

## Group Application - Small Employer

**PLEASE NOTE: INCOMPLETE OR MISSING INFORMATION THAT IS MATERIAL TO THE UNDERWRITING OF THE GROUP WILL CAUSE A GROUP TO BE CONSIDERED AS A NON-SUBMISSION UNTIL THE INFORMATION IS COMPLETE.**

**Please complete these forms and verify or attach the following:**

- Completed Small Group Employer Application
- Minnesota State Employer's Quarterly Wage and Detail Report (Form MDES-1D) including the following:
  - Termination dates for all employees no longer employed by the company and whether or not they accepted COBRA/Continuation coverage through the employer
  - Include information regarding any **NEW HIRES AND OWNERS** not listed on the Minnesota State Employer's Quarterly Wage and Detail Report (Form MDES-1D) on page 2 of this form
  - Indicate all part-time employees, including the number of hours per week worked by each.
- Complete business filings from most recent tax year for business owners**  
**Please refer to your tax document guidelines for small employer (2-50)**
- Copy of most recent bill from current HEALTH insurance carrier.
- Copy of most recent renewal and claims information from current HEALTH insurance carrier.
- All completed enrollment forms - *Please verify that forms are complete, especially the prior health carrier/pre-existing condition information (section V of the Small Group Employee Application).* Other commonly missing information includes: hours worked per week, signature and date, height, weight, birthdates and health information (in section VI). The enrollment application must be completed only by the employee.
- If an employee is waiving coverage, be sure that the employee has indicated the reason for waiving by checking the appropriate box and signing within Section III of the Small Group Employee Application.
- All spouses/dependent children must be accounted for on the enrollment application or appropriately indicated within the waiver section with signature.
- Upon acceptance and prior to the requested effective date, a check for the first month's premium made payable to HEALTHPARTNERS, INC. If a check is not submitted prior to the effective date there may be delays in implementation.

Please be sure to account for Employees and Owners NOT included on the Minnesota State Employer's Quarterly Wage and Detail Report (Form MDES-1D) in the space provided on Page 2.

**HealthPartners will request additional information as deemed necessary.**  
**Please refer to our Tax Documentation Guidelines for Small Employers.**

**Reminder: To ensure timely delivery of an effective date, please submit completed information at least 30 days before the requested effective date.**



**EMPLOYER ELIGIBILITY INFORMATION**

Today's Date \_\_\_\_\_ Requested Eff. Date \_\_\_\_\_ HealthPartners Sales Executive \_\_\_\_\_

Full Legal Group Name \_\_\_\_\_ DBA (if applicable) \_\_\_\_\_

Address \_\_\_\_\_ County \_\_\_\_\_ Phone( ) \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_ email \_\_\_\_\_

Is Contact Person an eligible employee?  YES  NO If NO, please explain: \_\_\_\_\_

Who are the owners? \_\_\_\_\_ Percent of ownership for each owner \_\_\_\_\_

Are they eligible for coverage?  Yes  No If NO, explain \_\_\_\_\_

Number of years in business \_\_\_\_\_ Group's Federal Tax ID number \_\_\_\_\_ Industry \_\_\_\_\_

**TYPE OF ENTITY:**  S Corporation  C Corporation  Sole Proprietorship  Partnership  
 Non-Profit  LLC (circle one to the right: C Corporation Sole Proprietorship Partnership)

Corporate headquarters location (City and State and/or Country): \_\_\_\_\_

■ Is this organization in any way related to other companies (such as a national corporation) as a wholly or partially owned subsidiary, or does this organization own any other companies or have wholly or partially owned subsidiaries?  
 YES  NO **If YES, please provide a cover letter explaining the structure.**

■ On average, how many individuals did this organization employ (in all locations combined), working a minimum of 20 hours per week, throughout the preceding calendar year (January to December)? \_\_\_\_\_ (Excluding seasonal,\* temporary and union employees covered under a collective bargaining agreement)

■ Currently, how many employees are working a minimum of 20 hours per week? \_\_\_\_\_

■ How many employees reside outside of Minnesota? \_\_\_\_\_ (Submit wage and tax for each state)

■ If you elect coverage, will you be offering a Medical Expense Reimbursement plan?  YES  NO

■ Does this organization currently have any leased employees?  YES  NO If YES, please explain: \_\_\_\_\_

■ Does this organization currently have, intend to have, or ever had a Professional Employer Organization (PEO) agreement?  
 YES  NO **If YES, please provide a copy of the agreement.**

Please provide the name of the PEO: \_\_\_\_\_ Date of PEO agreement termination: \_\_\_\_\_

■ Does this organization intend to offer domestic partner coverage?  YES  Same gender  NO  
 If yes, please complete domestic partnership agreement and affidavit.  Opposite gender  
 ♦ Additional information may be required by HealthPartners.

