Connecticut Small-Group Employer Application

Directions and Checklist

IMPORTANT: Directions

1. In order to ensure that your group receives its ID cards/member materials for the requested effective date, we require a 15th of the month submission date. If a case submission is not complete and received in a timely manner, we will require the completion of a Late Submission Form. Groups submitted after the 15th of the month are not guaranteed approval for the requested effective date.
2. Participation:
   - Groups of 2-9, 75% minimum participation is required of all eligible employees.
   - Groups of 10-50, 65% minimum participation is required of all eligible employees.
   - POS and FlexPOS plans require 70% of eligible enrollees to live in the ConnectiCare service area.
     – Eligible employees must work a minimum of 30 hours per week.
     – Waiver Forms are used in conjunction with Enrollment Forms to calculate participation.
3. Small Group Application:
   - Employer is required to read, complete, date, and sign the Application indicating Medical Plan Option, Pharmacy Option and Dental Plan Option choices. Subsequent plan changes are available only on group renewal date.
   - Please select a new hire waiting period (can select zero.)
   - Agent Information must be completely filled out, including the tax ID #'s. Agents must be licensed and appointed with ConnectiCare.
4. Each enrolling employee must fully complete, date, and sign all sections of the ConnectiCare Enrollment/Change Form. Please indicate a PCP; please remember to complete the date of birth.
5. Each enrolling employee must complete, date and sign the "Family Health Statement."
   - All "yes" answers must be explained (on front and back).
   - Number of hours worked and date of hire must be completed on Family Health Statement
6. Employers are required to submit proof of full-time employment (30-hours-per-week or more) for all employees wishing to enroll in the group plan. Acceptable proof of employment includes:
   - Employee is listed on the quarterly tax-and-wage report with income that supports a 30-hour, or more, work week; or
   - Proof of income paid via copies of cleared checks issued by the employer and indicating full-time employment.
7. Tax documents: Please submit the most recent tax information described below. NOTE: Payroll journals are not acceptable. Please indicate employees' status (full-time, part-time, waiving, etc.) on this form. Everyone on tax documentation must be accounted for: # of waivers + # of enrollment forms = total eligibles.
   A. Sole proprietor and single owner LLC: Schedule C. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
   B. Multiple owners/Partnership(s): 1065 with K-1's for all partners totaling 100% ownership. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
   C. Corporation: Form 1120C or 1120S. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
   D. Non-Profit with employees: most recent state quarterly earnings report (UC-5A/UC-2.)
   E. New Business: New Business Certification Statement with a copy of federal EIN notification letter or Sales & Use Tax Permit (if applicable).
8. Please submit first month's premium, payable via *business* check, to ConnectiCare.

Small-Group Case Submission Checklist (1-50 lives)

❑ Small-Group Employer Application **dated and signed** with
  – Medical Plan Option
  – Pharmacy Option
  – Dental Plan Option
  – New Hire Waiting Period Option
❑ Waiver form: Waivers must indicate number of hours worked and date of hire. (Please submit on ConnectiCare's Waiver Form.)
❑ ConnectiCare Enrollment/Change Forms **dated and signed**
❑ Completed Family Health Statements for every eligible enrolling employee **dated and signed**
❑ Copy of **most recent Tax Filing State Quarterly Wage & Tax Form.**
Please indicate employee's status (full-time, part-time, waiving, etc.) on this form.
❑ Copy of the current carrier bill
❑ Copy of complete quote with employee census
❑ First Month's Premium — **Please make business check payable to ConnectiCare.**
❑ 50% Coinsurance Funding Attestation

Submit all paperwork to: ConnectiCare Small-Group Sales, P.O. Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050.
Please do not mail your application directly to your Sales Representative's attention; doing so will delay your application.

