Security Health Plan℠

Promises kept, plain and simple.®

Security Health Plan℠

Security Administrative Services

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

1.800.622.7790 | TTY 711

Large and Small Employer

Employer Health Insurance/Level-funded Application

Please complete entire application using dark blue or black ink.

Requested effective date *(m/d/y)* ______ /______ /______ Annual open enrollment *(month)* ______________

Coverage requested: ☐ Fully-insured ☐ Level-funded

Important: Coverage will not become effective until we notify you in writing.

A. General

Employer legal name ______________________ DBA ______________________

Physical address *(PO box not accepted)*: ______________________

City ______________ State ________ ZIP ________ County ________

Phone ______________________

Mailing address: ☐ *Check if same as your physical address.* ______________________

City ______________ State ________ ZIP ________ County ________

Billing address: ☐ *Check if same as your physical address.* ______________________

City ______________ State ________ ZIP ________ County ________

Administrative contact: ______________________ Title ______________

Email address ______________________ Phone ______________

Billing contact: ______________________ Title ______________

Email address ______________________ Phone ______________

Business type: ☐ Sole proprietorship ☐ Partnership ☐ Corporation ☐ Other ______________

SIC code or nature of business ______________ Federal tax ID number ______________

1. **Does your business have multiple locations:** ☐ Yes ☐ No If yes, list the city and state of each location:

   City ______________ State ______________ County ______________

   City ______________ State ______________ County ______________

2. **Does your business have multiple tax identification numbers or multiple entities:** ☐ Yes ☐ No

3. **List the names of the businesses with common ownership (where an owner owns 50% or more of more than one business) that are applying for coverage as part of this offering:**

Company name	Company address (street, city, state)	No. of employees	Federal Tax ID Number

4. **List all businesses that qualify as one employer under the above referenced Internal Revenue Code:**

   Business name ______________________ Employer identification number ______________

   Business name ______________________ Employer identification number ______________

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B. Eligibility

1. **Is coverage applied for subject to or part of a union-negotiated collective bargaining agreement:** ☐ Yes ☐ No
   If yes, name of bargaining group ____________________ Agreement expires ____________
2. **Are any classes of eligible employees to be excluded from coverage:** ☐ Yes ☐ No
   If yes, identify and explain each class____
3. **Domestic partner coverage (see criteria on amendment):** ☐ Yes ☐ No
   If yes, indicate types of coverage: ☐ Same gender and opposite gender ☐ Same gender only
   Eligible dependent children of domestic partner: ☐ Yes ☐ No
4. **All full-time proprietors, full-time corporate officers, full-time directors, and full-time employees who are working 30 hours or more per week are eligible for coverage. Please complete group size information below:**
   Using the numbers reported on your Quarterly Wage and Tax Statement filed with the State of Wisconsin, for the four quarters of the last full calendar year (Jan. to Dec.), what was the average number of employees (full-time, part-time, seasonal, temporary; small group status is defined as groups with 2 – 50 employees) ________________

   Attach a copy of the group's most recent Quarterly Wage and Tax Statement.

Total no. of employees	Total no. of eligible employees	Total no. of employees enrolled

Applications must be submitted for all eligible employees unless a waiver of coverage is submitted in its place.

5. **Do you currently offer a Retiree Benefit Plan:** ☐ Yes ☐ No (***Applies to large employer applicants with more than 50 employees)***

Minimum requirements for retiree coverage:

- A written copy of the employer's retiree benefits and eligibility criteria, either from corporate minutes or an employee handbook, must be provided to Security Health Plan.
- The number of retirees may not exceed 10% of the combined total retiree and active eligible employee enrollment. Should this proportion exceed 10% in the future, Security Health Plan retains the right to terminate eligibility for coverage for retirees with 60 days advance written notice.

If the above requirements are met, the employer may apply for retiree coverage by completing the form below. **Such coverage is subject to approval of the Security Health Plan Underwriting Department.**

- The minimum retirement age allowed is upon attainment of age ________.
- The minimum years of service required with the employer immediately prior to retirement is _____ years.
- The minimum years of enrollment required in the employer group coverage immediately prior to retirement is ___ years.

6. **Do you want SHP to administer COBRA/WI state continuation for your business:** ☐ Yes ☐ No
   Note: If you answered yes, there is a separate fee and you will be receiving a separate contract from your sales executive.