**PARTICIPATION / EMPLOYEE ELIGIBILITY INFORMATION**

**All Eligible Employees Must Work AT LEAST \_\_\_\_\_ Hours Per Week**

Classification(s) of Employees Excluded from Coverage:  Union covered by a collective bargaining agreement  Part-time  
 Union not covered by a collective bargaining agreement  Salaried  
 Other (explain): \_\_\_\_\_  Hourly  
 Owners

Are Retirees eligible for coverage?  YES  NO

Waiting Period for New Employees:  Date of Hire **OR** First of the month following (check one below):  
 30 days  60 days  90 days  Other, explain: \_\_\_\_\_

Total number of eligible employees including employees in their waiting period that meet the above eligibility requirements: \_\_\_\_\_

Total number of eligible employees that are applying for coverage: \_\_\_\_\_

Total number of employees that are waiving coverage: \_\_\_\_\_

Number of former employees on COBRA continuation: \_\_\_\_\_

**Employer Contribution:** Minimum 50% of single coverage, or **Medical:** \_\_\_ Single \_\_\_ Family **Dental:** \_\_\_ Single \_\_\_ Family (if applicable)

\* Some seasonal employees may be eligible for coverage if certain conditions are met concerning their employment. If providing coverage for seasonal employees, the employer must complete the Small Employer Agreement to Cover Seasonal Employees form (HP490011). Contact your HealthPartners Sales Representative for details.  
 If providing coverage to seasonal employees, please indicate the number of seasonal employees working a minimum of 20 hours per week: \_\_\_\_\_

## EMPLOYEES AND OWNERS NOT ACCOUNTED FOR ON QUARTERLY WAGE AND DETAIL REPORT

Please use this space to account for Employees and Owners NOT included on the Minnesota State Employer's Quarterly Wage and Detail Report (Form MDES-1D). Additional documentation may be required regarding owners.

EMPLOYEE / OWNER NAME	SOCIAL SECURITY NUMBER	HIRE DATE	TERMINATION DATE	# OF HOURS WORKED

## FORMER EMPLOYEES ENROLLED WITH COBRA COVERAGE

Please use this space to account for former employees covered by COBRA continuation. Indicate either the notification date if the individual is currently under COBRA or the cancellation date if an individual's COBRA coverage is terminating. **Employers must also complete the Small Employer Verification of Terminated Employees form (HP490016).**

FORMER EMPLOYEE NAME	SOCIAL SECURITY NUMBER	NOTIFICATION DATE	COBRA TERMINATION DATE

## CURRENT CARRIER INFORMATION

Current **MEDICAL** Insurance Carrier \_\_\_\_\_ Type of Coverage (circle one)  GROUP  INDIVIDUAL

Please list ALL medical carriers for the previous 5 years (if needed, attach additional pages):

NAME OF CARRIER	RENEWAL DATE	DATES OF COVERAGE	REASON FOR TERMINATION

Renewal Rates:  Single  Family Renewal Plan (product) Name: \_\_\_\_\_

Current **DENTAL** Insurance Carrier \_\_\_\_\_ Renewal Date \_\_\_\_\_

## AGENT / BROKER INFORMATION

Agent Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Broker Number \_\_\_\_\_

email Address \_\_\_\_\_

Agent of Record signature \_\_\_\_\_ Printed Name and Company \_\_\_\_\_ Date \_\_\_\_\_  
(if applicable)

## EMPLOYER SIGNATURE

I hereby certify that the information provided in this document, and any additional information submitted to support this application, is accurate and complete.

I understand that errors or omissions regarding this information may result in premium adjustments and/or termination of the contract as permitted by Minnesota law.

