SMALL BUSINESS GROUP

GroupHealth®

2015 Employer application for groups of 1 to 50 employees

For coverage effective on or after January 1, 2015

1 APPLICATION CHECKLIST

Please make sure your application package includes:

- ☐ Signed employer application.
- ☐ A copy of employer's license to do business in Washington state.
- ☐ Signed enrollment form for each employee wanting coverage.
- ☐ Enrollment forms for former employees who are eligible for COBRA.
- ☐ Waiver form for each eligible employee declining coverage.
- ☐ A self-employed individual or sole proprietor who is applying for coverage as a group of 1 must have been employed by the same small employer or small group for at least 12 months prior to application for coverage. We also require verification that at least 75 percent of income has been derived from the business. For a business that is an agricultural trade or business, we require verification that at least 51 percent of income has been derived from the business.
- ☐ For groups of 1–3 subscribers, show proof of being a business by submitting the appropriate tax documentation forms:

Sole proprietor	1040 and Schedule C from prior taxable year (first and second page of 1040, with taxpayer's signature)
Farmer	1040 and Schedule F from prior taxable year (first and second page of 1040, with taxpayer's signature)
Corporation	1120 (first four pages with preparer's or owner's signature)
Subchapter S corporation	1120S (first four pages with preparer's or owner's signature)
Partnership	1065 (first four pages with preparer's or owner's signature)
Nonprofit	990
Religious organizations	Tax forms not required

Note: You must meet the underwriting guidelines for small groups in order to qualify for coverage. If choosing an HSA plan, no employer contributions to employee HSA funds are permitted. Continuation of coverage is available upon request in accordance with Washington state law for employees and their dependents who choose to exercise this option when they become ineligible for group coverage.

2 SEND THE MATERIALS TO THE SALES OFFICE NEAREST TO YOU

Western Washington

Group Health Cooperative
Small Business Group
320 Westlake Ave. N., Suite 100
Seattle, WA 98109-5233
206-448-4140 or 1-800-542-6312
E-mail: smallbusinessgroup@ghc.org

Eastern Washington

Group Health Cooperative
Small Business Group
5615 W. Sunset Highway
Spokane, WA 99224-9454
509-459-9100 or 1-800-497-2210
E-mail: smallbusinessgroup@ghc.org

1. Materials must be fully completed and received by the **20th of the month** for coverage to be effective on the **first of the following month**.
2. If you have questions about this application process, please call your producer, or one of the numbers above, and we will be happy to help you.

3 SELECT COVERAGE EFFECTIVE DATE

First of _____

Month

4 REQUIRED COMPANY INFORMATION

Company name _____

Address _____

City _____ State _____ ZIP_____ County _____

Doing business as _____

Type of business _____

In business since _____ Phone _____ Fax _____

E-mail _____ Tax ID #_____ SIC # _____

Is this business a branch office? ☐ Yes ☐ No Or subsidiary? ☐ Yes ☐ No

In which city and state is your company headquartered? City_____ State _____

Has your firm ever been covered in the past by a plan offered by Group Health Cooperative or Group Health Options, Inc.?

☐ Yes ☐ No If yes, under what name? _____

Date last covered _____

Are you replacing existing group coverage? ☐ Yes ☐ No If yes, which carrier provided that coverage?

_____

5 REQUIRED CONTACT INFORMATION

Main contact name_____ Title _____

Company name _____ Phone _____ E-mail _____

Address _____

City _____ State _____ ZIP _____

Who should receive billing statements (if different from above)?

Name _____ Title _____

Company name _____ Phone _____ E-mail _____

Address _____

City _____ State _____ ZIP _____

6 REQUIRED ENROLLMENT INFORMATION

1. A small group is a business with 1–50 employees, as defined under RCW 48.43.005(33).
   How many total employees, part-time and full-time combined, does your company have? Please include out-of-state and worldwide employees for all parent, subsidiary, and sibling companies in this total. _____
2. If your answer to question 1 was less than 20 employees, did you ever employ 20 or more employees (part-time and full-time combined) for 20 or more calendar weeks in either the current or previous calendar year? ☐ Yes ☐ No
3. How many hours per week must employees work to be eligible for benefits? _____
4. How many employees meet the above requirement? _____
5. Of these employees, how many are enrolling? _____

   How many are waiving coverage? _____
6. Does your company have any terminated employees on COBRA benefits now? ☐ Yes ☐ No

