SecurityHealth Plan℠
Promises kept, plain and simple.®

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

1.800.472.2363 | 715.221.9555
TTY: 711

Large and Small Employer

Employer Health Insurance Application

Please complete entire application using dark blue or black ink.

Requested effective date *(m/d/y)* _____ /_____ /_____ Annual enrollment date *(m/d/y)* _____ /_____ /_____

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

A. General

Employer legal name _____

DBA _____

Physical address *(PO box not accepted)*:

Address line 1 _____

Address line 2 _____

City _____ State _____ ZIP _____ County _____

Phone _____

Mailing address: ☐ *Check here if your mailing address is the same as your physical address.*

Address line 1 _____

Address line 2 _____

City _____ State _____ ZIP _____ County _____

Billing address: ☐ *Check here if your billing address is the same as your physical address.*

Address line 1 _____

Address line 2 _____

City _____ State _____ ZIP _____ County _____

Administrative contact:

Name _____ Title _____

Email address _____ Phone _____

Billing contact:

Name _____ Title _____

Email address _____ Phone _____

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

SIC code _____ SIC description _____

Nature of business _____

Federal tax ID number _____ Business start date _____

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 _____

   City _____ State _____ County _____

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

   If yes, also complete Section D of this form.

B. Eligibility

1. **Is coverage applied for subject to or part of a union-negotiated collective bargaining agreement:** ☐ Yes ☐ No
   If yes, list name of bargaining group _____
   When does that agreement expire _____
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 number of employees _____
   Total number of eligible employees _____
   Total number of employees enrolling _____

   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
   Note: Applicable only to large employer applicants with more than 50 employees.
   If yes, also complete Section E of this form.

C. Health plan information

1. **Requested waiting period:**
   ☐ Immediately ☐ First of the month following date of hire ☐ 30 days
   ☐ First of the month following 30 days ☐ 60 days ☐ First of the month following 60 days ☐ 90 days
   Note: Patient Protection and Affordable Care Act regulations prohibit employers from having a waiting period of more than 90 days for plan years that begin on or after January 1, 2014.
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. Common ownership confirmation general

Complete this section only if you answered yes to Section A, question #2.

The Health Insurance Portability and Accountability Act of 1996 states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

Name of employer group listed on the request for group insurance _____

Employer tax identification number _____

1. **Primary business location:**

   Address line 1 _____

   Address line 2 _____

   City _____ State _____ ZIP _____ County _____

2. **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 _____

   Business name _____ Employer identification number _____

   I acknowledge that the applicant is a single employer under section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414 (b), (c), (m), or (o), and any applicable state law. I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I understand that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date or other consequences as permitted by law.

E. Retiree coverage

Complete this section only if you are a large employer and answered yes to Section B, question #5.

Eligibility is amended as follows:

Minimum requirements for retiree coverage:

- The employer must be a **large employer** group.
- 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 percent of the combined total retiree and active eligible employee enrollment. Should this proportion exceed 10 percent 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.**

1. The minimum retirement age allowed is upon attainment of age _____.
2. The minimum years of service required with the employer immediately prior to retirement is _____ years.
3. The minimum years of enrollment required in the employer group coverage immediately prior to retirement is ____ years.
4. Upon death of a covered retiree who had family coverage, eligibility for coverage for the surviving dependent(s):
   - ☐ will continue, as shown in the next item
   - ☐ will not continue past the end of the month of the retiree's death
5. Eligibility for coverage for a retiree (and surviving dependents if applicable):
   - ☐ will cease upon eligibility for Medicare
   - ☐ will continue upon and after eligibility for Medicare
6. Eligibility for coverage for retirees:
   - ☐ is available to all retirees who meet the minimum age, years of service and years of enrollment requirements
   - ☐ is based on classification of retired employees, such class defined as _____

F. Continuation/Disability

1. **Are any employees or dependents (including spouse) proposed for coverage currently on COBRA/Wisconsin continuation coverage or in their election period for such coverage:** ☐ Yes ☐ No

   If yes, for each individual list:

   - Name _____

     When continuous coverage began _____

     Number of months person is eligible (i.e. 18, 29, or 36 months) _____
   - Name _____

     When continuous coverage began _____

     Number of months person is eligible (i.e. 18, 29, or 36 months) _____
   - Name _____

     When continuous coverage began _____

     Number of months person is eligible (i.e. 18, 29, or 36 months) _____
   - Name _____

     When continuous coverage began _____

     Number of months person is eligible (i.e. 18, 29, or 36 months) _____

2. **To the best of your knowledge and belief, is any employee or dependent (including spouse) proposed for coverage disabled; unable to work; or not at work because of a current or approaching hospital confinement, other incapacity or leave of absence:** ☐ Yes ☐ No

   If yes, provide each person's:

   Name _____ Status _____

   Name _____ Status _____

   Name _____ Status _____

G. HRA/HSA information

1. **Does your business offer an HRA:** ☐ Yes ☐ No

   If yes, name of 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. **Does your business offer an HSA:** ☐ Yes ☐ No

   Indicate your contribution amount: Single _____ Family _____

H. COBRA/WI state continuation administration

1. **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.

I. 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

   If yes, name of current group insurance carrier/administrator _____

   Original effective date of coverage _____

   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

   If yes, name of current Workers' Compensation carrier _____

   Original 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 _____

   - First and last name _____

     Job classification _____

J. Billing

Upon its review and approval of this application, Security Health Plan 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 on the 20th day of the month before the coverage month.