CEO/Owner/Authorized Company Representative \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**PRODUCT SELECTION**

**MEDICAL PRODUCTS:**

**HealthPartners Open Access Choice Plans**

**Copayment options:**

- |                                  |                                 |                                 |                                 |
|----------------------------------|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> 15-100% | <input type="checkbox"/> 15-90% | <input type="checkbox"/> 15-80% | <input type="checkbox"/> 25-80% |
| <input type="checkbox"/> 20-100% | <input type="checkbox"/> 25-90% | <input type="checkbox"/> 20-80% | <input type="checkbox"/> 35-80% |
|                                  |                                 |                                 | <input type="checkbox"/> 45-80% |

**Deductible / Copay Choice Plans**

- | <b>200 Series</b>               | <b>300 Series</b>               | <b>500 Series</b>               | <b>750 Series</b>               |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> 200/15 | <input type="checkbox"/> 300/15 | <input type="checkbox"/> 500/15 | <input type="checkbox"/> 750/15 |
| <input type="checkbox"/> 200/25 | <input type="checkbox"/> 300/25 | <input type="checkbox"/> 500/25 | <input type="checkbox"/> 750/25 |
| <input type="checkbox"/> 200/35 | <input type="checkbox"/> 300/35 | <input type="checkbox"/> 500/35 | <input type="checkbox"/> 750/35 |
|                                 |                                 | <input type="checkbox"/> 500/45 | <input type="checkbox"/> 750/45 |

**Deductible Choice Plans**

- |                                     |                                      |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Choice 200 | <input type="checkbox"/> Choice 750  |
| <input type="checkbox"/> Choice 300 | <input type="checkbox"/> Choice 1000 |
| <input type="checkbox"/> Choice 500 |                                      |

**Empower HSA Midwest Choice<sup>SM</sup> Plan (HDHP)**

- |                                      |                                      |                                      |                                      |
|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> \$1,200/100 | <input type="checkbox"/> \$1,500/100 | <input type="checkbox"/> \$2,000/100 | <input type="checkbox"/> \$2,600/100 |
| <input type="checkbox"/> \$1,200/80  | <input type="checkbox"/> \$1,500/80  | <input type="checkbox"/> \$2,000/80  | <input type="checkbox"/> \$2,600/80  |

**Distinctions<sup>SM</sup>**

- |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> \$15-\$30 | <input type="checkbox"/> \$20-\$35 | <input type="checkbox"/> \$25-\$45 |
|------------------------------------|------------------------------------|------------------------------------|

**National Choice** (available for groups with more than 5 employees enrolled)

- |                                  |  |
|----------------------------------|--|
| <input type="checkbox"/> 15-100% | <input type="checkbox"/> 20-80%                  |
| <input type="checkbox"/> 15-80%  | <input type="checkbox"/> 500-15 Deductible-Copay |
|                                  | <input type="checkbox"/> 1000 Deductible         |

**HealthPartners Compliance Plans**

- |   |  |
|---|--|
| <input type="checkbox"/> Copayment Plan | <input type="checkbox"/> Deductible Plan |
|---|--|

**Health Investment Program**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**DENTAL PRODUCTS:**

May also be purchased on a stand-alone basis.

<b>Select network:</b>	<input type="checkbox"/> Classic	<input type="checkbox"/> HealthPartners
<b>Select plan:</b>	<input type="checkbox"/> Basic Choice	<input type="checkbox"/> Standard Choice
	<input type="checkbox"/> Basic Voluntary <sup>2</sup>	<input type="checkbox"/> Advantage Choice
	No Ortho with Voluntary plans	
<b>Select Ortho:</b> (OPTIONAL)	<input type="checkbox"/> Ortho Plan 750 <sup>1</sup>	<input type="checkbox"/> Ortho Plan 1000 <sup>1</sup>

<input type="checkbox"/> Exceed Choice	<input type="checkbox"/> Ortho Plan 750 <sup>1</sup> (OPTIONAL)
<input type="checkbox"/> Exceed Voluntary <sup>2</sup>	<input type="checkbox"/> Ortho Plan 1000 <sup>1</sup> (OPTIONAL)
No Ortho with Voluntary plans	
<input type="checkbox"/> Customized Options 1000 <sup>3</sup>	
<input type="checkbox"/> Customized Options 1000 (with ortho)	
<input type="checkbox"/> Customized Options 2000 <sup>4</sup>	
<input type="checkbox"/> Customized Options 2000 (with ortho)	

<sup>1</sup> Must have 10 or more employees enrolled to be eligible for orthodontic products and currently offer an orthodontia benefit.

<sup>2</sup> Must have 5 or more employees enrolled to be eligible for voluntary plans.

<sup>3</sup> Available to groups with 15-200 enrolled employees

<sup>4</sup> Available to groups with 30-200 enrolled employees

HealthPartners will notify employees covered on HealthPartners plans of the special enrollment periods detailed in the Federal Register 2590.701-6. It is the responsibility of the employer to notify those employees who decline HealthPartners coverage of their special enrollment rights.



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