



Group Health Cooperative

of South Central Wisconsin

APPLICATION FOR GROUP SERVICE AGREEMENT (Small Group Non-ACA Transitional 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 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.*

- Renewal Application Health
- 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.

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.

- | | | |
|---|---|---|
| <input type="radio"/> (20) Immediately on Date of Hire (DOH) | <input type="radio"/> (21) 1st Month from DOH | <input type="radio"/> (22) Immediately after 15 Days from DOH |
| <input type="radio"/> (23) 1st Month Following 15 Days from DOH | <input type="radio"/> (24) Immediately after 30 Days from DOH | <input type="radio"/> (25) 1st Mo. Following 30 Days from DOH |
| <input type="radio"/> (26) Immediately after 45 Days from DOH | <input type="radio"/> (27) 1st Month Following 45 Days from DOH | <input type="radio"/> (28) Immediately after 60 Days from DOH |
| <input type="radio"/> (29) 1st Month Following 60 Days from DOH | <input type="radio"/> (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)*

- 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) _____

PLAN SELECTION For renewal – only complete if making change

- Plan numbers below allow you to access detailed Benefit Summaries and SBC's at ghscsw.com.
- Please check the plan(s) you are offering for the coming plan year.

Small Group Non-ACA Transition Plans

Plan Type	Plan Name	2024 Plan #	2025 Plan #		Plan Type	Plan Name	2024 Plan #	2025 Plan #	
HMO	\$0 Co-payment Plan	2461501	2561501	<input type="radio"/>	HMO	\$2,500 High Deductible Health Plan - 0%	2461525	2561525	<input type="radio"/>
HMO	\$10 Co-payment Plan	2461502	2561502	<input type="radio"/>	HMO	\$2,500 High Deductible Health Plan with Rx - 0%	2461526	2561526	<input type="radio"/>
HMO	\$20 Co-payment Plan	2461503	2561503	<input type="radio"/>	HMO	\$2,500 High Deductible Health Plan with Rx - 20%	2461527	2561527	<input type="radio"/>
HMO	\$30 Co-payment Plan	2461504	2561504	<input type="radio"/>	HMO	\$5,250 High Deductible Health Plan - 0%	2461528	2561528	<input type="radio"/>
HMO	\$30 Co-payment Plan No Rx	2461505	2561505	<input type="radio"/>	HMO	\$5,250 High Deductible Health Plan with Rx - 0%	2461529	2561529	<input type="radio"/>
HMO	\$20 Co-payment Plan with \$100 ER Co-payment	2461506	2561506	<input type="radio"/>	HMO	\$20 Co-payment Plan	2461530	2561530	<input type="radio"/>
HMO	\$30 Co-payment & \$100 ER Copayment Plan	2461507	2561507	<input type="radio"/>	HMO	\$15 Co-payment Plan	2461531	2561531	<input type="radio"/>
HMO	\$40 Co-payment with \$100 ER Plan	2461508	2561508	<input type="radio"/>	HMO	\$1,650 High Deductible Health Plan - 20%	2461532	2561532	<input type="radio"/>
HMO	\$500 Deductible \$20 Co-payment Plan	2461509	2561509	<input type="radio"/>	PPO	\$0 Deductible \$10 Co-payment PPO Plan	2463501	2563501	<input type="radio"/>
HMO	\$500 Deductible Plan	2461510	2561510	<input type="radio"/>	PPO	\$0 Deductible \$20 Co-payment PPO Plan	2463502	2563502	<input type="radio"/>
HMO	\$1,000 Deductible \$30 Co-payment Plan	2461511	2561511	<input type="radio"/>	PPO	\$0 Deductible \$30 Co-payment PPO Plan	2463503	2563503	<input type="radio"/>
HMO	\$1,000 Deductible Plan	2461512	2561512	<input type="radio"/>	PPO	\$500 Deductible, \$20 Co-payment PPO Plan	2463504	2563504	<input type="radio"/>
HMO	\$1,500 Deductible Plan	2461513	2561513	<input type="radio"/>	PPO	\$500 Deductible 80/20 Co-insurance PPO Plan	2463505	2563505	<input type="radio"/>
HMO	\$2,000 Deductible \$40 Co-payment Plan	2461514	2561514	<input type="radio"/>	PPO	\$1,000 Deductible, \$30 Co-payment PPO Plan	2463506	2563506	<input type="radio"/>
HMO	\$2,000 Deductible Plan	2461515	2561515	<input type="radio"/>	PPO	\$1,000 Deductible 70/30 Co-insurance PPO Plan	2463507	2563507	<input type="radio"/>
HMO	Consumer Driven \$500 Deductible Plan	2461516	2561516	<input type="radio"/>	PPO	\$2,000 Deductible, \$40 Co-payment PPO Plan	2463508	2563508	<input type="radio"/>
HMO	Consumer Driven \$1,000 Deductible \$30 Co-payment Plan	2461517	2561517	<input type="radio"/>	PPO	\$1,500 Deductible 70/30 Co-insurance PPO Plan	2463509	2563509	<input type="radio"/>
HMO	Consumer Driven \$1,000 Deductible Plan	2461518	2561518	<input type="radio"/>	PPO	Consumer Driven \$1,000 Deductible \$30 Co-pay PPO Plan	2463510	2563510	<input type="radio"/>
HMO	Consumer Driven \$1,500 Deductible Plan	2461519	2561519	<input type="radio"/>	PPO	Consumer Driven \$2,000 Deductible \$40 Co-pay PPO Plan	2463511	2563511	<input type="radio"/>
HMO	Consumer Driven \$2,000 Deductible \$40 Co-payment Plan	2461520	2561520	<input type="radio"/>	PPO	\$1,650 PPO High Deductible Health Plan w/ Rx - 0%	2463512	2563512	<input type="radio"/>
HMO	Consumer Driven \$2,000 Deductible Plan	2461521	2561521	<input type="radio"/>	PPO	\$1,650 PPO High Deductible Health Plan w/ Rx - 20%	2463513	2563513	<input type="radio"/>
HMO	\$1,650 High Deductible Health Plan - 0%	2461522	2561522	<input type="radio"/>	PPO	\$2,500 PPO High Deductible Health Plan w/ Rx - 0%	2463514	2563514	<input type="radio"/>
HMO	\$1,650 High Deductible Health Plan with Rx - 0%	2461523	2561523	<input type="radio"/>	PPO	\$2,500 PPO High Deductible Health Plan w/ Rx - 20%	2463515	2563515	<input type="radio"/>
HMO	\$1,650 High Deductible Health Plan with Rx - 20%	2461524	2561524	<input type="radio"/>					

* 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

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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