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

Annual Medicare Secondary Payer Disclosure

Under federal law, it is the employer's responsibility to inform their insurer or third-party administrator, Security Health Plan of WI, Inc. (SHP) of accurate employee counts for the purpose of determining the primary payer between Medicare and another insurer. In addition to providing this information annually, employers are required to notify SHP if a change occurs that impacts your employee count. In the absence of the employee count, CMS requires that the employer's group health plan coverage be considered **primary to Medicare.**

Per 42 CFR § 411.172, an individual "is covered under a group health plan of an employer that has at least 20 employees (including a multi-employer plan in which at least one of the participating employers meets that condition), and coverage under the plan is by virtue of the individual's current employment status."

Per 42 CFR § 411.101, "*Larger group health plan (LGHP)* means a group health plan that covers employees of either – (1) a single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or (2) two or more employers, or employee organizations, at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year."

Complete the below questions. Guidance is provided to help you understand how to correctly answer the questions, however, please refer to 42 CFR § 411 – Exclusions from Medicare and Limitations on Medicare Payment if desired.

Definitions:

- **Current year** is defined as the year of your upcoming renewal. For example:
  - Upcoming renewal is effective January 1, 2020 – base your current year answer on what your 2020 employee count will be
  - Upcoming renewal is effective July 1, 2020 – base your current year answer on what your employee count has been in 2020
- **Preceding year** is defined as the year preceding your upcoming renewal. For example:
  - Upcoming renewal is effective January 1, 2020 – base your preceding year answer on what your 2019 employee count was
  - Upcoming renewal is effective July 1, 2020 – base your preceding year answer on what your 2019 employee count was
- **Multi-employer/multiple employer group plan:** Any trust, plan, association, or any other arrangement that is sponsored jointly by two or more employers or by employers and unions, where they contribute, sponsor, directly provide health benefits, or facilitate directly or indirectly the acquisition of health insurance by an employer member. A multi-employer/multiple employer group health plan exists if the above criteria is met, even if the employers have a separate contract with Security Health Plan.

K. Determining group size for Medicare secondary payer (MSP) (continued)

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

   1a Current year: ☐ Yes ☐ No

   1b Preceding year: ☐ Yes ☐ No

   If you answered no to both 1a and 1b, 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.***

   2a Current year: ☐ Yes ☐ No

   2b Preceding year: ☐ Yes ☐ No

   If you answered yes to 2a and no to 2b, 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 percent or more of your business days in the preceding calendar year:**

   ☐ Yes ☐ No

   If you answered yes to both 1a and 1b, and you answered questions 2 and 3, 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.***

   4a Current year: ☐ Yes ☐ No

   4b Preceding year: ☐ Yes ☐ No

   If you answered yes to 4a and no to 4b, 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 percent or more of your business days in the preceding calendar year:**

   ☐ Yes ☐ No

L. Employer's statement

This group medical coverage is guaranteed renewable. However, your group medical coverage could be cancelled if Security Health Plan terminates all of its group medical insurance policies for this group class, or if you:

- Fail to pay your monthly premium timely
- Engage in fraud or misrepresentation
- Breach the Security Health Plan group insurance policy
- Become ineligible as a group due to (a) losing status of legal entity, or (b) moving the business or all members to a state or area where this type of group medical insurance policy is not offered by Security Health Plan

Security Health Plan may investigate the information on this application. For large employers, any findings or misrepresentation of group information may cause a delay in the coverage effective date or revision of the premiums. Please indicate the name, title and telephone number of an employee in your firm who can provide necessary clarification of the employee and group information provided on this application.

Name _____ Position/Title _____ Telephone no. _____

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been 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

I understand that the plan year for purposes of application to the policy of the rules set forth in the federal Patient Protection and Affordable Care Act, as amended, and first effective for plan years beginning on or after January 1, 2014, shall be the year beginning on the policy effective date shown on the coverage page, as well as each renewal period thereafter. Notwithstanding the foregoing, I understand that Security Health Plan may, in its discretion, agree to establish a different plan year with my written consent.

I understand that Security Health Plan will rely, in part, on the information provided in this application to issue or delay until an open enrollment period under Patient Protection and Affordable Care Act regulations, or deny coverage(s). 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 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. I understand the employer represents its employees and their dependents, not Security Health Plan. As the employer's authorized representative and acting on that employer's behalf, I understand, agree with, and approve each and every certification made by the agent in the attached Independent Agent Certification of this application (if applicable). This application will form part of any contract issued. Coverage is not in effect unless and until you receive written notice from us.

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. 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. I further understand that employer is obligated to provide notice and information to its employees with regard to special enrollment rights and consequences of late enrollment under HIPAA and state law.

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 accurate and truthful to the best of my knowledge.

_____	_____
Name *(print)*	Telephone number
_____	_____
Title	Email address
_____	_____
Employer representative signature	Date *(m/d/y)*

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.

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

M. 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 asked all questions accurately and fully recorded all information given by the employer representative in this application (if agent completed application).
- I advised the employer representative not to terminate existing coverage unless, and until Security Health Plan notifies him/her, in writing, that this application has been approved.
- I used only advertising approved by Security Health Plan to solicit the application.
- I told the employer representative nothing inconsistent with, or contrary to, the approved advertising about the benefits, group policy and/or coverage.
- I did not guarantee Security Health Plan's approval of this application or Security Health Plan's issuance of coverage.
- I did not tell the employer representative that Security Health Plan will cover any pre-existing condition(s) of any person proposed for coverage.
- I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and the marketing/sales standards maintained by Security Health Plan.

I hereby certify and represent all of the following as being true:

- I told the employer representative that Security Health Plan is not liable for any statement, representation or other information provided to that representative or anyone else that is not expressly contained in a written document provided to them and signed by an Security Health Plan authorized officer.
- I understand that I am liable for my acts and omissions to the extent provided by law.
- I understand I have no authority to alter this application, bind Security Health Plan by making promises and/or representations, or to waive or change the 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

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.