Group Health Cooperative
of South Central Wisconsin

Employer Group Annual Information Form

Please complete this form in its entirety. Group Health Cooperative of South Central Wisconsin (GHC-SCW) requires this information on an annual basis, at minimum, for various regulatory requirements. GHC-SCW may request an updated form at any time. Failure to complete could result in your policy being cancelled and/or group health plan reporting requirements to be non-compliant.

Section 1: General Group Information

1. Group Number (can be located on monthly invoice): _____
2. Legal Entity Name: _____
3. Tax Identification Number (EIN/TIN): _____
4. Business Physical Address: _____

_____

5. If applicable, 3-digit plan number reported in the IRS Form 5500 filed with the Department of Labor (if more than one, separate with a semicolon): _____

Section 2: Group Size Information

1. Average number of owners and employees (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: _____
2. To the best of your knowledge, how many eligible employees not covered by a plan offered by your business have other creditable coverage _____

[Creditable coverage includes other employer group coverage, individual coverage, Medicare, Medicaid, BadgerCare or Tricare (military service coverage). The employee waivers you have on file reflect this number.]

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Section 3: Medicare Coordination of Benefits

In accordance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, Group Health Cooperative of South Central Wisconsin is required to verify your employer group size. This mandatory verification provides us with the necessary data to report Medicare Secondary Payer information to the Centers for Medicare and Medicaid Services (CMS). If any information provided in this Section 3 changes prior to GHC-SCW's next annual request, you must complete an updated form and notify GHC-SCW within thirty (30) days of the change.

When calculating the number of employees*:_____

- use the total number of employees in the organizational structure (parent, subsidiaries, and siblings), not just the subsidiary being reported on this form.
- report the size of the largest employer in the plan if your business is part of a multi-employer/multiple employer plan
- include part-time and full-time employees

*See 42 CFR 411.101 for the definition of employee

1. Did your business employ 20 or more employees who worked at least 20 weeks in the prior calendar year?

☐ Yes ☐ No

- If No, go to Question 2
- If Yes, go to Question 3

2. Did your business employ 20 or more employees who worked at least 20 weeks in the current calendar year?

☐ Yes ☐ No

- If No, continue to next section
- If Yes, date of the first day of the 20th week in which your business had 20 or more employees in the current calendar year:_____

3. Did your business employ 100 or more employees on 50% or more of your business days in the prior calendar year?

☐ Yes ☐ No

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Section 4: Contribution

1. What is the Employer Contribution percentage for each of the following coverages (as applicable)?

- Employee:_____
- Employee + 1 (if applicable):_____
- Family:_____

2. Do you contribute money toward your employees' out-of-pocket expenses using a health savings account (HSA) or health reimbursement arrangement (HRA)?

☐ Yes ☐ No

- HSA Vendor Name:_____
- HRA Vendor Name:_____
- Annual Employer Contribution to Health Savings Account: Single $_____ Family $_____
- Annual Employer Contribution to Health Reimbursement Account: Single $_____Family $_____

Section 5: Gag Clause Prohibition Compliance Attestation Information ("Gag Clause Attestation")

Do you want GHC-SCW to complete this entity's Gag Clause Attestation on its behalf?

☐ Yes ☐ No

- If yes, complete the below information
- If no, continue to Section 6.

1. Entity Mailing Address:_____
2. Entity Point of Contact Name: _____
3. Entity Point of Contact E-mail: _____

Section 6: RxDC Reporting Information

1. Average Monthly Premium Paid by Members:_____
2. Average Monthly Premium Paid by Employers: _____

To calculate the average monthly premium for Members take the total annual premium paid by Members (the employee contribution portion) during the prior calendar year and divide by 12.

To calculate the average monthly premium for Employers take the total annual premium paid by the Employer on behalf of members (the employer contribution portion) in the prior calendar year and divide by 12.

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Section 7: Reporting

1. This form must be returned to GHC-SCW within thirty (30) days of GHC-SCW's request.
2. This form must be completed in full, with complete and accurate information. **GHC-SCW is not responsible for reporting errors that occur due to incomplete or inaccurate information provided on this form.**
3. GHC-SCW may revise this Employer Group Annual Information Form at any time and request an updated completed form be returned to GHC-SCW with thirty (30) days to comply with current or new reporting requirements GHC-SCW may perform on behalf of its Groups, or to meet its own reporting requirements.
4. GHC-SCW may utilize the information included on this form to report employer group information to the Centers for Medicare and Medicaid Services (CMS) for purposes of Medicare Secondary Payer reporting.
5. Upon receipt of this Group Information Form, and provided all information is completed in full and duly executed by an authorized representative of the Employer, GHC-SCW agrees to the following:

    a. GHC-SCW shall post Employer's machine-readable files to GHC-SCW's public website, as required pursuant to the Transparency in Coverage Final Rule (CMS-9115-F).

    b. If indicated "Yes" in Section 5, GHC-SCW shall submit Employer's Gag Clause Attestation on its behalf, as required pursuant to the Transparency in Coverage Final Rule.

    c. GHC-SCW shall submit Employer's Prescription Drug Data Collection (RxDC) data submission, as required pursuant to Section 204 of Division BB, Title II (Section 204) of the Consolidated Appropriations Act, 2021.

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The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week. By signing and returning this form to GHC-SCW, the undersigned agrees to cooperate with GHC-SCW to provide updated information to GHC-SCW upon request to ensure compliance with any and all GHC-SCW reporting requirements and that incomplete or incorrect information may result in reporting errors. **The undersigned agrees that if any information provided in Section 3 of this form changes prior to GHC-SCW's next annual request, an updated form will be completed and provided to GHC-SCW within thirty (30) days of the change.**

Employer Authorized Representative Signature:_____ Date:_____
Print Name:_____ Email Address:_____

Returned Signed Form To:

Secure Upload: Visit ghcscw.com/employers – select "Employer Group Annual Form Upload" button
By E-mail: **enrollment@ghcscw.com**
By Fax: (608) 662-4837

Group Health Cooperative of South Central Wisconsin
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