SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

(800) 622-7790 | TTY: 711

Employer Health Insurance Application

Please complete entire application using dark blue or black ink.

Requested effective date (m/d/y) _____ /_____ /_____

Does open enrollment coincide with renewal month: ☐ Yes ☐ No If no, indicate month _____

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

A. General

Employer legal name _____ DBA _____

Physical address *(P.O. box not accepted)*: _____

City _____ State _____ ZIP _____ County _____

Phone _____

Mailing address: ☐ Check if same as physical address _____

City _____ State _____ ZIP _____ County _____

Billing address: ☐ Check if same as physical address _____

City _____ State _____ ZIP _____ County _____

Administrative contact: _____ Title _____

Email _____ Phone _____

Requesting employer portal access: ☐ Yes ☐ No

Billing contact: _____ Title _____

Email _____ Phone _____

Requesting employer portal access for detailed billing statements: ☐ Yes ☐ No

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 following for each location:

   City _____ State _____ County _____

   City _____ State _____ County _____

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

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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 Federal Tax ID Number:**

Business name _____ Employer identification number _____

Business name _____ Employer identification number _____

5. **If separate billing is needed for multiple businesses, indicate here:** _____

_____

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 (m/d/y) _____ /_____ /_____
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 (criteria on amendment; non-governmental groups only):** ☐ Yes ☐ No
   If yes, indicate types of coverage: ☐ Same sex and opposite sex ☐ Same sex only
   Eligible dependent children of domestic partner: ☐ Yes ☐ No
4. **List number of employees eligible for health insurance benefits** _____.
   At minimum, you must offer benefits to those eligible under Wis. Stats. 632.745 (5) (a).

   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 employers only)***

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.

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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: ☐ Date of hire ☐ 30 days ☐ 60 days
   - ☐ Date of hire ☐ 30 days ☐ 60 days ☐ 90 days
   - Employee changes from part-time to full-time status:
     ☐ Follow waiting period ☐ Immediately following status change
2. **Continuing employee return to work period:**
   ☐ First of month following return to work ☐ Immediately following return to work
3. **Requested termination of coverage:**
   ☐ End of month in which employment terminates ☐ End of day that employment terminates
4. **Provide your contribution for each of the following coverages:**
   All categories must be completed.
   Employee _____ Employee & spouse _____ Employee & child(ren) _____ Family _____

NOTE: The employer must **contribute at least 50% of the Employee-Only** cost for each enrolled employee. The contribution amount may vary based on each employee's age. The group may also vary the contribution amount by class of employee. If multiple plans are offered, the employer may make the contribution based on the plan of choice. However, the contribution must be a minimum of 50% of the employee cost for the lowest priced option that is available to the employee.

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; g. Receiving Workers' Compensation

If you need more space, attach an additional sheet.

2. **Who administers your COBRA/State Continuation:** ☐ EBC ☐ DBS ☐ Self-administered ☐ Other _____

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
   Indicate your contribution amount in dollars: Single _____ Family _____
   Attach additional documentation, as needed.
2. **Do you offer an Individual Contribution HRA (ICHRA) to any employees:** ☐ Yes ☐ No
   Explain who is eligible for ICHRA _____
   Indicate your contribution amount in dollars: Single _____ Family _____
3. **Do you offer an HSA:** ☐ Yes ☐ No Contribution amount in 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. **Do you anticipate replacing existing group health coverage:** ☐ Yes ☐ No

   Current group insurance carrier/administrator _____ Effective date (m/d/y) _____

   Reason for changing carrier/administrator _____

   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 (m/d/y)_____

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 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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H. Automatic payment authorization

Set up automatic payment via the employer portal or complete this section.

Financial institution ☐ Checking ☐ Savings

ABA routing number	Account number

I (Payer) authorize Security Health Plan of Wisconsin, Inc. 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 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 seven 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 (m/d/y)

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

_____ _____

Name of assistant agent, if applicable Email

_____ _____

Agency Agency tax ID number

_____

Agency address

_____ _____

Agency telephone 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 existing coverage, whether on a fully-insured or self-insured basis, unless and until Security Health Plan notifies employer 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. will determine the initial premium amount to be submitted to Security Health Plan of Wisconsin, Inc. The monthly premium billed by Security Health Plan will be due and payable to Security Health Plan of Wisconsin, Inc. 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
Title	Email
Employer representative signature	Date (m/d/y)

Return form by email to your account manager or shp.new.quotes-mfld@sanfordhealth.org or by fax at (715) 221-9456.

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