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C. Health plan information

1. **Waiting period for new employees to obtain health insurance coverage *(Note: Cannot exceed 90 calendar days)*:**
   - First of the month following: ☐ 0 days ☐ 30 days ☐ 60 days
   - Immediately following: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days

2. **Date for recalled employee:**
   ☐ Following original waiting period ☐ 1st of month following return to work ☐ Immediately after return to work

3. **Requested termination of coverage:**
   ☐ End of month in which employment terminates ☐ End of day that employment terminates

4. **What percentage of the monthly premium is to be paid by the employer for each of the following coverages (each must be at least 25%):**
   Single __________ Employee and spouse __________ Employee and children __________ Full family __________

The applicable benefit options (deductible, coinsurance, annual out-of-pocket limits, etc.) are the coverage and corresponding benefit options stated in the proposal that was issued by Security Health Plan. If Security Health Plan approves this application, the actual benefit options for this employer's group coverage(s) will be contained in the Security Health Plan Certificate and Schedule of Benefits, which are part of the group insurance policy issued by Security Health Plan to the employer as the Security Health Plan group policyholder.

D. Continuation/Disability

1. **Provide the following details for any employee that is not currently active at work. For each employee choose from the following list to indicate the reason they are not actively working *(If you have policies pertaining to any of the reasons listed below, provide a copy)*:**

Name	Last day at work	Anticipated return to work or coverage end date	Reason code

Reason codes:
a. Currently on COBRA or State Continuation, within election period
b. Laid off
c. Medical leave of absence
d. Non-medical leave of absence
e. Military leave
f. Health coverage through severance agreement
e. Receiving Worker's Compensation

If you need more space, attach an additional sheet.

E. HRA/HSA information

1. **Does your business offer an HRA:** ☐ Yes ☐ No Administrator: ☐ DBS ☐ EBC ☐ Other __________________
   Does your contribution vary by employee location or benefit plan: ☐ Yes ☐ No
   Do you pay a percent or dollar amount: ☐ Percent ☐ Dollar amount
   Indicate your contribution amount in percent or dollars: Single _________ Family _________
   Attach additional documentation, as needed.
2. **Do you offer an HSA:** ☐ Yes ☐ No Contribution amount in percent or dollars: Single _________ Family _________

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F. Current coverage

1. **Will/Does your business offer other group coverage in addition to Security Health Plan:** ☐ Yes ☐ No

   If yes, list name of carrier ***(Please be advised that Security Health Plan does not offer dual coverage between carriers.)***

   ____

2. **Are you replacing existing group health coverage:** ☐ Yes ☐ No

   Current group insurance carrier/administrator ______________________________ Effective date ____________

   Reason for changing carriers/administrators ____

   Attach a copy of the most recent bill from the prior carrier or administrator.

3. **Do you currently have a Workers' Compensation carrier:** ☐ Yes ☐ No

   Workers' Compensation carrier______________________________________ Effective date ____________

4. **Are any employees not covered by Workers' Compensation insurance:** ☐ Yes ☐ No

   If yes, for each employee list:

   - First and last name ______________________________ Job classification ___________________________
   - First and last name ______________________________ Job classification ___________________________

If you need more space, attach an additional sheet.

G. Determining group size for Medicare secondary payer (MSP)

1. **Are you part of a multi-employer group?**

   Current year: ☐ Yes ☐ No Preceding year: ☐ Yes ☐ No

   If you answered no to both, proceed to question #4.

2. **Did any one employer that is a part of the multi-employer group health plan have a total of 20 or more full-time, part-time or seasonal employees for each working day, for at least 20 or more calendar weeks?** ***The 20 weeks do not need to be consecutive.***

   Current year: ☐ Yes ☐ No Preceding year: ☐ Yes ☐ No

   If you answered yes to the current year and no to the preceding year, enter the date that your employee count totaled 20 or more full-time, part-time or seasonal employees, for each working day, for 20 or more non-consecutive calendar weeks Date (m/d/y) _____ /_____ /_____

3. **Did any one employer that is part of the multi-employer group health plan have 100 or more full-time, part-time or seasonal total employees on 50% or more of your business days in the preceding calendar year:**

   ☐ Yes ☐ No

   If you answered yes to both the current year and the preceding year in question 1, you may skip the remaining questions in this section.