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Part 1 Application

Company Information

1. Desired Effective Date _____ Small Group # _____ (ConnectiCare use only)

2. Legal Business Name _____

3. DBA/Doing Business As (if applicable) _____

4. Physical Address _____ P.O. Box _____

City _____ State ____ ZIP _____ Phone ( ) _____ Fax ( ) _____

5. Nature of Business _____ Billing/Contact Person _____

6. Organization Type ❑ Corporation ❑ Partnership ❑ Sole Proprietorship ❑ Other _____

7. Federal Tax Identification Number _____ Business Effective Date _____ Current Ownership Date _____

8. Are you affiliated with any other company? ❑ Yes ❑ No If yes, relationship type _____

Name of affiliated company _____ Relationship effective date _____ Total number of employees _____

9. Total number of employees (including part-time and seasonal) _____

Number of full-time eligible employees working 30 hours or more per week _____ Number of enrolling employees _____

Number of spousal/applicable waivers _____ Number of "other" waivers _____

10. New Hire Waiting Period ❑ 0 ❑ 30 ❑ 60 ❑ 90 ❑ 180 Days ❑ First of month following new hire waiting period selected

11. Will coverage be transferring from another carrier? ❑ Yes ❑ No

If yes, prior carrier name _____ Proposed termination date _____
(Please include a copy of the current premium bill with this carrier.)
If prior carrier is ConnectiCare, provide group #: _____ Total replacement? ❑ Yes ❑ No
Has the group been uninsured for three or more months prior to the requested effective date? ❑ Yes ❑ No

12. Small Employer Certification: *Pursuant to state law, carriers need information from an employer to determine if the employer qualifies as a small employer under the law. Guaranteed issue and renewability and ConnectiCare's underwriting guidelines are contingent upon this criteria being met. Certification of eligibility is required herein and prior to renewal. Your group health plan will become effective only as approved by ConnectiCare.* I hereby certify the employer applying for coverage is a small group under applicable state law. I certify that the information herein is true and complete to the best of my knowledge. I also certify that all eligible employees are covered by Workers' Compensation insurance except when exempt under applicable law and all eligible employees have equal access to ConnectiCare coverage. I agree to immediately notify ConnectiCare of any changes to the information provided herein. On behalf of the employer, I also agree to the terms and conditions of the Group Membership Agreements, including any riders and addendums, that govern the plans issued by ConnectiCare to the employer. I understand that false and/or incomplete responses or statements may result in cancellation or rescission of coverage. I acknowledge that ConnectiCare reserves the right to request any reasonable documentation from the employer, its affiliates, subscribers or dependents in order to verify eligibility.

Employer Signature X _____ Title _____ Date _____

E-mail Address _____

Agent Information

13. Agency Name _____ Agent Name _____

14. Address _____ City _____ State _____ ZIP _____

Phone ( ) _____ Fax ( ) _____ Commission Paid to: ❑ Agency ❑ Agent

Social Security # or Tax ID # _____ ConnectiCare Appointment ❑ Yes ❑ No
(Must be completed to ensure proper commission payment.)

Contact Person _____ Agent E-mail Address _____

15. I have reviewed the answers on all applications and forms and I am not aware of any additional information that would affect the underwriting of this case. I agree to immediately notify ConnectiCare of any changes to the information provided herein or if I become aware of any information that could affect the underwriting of this case. I certify that each employee has completed and signed all forms, and selected a PCP.

Agent Signature X _____ Date _____

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Part 2 Plan Choice

Connecticare, Inc. (CCI): Connecticut Domiciled Only

Hospital Copayment Plans (Calendar Year Plans)

1. ❑ HMO-OA-15/25-100D-CAL
2. ❑ HMO-OA-20/30-250D-CAL
3. ❑ HMO-OA-20/30-500D-CAL
4. ❑ HMO-OA-30/45-250D-CAL
5. ❑ HMO-OA-30/45-500D-CAL
6. ❑ POS-OA-15/25-100D-CAL
7. ❑ POS-OA-20/30-250D-CAL
8. ❑ POS-OA-20/30-500D-CAL
9. ❑ POS-OA-30/45-500D-CAL

Hospital Deductible Plans (Calendar and Contract Year Plans)

