SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

Large or Small Employer (Existing)

Employer Renewal Questionnaire

General

Employer group name _____ Group no. _____

1. Number of employees as of today _____
   [Including new hires in waiting period, all part-time employees, owners, partners and those working outside the state of Wisconsin. This information is needed to identify if your business is subject to COBRA requirements. You can find this information on your Quarterly Wage and Tax Statement.] Public employers – include your volunteer workforce counts that are typically included on your Workers' Compensation (WC) submissions.
2. List number of employees eligible for health insurance benefits _____
   [Number of employees who work on a permanent basis and have a normal work week of 30 or more hours. This includes a sole proprietor, a business owner (including the owner of a farm business), a partner of a partnership or a member of a limited liability company, if the sole proprietor, business owner, partner or member is included as an employee under the health benefit plan of an employer. Do not include employees who work on a temporary or independent contractor basis. (reference Wis. Stats. 632.745 (5) (a))]
3. To the best of your knowledge, how many eligible employees not covered by Security Health Plan have other creditable coverage _____
   [Creditable coverage includes other employer group coverage, individual coverage, Medicare, Medicaid, BadgerCare or Tricare (military service coverage). The employee waivers you have on file reflect this number.]
4. Are all your employees covered under your WC coverage: ☐ Yes ☐ No

   If no, list employees who are not on WC coverage _____

   _____
5. Is your company under common ownership with other companies or part of a national company *(including, but not limited to, multiple locations and subsidiaries)*: ☐ Yes ☐ No

   If yes, list name and location of business (Security Health Plan may request that you complete a new Employer Group Application) _____

   _____
6. What **percentage** of the monthly premium is to be paid by the employer for each of the following coverages **(each must be at lease 25%)**: Single _____ Employee & spouse _____ Employee & child(ren) _____ Full family _____
7. Does your company contribute money toward your employees' out-of-pocket expenses (deductible and/or coinsurance)? This may be in the form of a health savings account (HSA) or a health reimbursement arrangement (HRA): ☐ Yes ☐ No

   If yes, indicate amount: **HSA** – Single $ _____ Family $ _____ **HRA** – Single $ _____ Family $ _____
   Indicate the HRA vendor: ☐ EBC ☐ DBS ☐ Other _____

The information provided above is accurate and complete to the best of my knowledge.

Completed by _____ Date _____

Title _____ Direct phone number _____

Email address _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Return this form via email to your Account Manager or fax to 715-221-9456, along with your renewal paperwork.