4. **Did you have a total of 20 or more full-time, part-time or seasonal employees for each working day, for at least 20 or more calendar weeks?** ***The 20 weeks do not need to be consecutive.***

   Current year: ☐ Yes ☐ No Preceding year: ☐ Yes ☐ No

   If you answered yes to the current year and no to the preceding year, enter the date that your employee count totaled 20 or more full-time, part-time or seasonal employees, for each working day, for 20 or more non-consecutive calendar weeks Date (m/d/y) _____ /_____ /_____

5. **Did you have a total of 100 or more full-time, part-time or seasonal employees on 50% or more of your business days in the preceding calendar year:**

   ☐ Yes ☐ No

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Section H – Automatic payment authorization

Complete authorization if choosing automatic payment option.

Financial institution ☐ Checking ☐ Savings

ABA routing number	Account number

I (Payer) authorize Security Health Plan of Wisconsin, Inc./Security Administrative Services, LLC, and the financial institution named above to initiate entries to my checking/savings account for payment. This authority will remain in effect until I notify you (Plan) and the financial institution in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I understand that the payment will be deducted on or after the 20th of the month. I can stop payment of any entry by notifying you and my financial institution 7 days before my account is charged. I understand the amount of an erroneous charge will be credited to my account upon notification.

______________________________ ____ /____ /____

Payer signature Date (mm/dd/yy)

I. Independent agent certification *(if applicable)*

With respect to the application for Security Health Plan of Wisconsin, Inc. coverage made

by ______________________________ represented by ______________________________

and signed on ______________________ , I hereby certify and represent all of the following as being true:

- I hereby 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 Security Health Plan by making any promise and/or representations, or to waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Security Health Plan.

Writing agent signature	Date *(m/d/y)*
Agent name *(print)*	Email address
Agency	Agency tax ID number
Agency address	
Agency telephone number	Agency number

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J. Employer's statement

Any findings or misrepresentation of group information may cause a delay in the coverage effective date or revision of the premiums.

Small group employers* are advised:

- Not to terminate all existing coverage, whether on an insured or self-funded basis, unless and until Security Health Plan notifies me in writing that coverage has been approved
- Security Health Plan does not guarantee approval of this application or issuance of coverage
- This application or any coverage may be declined by Security Health Plan if any statements are found to be fraudulent and/or untrue

*Note the above does not apply to Large Group Employers due to the guaranteed availability requirements under HIPAA and PPACA, 42 USC § 300gg-1 and Wis. Stat. § 635.19.

If Security Health Plan approves this application, I understand coverage(s) will become effective on the date assigned by them, and no coverage(s) will be in force until that date. I understand no coverage(s) will become effective for an eligible employee (and his/her dependents, if any) if he/she is not actively at work with the employer on the assigned effective date. Such coverage will become effective on the first day after he/she returns to work on a full-time basis.

I understand no agent or other person has the authority to alter, bind Security Health Plan, waive or change any terms, conditions, and/or provisions of the policy or any other requirement imposed by Security Health Plan. This application will form part of any contract issued.

If this application is approved, I understand that Security Health Plan will not be, and is not, a plan sponsor, plan administrator, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any other state or federal law, except to the extent that such applicable law automatically imposes fiduciary status upon Security Health Plan. I understand the employer is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies. Security Health Plan, by law, is responsible for deciding initial claims and hearing appeals per ERISA claims procedure rules.

I further understand that employer is obligated to provide notice and information to its employees with regard to various legal obligations, including COBRA continuation coverage and special enrollment rights and consequences of late enrollment under HIPAA and state law.

If this application is approved, Security Health Plan of Wisconsin, Inc./Security Administrative Services, LLC will determine the initial premium amount to be submitted to Security Health Plan. The monthly premium billed by Security Health Plan will be due and payable to Security Health Plan of Wisconsin, Inc./Security Administrative Services, LLC on the 20th day of the month before the coverage month.

I certify that I have authority to make legal binding decisions for this business. I certify that all the information completed in each section of this document is true and complete to the best of my knowledge.

______________________________ ______________________________
Name *(print)* Telephone number

______________________________ ______________________________
Title Email address

______________________________ ______________________________
Employer representative signature Date *(m/d/y)*

Contract documents shall be issued to the employer unless otherwise indicated ______________________________

SECURITY HEALTH PLAN USE ONLY

Name of Security Health Plan representative

____

☐ Sales review

☐ Underwriting review

Comments ______________________________

____

____

Final approval

Effective date *(m/d/y)* ______ /______ /______

Parent group number ______________________________

Underwriting final approval ______________________________

Return form by email at shpacctcoord@securityhealth.org or by fax at 715-221-9456.

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