of South Central Wisconsin

APPLICATION FOR GROUP SERVICE AGREEMENT (Small Group ACA Plans)

GHC-SCW Administration • Attn: Sales, P.O. BOX 44971
Madison, WI 53744-4971 • Phone: (608) 251-3356

Application is hereby made to Group Health Cooperative of South Central Wisconsin (GHC-SCW) for issuance or renewal of a Group Service Agreement. This application provides the specifics for the Administration of the Group Service Agreement and is to be reviewed annually. *Please complete all of the blank areas and indicate any change by crossing through the current information and writing in the correct information to help us update our records.*

◯ Initial Application ◯ Health
◯ Renewal Application
◯ Change of Status

EMPLOYER INFORMATION

Legal Name of Group		Corp. ID	SIC #	Federal Employer ID #
Street Address				City
State	Zip	Nature of Business		Total # of Employees on Payroll
# of Employees Eligible for Coverage in GHC-SCW Service Area		*Minimum Hours Worked to be Considered Eligible	Effective Date	Renewal Date

**Coverage must be offered to all employees who work 30 or more hours per week to meet WI law. GHC-SCW underwriting guidelines allow employers to select a minimum hourly requirement of no less than 20 hours and no more than 30 hours per week.*

◯ Renew same as previous year *If checked, Eligibility, Termination and Plan Selection will remain the same.*

ELIGIBILITY

For renewal – Only complete if making change.

- *Any changes requested will become effective on your renewal date.*
- *Your employee's application must be received within 30 days after becoming eligible.*
- *If your employee does not enroll when eligible, he or she may be considered a late entrant and subject to a waiting period of up to 12 months.*

New Group *Check appropriate box below*

◯ Apply eligibility provision for initial enrollment
◯ Waive eligibility provision for initial enrollment *(if your employee does not enroll when eligible, he or she may be considered a late entrant and subject to a waiting period of up to 12 months.)*

New or Existing Group *Check desired eligibility provision below*

◯ Please check this box if you would like to have a 1-month orientation period prior to the beginning of the employee waiting period. If you would like this option, please check this box in addition to one of the eligibility provisions listed below.

The orientation period is measured by adding one calendar month and subtracting one calendar month from the employee's date of hire. *Here are some examples:*

- *If an employee is hired on June 5th, the employee's orientation period will end on July 4th, and the employee's waiting period will begin on July 5th.*
- *If an employee is hired on October 1st, the employee's orientation period will end on October 31st, and the employee's waiting period will begin on November 1st.*

Please note that a 1-month orientation period could result in the employer group being responsible for an Employer Shared Responsibility payment under IRS Code § 4980. Under IRS Code § 4980, certain large employers could be subject to penalty if they fail to give full-time employees the opportunity to enroll in coverage by the first day of the fourth month of employment.

◯ **(20)** Immediately on Date of Hire (DOH)
◯ **(21)** 1st Month from DOH
◯ **(22)** Immediately after 15 Days from DOH
◯ **(23)** 1st Month Following 15 Days from DOH
◯ **(24)** Immediately after 30 Days from DOH
◯ **(25)** 1st Mo. Following 30 Days from DOH
◯ **(26)** Immediately after 45 Days from DOH
◯ **(27)** 1st Month Following 45 Days from DOH
◯ **(28)** Immediately after 60 Days from DOH
◯ **(29)** 1st Month Following 60 Days from DOH
◯ **(30)** Other (please explain) ______________________

Is the eligibility period the same as listed above for employees in the following situations: *(applicant must meet group's eligibility period first before these provisions apply)*

Situation			
Changing from Part-time to Full-time	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* ______
Return from leave of absence	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* ______
Return from Layoff	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* ______
Rehire	◯ Yes	◯ No	*If no, please explain eligibility guidelines:* ______

Effective Date from 1st to 15th, Full Month Premium Due, Effective Date from 16th to 31st, Premium Waived for Balance of Month.

