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 Group Quote Request

A. General

Employer legal name _____ DBA _____

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

City _____ State _____ ZIP _____ County _____

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 following for each location:

   City _____ State _____ County _____

   City _____ State _____ County _____

2. **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

B. Eligibility and health plan information

1. **Are any classes of eligible employees to be excluded from coverage:** ☐ Yes ☐ No

   If yes, identify and explain each class _____

   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

2. **Are you currently insuring retirees:** ☐ Yes ☐ No

3. 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.

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C. 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 _____

3. **Does the Family Medical Leave Act (FMLA) apply to you:** ☐ Yes ☐ No

D. HRA/HSA information

1. **Do you offer an HRA:** ☐ Yes ☐ No Contribution amount in dollars: Single _____ Family _____
2. **Do you offer an Individual Contribution HRA (ICHRA):** ☐ Yes ☐ No

   Contribution amount in dollars: Single _____ Family _____
3. **Do you offer an HSA:** ☐ Yes ☐ No Contribution amount in dollars: Single _____ Family _____

E. Current coverage

1. **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.

F. 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) Agency

Are you currently the agent of record for this employer: ☐ Yes ☐ No

Name of assistant agent, if applicable _____ Email _____

Return completed from by email at shp.new.quotes-mfld@sanfordhealth.org or by fax at (715) 221-9456.

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