10. ❑ HMO-OA-15/25-1500HospDed-CAL
11. ❑ HMO-OA-20/30-2500HospDed-CAL
12. ❑ HMO-OA-30/45-1500HospDed-CAL
13. ❑ HMO-OA-30/45-2500HospDed-CAL
14. ❑ HMO-OA-30/45-5000HospDed-CAL
15. ❑ HMO-OA-20/30-1500HospDed-CNT
16. ❑ POS-OA-15/25-1500HospDed-CAL
17. ❑ POS-OA-20/30-2500HospDed-CAL
18. ❑ POS-OA-30/45-1500HospDed-CAL
19. ❑ POS-OA-30/45-2500HospDed-CAL
20. ❑ POS-OA-30/45-3000HospDed-CAL
21. ❑ POS-OA-30/45-3000HospDed-CNT

Upfront Deductible Plans (Calendar and Contract Year Plans)

22. ❑ HMO-OA-1500Upfront-30/45-CAL
23. ❑ HMO-OA-2500Upfront-30/45-CAL
24. ❑ HMO-OA-5000Upfront-30/45-CAL
25. ❑ HMO-OA-1500Upfront-30/45-CNT
26. ❑ HMO-OA-2500Upfront-30/45-CNT
27. ❑ HMO-OA-5000Upfront-30/45-CNT
28. ❑ POS-OA-30/45-3000Ded-CAL
29. ❑ POS-OA-1500Upfront-30/45-CNT
30. ❑ POS-OA-2500Upfront-30/45-CNT
31. ❑ POS-OA-30/45-3000-Ded-CNT

Pharmacy Options

A. ❑ $10/$20/$35
B. ❑ $15/$30/$40
C. ❑ $15/$30/$40 with a $200 Calendar or Contract Year Deductible
D. ❑ $15/50%/50% $200 Deductible T2/T3 $100 per script max

FLEX POS PLANS Contract Year Plans

Hospital Copayment Plans

32. ❑ FlexPOS-20/30-500D-CNT
33. ❑ FlexPOS-30/45-500D-CNT

Hospital Deductible Plans

34. ❑ FlexPOS-20/35-2500HospDed-CNT
35. ❑ FlexPOS-30/45-1500HospDed-CNT

Upfront Deductible Plans

36. ❑ FlexPOS-20/30-3000Ded-10%-CNT
37. ❑ FlexPOS-30/45-2500Ded-10%-CNT
38. ❑ FlexPOS-250Upfront-30/45-80%-CNT
39. ❑ FlexPOS-500Upfront-30/45-80%-CNT
40 ❑ FlexPOS-750Upfront-30/45-80%-CNT
41. ❑ FlexPOS-1000Upfront-30/45-80%-CNT

Pharmacy Options

E. ❑ $15/$30/$40 (50% Out-of-Network Coinsurance)
F. ❑ $15/$30/$40 with $200 Deductible (50% Out-of-Network Coinsurance)
G . ❑ $15/50%/50% $200 Deductible T2/T3 $100 per script max

Other plan: _____

HSA COMPATIBLE PLANS

Calendar Year Plans

42. ❑ HMO-OA-HSA-2500I/5000F-CAL
43. ❑ HMO-OA-HSA-3500I/7000F-CAL
44. ❑ HMO-OA-HSA-5000I/10000F-CAL
45. ❑ HMO-OA-HSA-1500I/3000F-15/25-CAL
46. ❑ POS-OA-HSA-2500I/5000F-CAL
47. ❑ POS-OA-HSA-3500I/7000F-CAL
48. ❑ POS-OA-HSA-5000I/10000F-CAL
49. ❑ POS-OA-HSA-1500I/3000F-15/25-CAL
50. ❑ FlexPOS-HSA-1500I/3000F-10%-CAL
51. ❑ FlexPOS-HSA-2500I/5000F-10%-CAL