   Employers with 20 or more full-time equivalent employees at least 50 percent of the year in the past calendar year are required by federal regulations to offer COBRA benefits to terminated employees. If you have any questions regarding COBRA applicability or eligibility, please seek the advice of independent legal counsel.
7. Employees will be eligible for benefits upon **(select one)**:
   - ☐ Date of hire
   - ☐ First of the month following date of hire
   - ☐ First of the month following: ☐ 30 days ☐ 60 days
   - ☐ 90 days from date of hire
   - ☐ Other—No longer than 90 days from date that employee is otherwise eligible to enroll. Any orientation period required for an employee to be eligible to enroll may not exceed one calendar month (please specify). _____

     _____
8. Rehire policy:
   The company will waive the waiting period if employee is rehired **(select one)**:
   - ☐ Within 30 days of termination
   - ☐ Within 60 days of termination
   - ☐ Within 90 days of termination
   - ☐ Other: _____
9. Employee transfers from part-time to full-time **(select one)**:
   - ☐ Probationary period begins upon date employee transfers to full-time
   - ☐ Probationary period begins on the 1st of the month following transfer to full-time
10. Does your company include non–state-registered domestic partners of employees as eligible dependents? ☐ Yes ☐ No

    Note: State-registered domestic partners will be treated as spouses as required by Washington State law.

7 RATING STRUCTURE

Select one:
- ☐ Age-banded rates (the most common selection; also called "list bill" and the way we rated 2014 plans)
- ☐ Composite rates (Available after the 10th of the month prior to your group's effective date and comprised of two rates: one for all enrollees aged 21 and over that is determined by their combined average age-banded rate, and another that matches the age-banded rate for those 0–20)

8 SELECT BENEFITS

Select one of the health plans listed below.

OR

Groups with 10 or more employees may offer 1 plan or 2 plans from any combination of Core and Connect plans. If offering 2 plans, groups with 10–24 employees must have at least 3 employees enrolled in each plan. Groups with 25–50 employees must have at least 5 employees enrolled in each plan.

Group Health Cooperative Core plans network also known as Group Health	**Group Health Options, Inc.** Connect plans network also known as Alliant Plus
Core ☐ Gold ☐ Silver ☐ Bronze HSA*	**Connect** ☐ Bronze HSA*
Core Plus ☐ Gold ☐ Silver ☐ Platinum	**Connect3** ☐ Gold ☐ Silver

* No employer contributions to employee HSA funds are allowed for these plans. These plans' actuarial values (which are used for Affordable Care Act compliance) were determined with no employer contributions to employee HSA funds.

Optional dental plan

Please elect or decline the optional adult dental plan for your employees and their dependents age 19 and older.

☐ Small Group adult dental plan

☐ No dental coverage

Coverage provided by Group Health Options, Inc. Plan is administered by United Concordia Dental. Your plan uses the United Concordia Dental Advantage Plus Network.

Premium Contribution

Employers must pay a minimum of 50 percent of the employee coverage to qualify for group insurance. If an employer with 10 or more employees selects 2 plans, the employer must pay a minimum 50 percent of the average employee premium on the base plan. The employer agrees to make the following contribution toward the employee and dependent coverage:

Employee $ or % _____ Dependents $ or % _____

9 ACKNOWLEDGEMENTS AND CERTIFICATION

Authorized representative certification

I certify that the information on this application is complete and accurate. I understand that if false information has been submitted, Group Health Cooperative or Group Health Options, Inc. will have the right to cancel the contract to the extent allowable under applicable federal and state law. Group Health Cooperative and Group Health Options, Inc. reserve the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses, or other damages. It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Full legal name _____ Title _____

Authorized representative's signature _____ Date _____

Full legal name _____ Title _____

Authorized representative's signature _____ Date _____

MyGroupHealth for Employers website:

To sign up for MyGroupHealth for Employers, please see the instructions on **employer.ghc.org.**

10 APPOINTMENT OF PRODUCER

Please complete this section if you have a Producer of Record representing your company.

Mail group contract to: ☐ Producer ☐ Group ☐ Both

Appointment of Producer of Record

I hereby appoint _____ (Producer)

with _____ (Agency),

as a Producer of Record, effective _____, for purposes of arranging and servicing health care coverage with Group Health Cooperative or Group Health Options, Inc. for the firm's employees and dependents.

This appointment rescinds all previous appointments and continues in effect until termination by either party in writing. Producer may make requests concerning rates, benefits, eligibility requirements, and other matters relating to our company's coverage. The firm understands that commissions due to the Producer for services provided pursuant to the appointment are governed by an agreement between the Producer and the health plan.

If you are a Producer who completed this application on behalf of a client, please indicate by signing here.

Producer signature_____ Phone number _____

Name of Producer (please print)_____ Fax number _____

Address _____ E-mail _____

SS or Tax ID number _____ License number _____

Group Health for Producers website:

To sign up for secure online access to your account information and more, go to **producer.ghc.org.**

ghc.org/sbg
1-800-542-6312