefits to retired employees up to age 65, state attained age and years of service for retiree class eligibility. Benefits will be effective for retirees if approved.

Age ___________ Years of Service ______________ Employer Contribution ____________________

14 **Are you enrolling as part of a Chamber of Commerce or Association?** ☐ Yes ☐ No

15 **If Yes, list name of Chamber or Association:** ____________________

16 **Is this contract part of a union negotiated agreement?** ☐ Yes ☐ No

17 **If Yes, please provide a copy of the union contract. Expiration date**: _____ / _____ / _____

18 **Requested Benefit Plan:** ____________________

19 **Plan or calendar year deductible:** ____________________

20 **(Open enrollment 51+)** Do you offer open enrollment at renewal? ☐ Yes ☐ No

If Yes, to be effective, the employee must complete and sign the enrollment application within 31 days of the group's renewal date.

NOTE: Late applications will be subject to an 18-month waiting period.

TERMS AND CONDITIONS

Application Submission

Group understands that providing incomplete, inaccurate, or untimely information may delay, void, reduce, or terminate an individual's coverage or the Group's coverage. The Group shall furnish to NHP any information required for NHP to administer the policy. NHP reserves the right to contact any employee at the place of business to complete the enrollment process. The Group shall have records available for NHP to inspect at any time insurance is in force, and to the earlier of three years after termination date or final adjustment and settlement of claims is made.

Please submit the following forms for application of coverage:

1. Employer Group Application
2. Completed employee enrollment forms
3. Waiver forms with copy of other insurance ID cards when requested
4. A copy of the quoted rates
5. A copy of your current carrier's benefit design(s)
6. A completed EFT application form when requested
7. New Group Submission Checklist (groups of 2-50 employees only)
8. Small Employer Renewability Provisions Form (groups of 2-50 employees only)
9. A completed copy of the most recent filing of UCT State Quarterly Unemployment Compensation Report Form (groups of 2-50 employees only)
10. A copy of current billing if replacing coverage (groups of 2-50 employees only)
11. First month's premium (groups of 2-50 employees only)

UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP COVERAGE WITHOUT PRIOR WRITTEN NOTICE OF APPROVAL BY NHP or NHIC.

Coverage is not in effect unless and until the Group receives written notification from NHP. The premium deposit amount will be returned to the Group if coverage is declined.

Application Terms

Group understands and agrees that neither the Group nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract or waive any of NHP's or NHIC's other rights or requirements. No agent or field representative of NHP or NHIC has the authority to modify any terms or conditions of applications, policies, or contracts.

Authority of Agent

No agent or field representative of the insurance company has the authority to waive any of NHP's or NHIC's other rights or requirements, pass on insurability, or waive a complete answer to any questions, nor bind the insurance company by making any promises or representations, written or verbal. The undersigned agrees that any such attempt by the agent is void and is not effective.

Participation

The Group must maintain NHP's employee participation requirements for all lines of coverage. Failure to maintain the participation requirement will terminate your coverage under the terms of the policy. Other termination provisions are stated in the policy.

For groups of 2 to 50 employees, the following are NHP's participation requirements.

Number of Eligible Employees	Number that Must Enroll
2-4	2
5-6	3
7	4
8-9	5
10	6
11-50	70%

Those waiving coverage under this policy, due to other creditable coverage, are not considered eligible employees.

Payment and Enrollment Submission

If an employee's effective date falls on or before the 15th of the month, the employer group will be charged for that full month's premium. If the effective date falls on the 16th – 31st, the employer group will be charged beginning with the following month of coverage.

If an employee's termination date falls on or before the 15th of the month, the employer group is not charged for that month's premium. However, if the termination date falls on the 16th -31st, the employer group is charged for the entire month of coverage.

The Group's first month's premium must be submitted with the Employer Group Application. All premiums must be paid with the Group's business check written out to NHP and/or by electronic transfer when an electronic fund transfer business account is established. A $15 fee per month will be charged to all employer groups that pay their premiums via check. Also, a $25 service fee will be applied to non-sufficient funds when allowed by state law. **Group agrees to collect any employee contribution toward premium.**

The Group agrees to submit to NHP enrollment information for each employee. The Group will submit any changes in enrollment information on at least a monthly basis, and to arrange for submission to NHP notice of the date on which any employee terminates enrollment. All enrollment information shall be submitted prior to or within 31 days of the date the employee's coverage becomes effective or terminates, as the case may be. The eligible employee must sign the enrollment information form and notice must be given to NHP before coverage is to become effective.

Termination

NHP or NHIC may cancel the Group's policy if the Group fails to make timely premium payment. Cancellation does not prejudice a valid claim existing on termination date. The Group is solely responsible to notify insured persons of termination, and to return to employees the portion of any contribution toward premium payment made after termination date. The Group shall be responsible to pay to NHP the premium amount owed during the grace period.

NHP will furnish the Group with notices in sufficient number to be distributed to covered employees advising them of their rights in the event of termination due to cessation of business or nonpayment of premium.

NHP or NHIC may discontinue offering a particular plan on a statewide basis in accordance with Wisconsin law.

In no case will NHP or NHIC return to the Group the premiums for more than 3 monthly periods in the case of a notice of termination of a member's enrollment which is received more than 30 days after the effective date of such termination.

Group termination notification must be made to NHP in writing no later than 31 days beyond the requested termination date. Failure to comply may result in forfeiture of premium.

90-Day Deferred Termination

When an employee ceases to be actively at work, i.e. an employee is on a leave of absence, after 90 days the employee will cease to be covered under this plan (disenrolled) and must be offered COBRA coverage and/or state continuation coverage by the employer.

SPECIAL COMMENTS

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EMPLOYER GROUP CERTIFICATION

The undersigned, as authorized representative of the Employer Group applying for insurance coverage, (“Group”) certifies reading the entire completed application and that the information provided is accurate and complete. The Group agrees to provide the documentation requested by NHP, which establishes that all eligibility and participation requirements of the policy are met. Group also certifies that business records maintained by the Group can substantiate the information provided here.

The Group also certifies that the insurance agent has explained the coverage, limitations, and exclusions, other details of coverage of the insurance applied for, and the rules and regulations of NHP or NHIC. This document will form part of any policy issued upon NHP’s acceptance of Group’s application for coverage. Group accepts and agrees to the provisions contained in this Employer Group Application.

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Signature of Authorized Group Representative

Title	Date

I, (agent) certify that I met with the Employer submitting this application and fully explained its contents. I discussed coverage, eligibility, pre-existing condition limitations, and effect of misrepresentations and termination provisions. I certify that I have made the rate disclosure required by **WI Statute 635.11 1-4.**

Signature of Writing Agent	Agent Code
Agency	Date
NHP or NHIC Representative	Date