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TERMINATION *For renewal – Only complete if making change.*

New or Existing Group *Check desired termination provision below*

◯ **(A)** Last Day of Employment
- *Date of Termination from 1st to 15th, No Premium Due for Month*
- *Date of Termination from 16th to 31st, Full Month Premium Due*

◯ **(B)** Last Day of Coverage Month
- *Full Premium Due Through End of Coverage Month*

◯ **(C)** 1st of Month Following One Month from Date of Termination

◯ **(D)** Other *(please explain)*

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PLAN SELECTION *For renewal – only complete if making change*

- Please check the plan(s) you are offering for the coming plan year.

Small Group ACA Plans

Plan Name	Select	HMO	POS	PPO
Platinum 500 Ded/1750 MOOP	2442120 ◯	2441120 ◯	2444120 ◯	2443120 ◯
Platinum No Ded/2400 MOOP	2442121 ◯	2441121 ◯	2444121 ◯	2443121 ◯
Platinum 500 Ded/2500 MOOP	2442122 ◯	2441122 ◯	2444122 ◯	2443122 ◯
Platinum 1000 Ded/3000 MOOP	2442123 ◯	2441123 ◯	2444123 ◯	2443123 ◯
Platinum 1000 Ded/4000 MOOP Primary Care Preferred	2442125 ◯	2441125 ◯	N/A	N/A
Gold 1500 Ded/7500 MOOP	2442224 ◯	2441224 ◯	2444224 ◯	2443224 ◯
Gold 1200 Ded/5600 MOOP	2442207 ◯	2441207 ◯	2444207 ◯	2443207 ◯
Gold 2500 Ded/6500 MOOP	2442226 ◯	2441226 ◯	2444226 ◯	2443226 ◯
Gold 4500 Ded/8500 MOOP Primary Care Preferred	2442227 ◯	2441227 ◯	N/A	N/A
Gold 3000 Ded/3000 MOOP HSA	2442223 ◯	2441223 ◯	2444223 ◯	2443223 ◯
Silver 3300 Ded/8950 MOOP	2442319 ◯	2441319 ◯	2444319 ◯	2443319 ◯
Silver 9050 Ded/9050 MOOP Primary Care Preferred	2442376 ◯	2441376 ◯	N/A	N/A
Silver 5100 Ded/5100 MOOP HSA	2442373 ◯	2441373 ◯	2444373 ◯	2443373 ◯
Silver 6000 Ded/8550 MOOP	2442374 ◯	2441374 ◯	2444374 ◯	2443374 ◯
Bronze No Ded/9450 MOOP	2442430 ◯	2441430 ◯	2444430 ◯	2443430 ◯
Bronze 8700 Ded/8700 MOOP	2442419 ◯	2441419 ◯	2444419 ◯	2443419 ◯
Bronze 7050 Ded/7050 MOOP HSA	2442404 ◯	2441404 ◯	2444404 ◯	2443404 ◯

Please consult the Member Certificate, Summary of Benefits and Coverage, Benefits Summary, Group Service Agreement and any applicable amendments for specific information regarding covered services, services that require Prior Authorization, and exclusions and limitations.

Optional Benefit/Amendments *For renewal – Only complete if making change.*

Domestic Partner Coverage ◯ No | ◯ Yes -
(Available at no extra cost. Subject to Eligibility Criteria)

HRA ◯ No | ◯ Yes Vendor ◯ EBC ◯ TASC ◯ Other ______________________

Employer Contribution. Employers must contribute a minimum of 50% of the employee rate for all enrolled employees and at least the same dollar amount towards the other rates. If more than one health plan is offered, the employer may pay 50% of the employee rate of the least expensive plan.

PREMIUMS ARE DUE BY THE 20TH OF THE MONTH FOR THE NEXT COVERAGE MONTH

ACCEPTANCE

All legal and tax questions concerning the Plan are the responsibility of the Employer. No service provided by the terms of this agreement will be construed as legal or tax advice or interpretation. The employer must rely on the opinions of its own tax or legal advisors, as it deems necessary or appropriate.
I agree and accept the benefit option(s) I have chosen.

Authorized Group Official

Date of Application	Signature
Printed Name	Title
Email	Phone and Fax