# 2016 Large Employer Group Application

| Full Legal Name of Group (the "Group") | Effective Date |
|---|---|
| Contact Name and Title | Billing/Enrollment Contact (if different) |

| Phone Number ( ) | Email Address | Website |
|---|---|---|

| Nature of Business | Date Business was Established / / |
|---|---|

**Corporate Headquarters Address**

| Street Name | P.O. Box | Town/City | State | Zip Code |
|---|---|---|---|---|

**Billing/Mailing Address and Contact Information (if different)**

| Street Name | P.O. Box | Town/City | State | Zip Code |
|---|---|---|---|---|

| Phone Number ( ) | Fax Number ( ) | Email Address |
|---|---|---|

**MANDATORY: The information below is required for Medicare Secondary Payer (MSP) reporting.**

The total number of current employees who receive wages, tips, or other compensation (refer to line 1 of your most recent federal tax return form 941 or 944) as of this date / / (includes FT, PT, seasonal, new hire)

**Eligibility: Active Employees**

Employees covered under a collective bargaining agreement are
☐ Included ☐ Excluded ☐ Applicable ☐ Other

Domestic partner coverage? ☐ Yes ☐ No

| Total # of full time employees *(30 hours+)* | # of part time employees *(20-29 hours)* |
|---|---|
| # of full time employees enrolling in coverage | # of part time employees *(fewer than 20 hours)* |
| # of full time employees waiving coverage | # of seasonal employees |

Total # of employees *(include ONLY active full time, part time, and seasonal)*

**New Hire Policy/Termination**

Waiting Period

☐ Date of Hire

☐ 1st after ___________

☐ Other ___________ (cannot exceed 90 days)

Termination

☐ Date of Termination

☐ End of month

Do you work with a COBRA administrator?
☐ Yes ☐ No

COBRA Administrator:______________________________

**Group's Existing Health Plan(s)**

Does the Group have an existing health plan(s)? ☐ Yes ☐ No

If yes, current carrier(s) and renewal date?

Plan 1 / /

Plan 2 / /

For billing purposes, how many divisions would you like HCT to set up?

**Employer Contribution Premiums ( % and $)**

| | EE | EE +1 | Family |
|---|---|---|---|
| HealthyCT | _____% $_____ | _____% $_____ | _____% $_____ |
| Existing Carrier | _____% $_____ | _____% $_____ | _____% $_____ |

| Broker Information | Group TIN |
|---|---|
| Broker Name | |

Flip over to sign!

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If you'd like to view and download your plan's most up-to-date Certificate of Coverage and Summary of Benefits and Coverage, please visit **www.healthyct.org** and click "Explore Our Plans." You can also check out the Uniform Glossary of Health Coverage and Medical Terms at **www.healthyct.org/glossary**. For a printed copy of these documents – free of charge – please call us at **1-855-458-4928**.

The undersigned authorized officer of the Applicant hereby confirms that the Applicant satisfies and, if this Application is accepted by HealthyCT, will continue to satisfy and remain in compliance with the Underwriting Guidelines set forth in Attachment A, hereto, and any additional underwriting guidelines that HealthyCT may promulgate and which the Applicant is given notice of in conjunction with future renewals. The Applicant hereby acknowledges that if at any time he/she is not in compliance with such underwriting guidelines or if any census data provided by the Applicant to HealthyCT, in conjunction with this Application for coverage does not accurately reflect, in the judgment of HealthyCT, the actual Applicant members covered by HealthyCT on the date coverage by HealthyCT first commences, then HealthyCT shall have the right at any time upon 30 days written notice to the Applicant to increase the monthly premiums payable by the Applicant in such amount as is determined by HealthyCT, in its absolute discretion, to reflect the increased risk of such non-compliance or census variance.

I hereby certify that the Group applying for coverage is a large 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 Worker's Compensation insurance except when exempt under applicable law and that all eligible employees have equal access to HealthyCT coverage. I agree to immediately notify HealthyCT of any changes to the information provided herein. On behalf of the Group, I also agree to the terms and conditions of the Group Membership Agreements, including any riders and addendums that govern the plans issued by HealthyCT to the Group. I understand that false and/or incomplete responses or statements may result in cancellation or rescission of coverage. I acknowledge that HealthyCT reserves the right to request reasonable documentation from the Group, its affiliates, subscribers or dependents in order to verify eligibility.

I also represent, warrant and agree that:

- The Group is not a subsidiary, affiliate or branch of any other corporation.
- Within the last 12 months, the Group has not:
  - Made more than three late payments to its insurance carrier(s), if any;
  - Committed fraud, misrepresented the eligibility of an employee, or misrepresented information necessary for a carrier to determine Group size, Group Participation, or the Group's premium rate; or
  - Failed to comply in a material manner with a health benefit plan provision, including carrier requirements for employer group premium contributions.
- With the exception of Continuation of Coverage participants, all subscribers who enroll for coverage with HealthyCT satisfy the following requirements:
  - They are considered regular, full-time employees compensated for working at least 30 hours per week for the Group;
  - They receive an annual W-2 form; and
  - They are hired to work for a period of not less than five months.

Participation in HealthyCT's Health Plan will not be effective until HealthyCT provides written notice to you. If HealthyCT accepts this application, the Employer Group Agreement will become effective on the latter of the effective date requested or on the first of the month following the date of HealthyCT's receipt of the first month's premium, whichever is later.

Authorized Group Representative

Sign ______________________________ Print ________________________________ Title__ _______________ Date_____________

Broker

Sign ______________________________ Print ________________________________ Title__ _______________ Date_____________



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**State Medical Loss Ratio:** 101.4%

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. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enroll educational programs, or other cost containment programs or features.

**Federal Medical Loss Ratio:** Individual: 97.8%
Small Group: 81.2%
Large Group: 114.1%

The Federal medical loss ratio has the same meaning as provided in and calculated in accordance with PPACA, PL 111-148, as amended form time to time, and regulations adopted thereunder.