Contract Year Plans

52. ❑ HMO-OA-HSA-2500I/5000F-CNT
53. ❑ HMO-OA-HSA-3500I/7000F-CNT
54. ❑ HMO-OA-HSA-5000I/10000F-CNT
55. ❑ HMO-OA-HSA-1500I/3000F-15/25-CNT
56. ❑ HMO-OA-HSA-2000I/4000F-15/25-CNT
57. ❑ HMO-OA-HSA-1500I/3000F-30/45-CNT
58. ❑ HMO-OA-HSA-2000I/4000F-30/45-CNT
59. ❑ HMO-OA-HSA-2500I/5000F-30/45-CNT
60. ❑ POS-OA-HSA-2500I/5000F-CNT
61. ❑ POS-OA-HSA-3500I/7000F-CNT
62. ❑ POS-OA-HSA-5000I/10000F-CNT
63. ❑ POS-OA-HSA-1500I/3000F-15/25-CNT
64. ❑ POS-OA-HSA-1500I/3000F-30/45-CNT
65. ❑ POS-OA-HSA-2000I/4000F-30/45-CNT
66. ❑ POS-OA-HSA-2500I/5000F-30/45-CNT
67. ❑ FlexPOS-HSA-2000I/4000F-15/25-CNT
68. ❑ FlexPOS-HSA-1500I/3000F-10%-CNT
69. ❑ FlexPOS-HSA-2500I/5000F-10%-CNT

All HSA Compatible Plans include Pharmacy Benefits

POS Coinsurance Plans (Contract Year Plans)

70. ❑ POS-Upfront1000-30PCP-50%-CNT
71. ❑ POS-Upfront2500-30PCP-50%-CNT

Pharmacy Option

H. ❑ $15/50%/50% $200 Deductible T2/T3 $100 per script max
I. ❑ $15/$30/$40 with a $200 Contract Year Deductible

DUAL OR TRIPLE OPTION

Offering Calendar Year and Contract Year plans side by side is not recommended

Plan # _____ Rx _____ Plan # _____ Rx _____

Plan # _____ Rx _____

Indicate sold plan number and Rx letter for all CT domiciled plans.

ConnectiCare Dental Plans (for groups with five or more employees)

NETWORK
❑ Value ❑ Plus ❑ Premium

PLAN
❑ $1,000 benefit maximum ❑ $1,500 benefit maximum (10+ ees only.)
❑ Basic Plan (10+ ees only) ❑ 5-9 employee plan

❑ with orthodontia (10+ ees only.) Not applicable to Basic Plan.

DOMESTIC PARTNER *(Dental only)*
❑ Yes ❑ No Note: Affidavit must be received with paperwork.

SIC CODE:

Premium $ _____ Check # _____

❑ Composite Rated (Group 25-50 in Connecticut)

The following information is being provided in accordance with the recent Connecticut State mandate (SB 46, PA 09-46), which requires Medical Loss Ratio (MLR) disclosure by all insurance companies.

Medical Loss Ratio for calendar year 2009: ConnectiCare, Inc. (CCI) **88.9%**
The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and is calculated in accordance with Connecticut law.

Medical Loss Ratio for calendar year 2009: ConnectiCare Insurance Company, Inc. (CICI) **96.0%**
The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and is calculated in accordance with Connecticut law.

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Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage is underwritten by ConnectiCare, Inc. FlexPOS, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.

ATTESTATION REGARDING THE FUNDING OF 50% COINSURANCE PLANS

ConnectiCare is committed to providing clients with affordable health insurance options for their employees. Inherent in the pricing of our 50% coinsurance plans is an actuarial assumption that the underlying members will be responsible consumers of medical care and will be liable for the full member out-of-pocket expenses without underlying employer funds being used to offset the exposure.

To maintain the integrity of the pricing of these products, ConnectiCare is requiring that an officer of the company attest to the fact that there is no underlying funding of the employees' out-of-pocket medical expenses associated with these plans. By signing below you are indicating that you will notify us immediately if you are currently using or if you intend to use an underlying plan to subsidize your employees' cost sharing responsibilities.

_____

Employer

_____

Signature of Officer

_____

Title

_____

Date

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