



# Group Health Cooperative

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.

- |   |   |   |
|---|---|---|
| <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.

**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

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

**Small Group ACA Plans**

Plan Name	Better Together HMO	Partners HMO	Partners Plus POS	Connections PPO
Platinum 500 Ded/1750 MOOP	2642120 <input type="radio"/>	2641120 <input type="radio"/>	2644120 <input type="radio"/>	2643120 <input type="radio"/>
Platinum No Ded/3500 MOOP	2642135 <input type="radio"/>	2641135 <input type="radio"/>	2644135 <input type="radio"/>	2643135 <input type="radio"/>
Platinum No Ded/2650 MOOP	2642121 <input type="radio"/>	2641121 <input type="radio"/>	2644121 <input type="radio"/>	2643121 <input type="radio"/>
Platinum 1000 Ded/4000 MOOP Primary Care Preferred	2642125 <input type="radio"/>	2641125 <input type="radio"/>	N/A	N/A
Platinum 500 Ded/2500 MOOP	2642122 <input type="radio"/>	2641122 <input type="radio"/>	2644122 <input type="radio"/>	2643122 <input type="radio"/>
Platinum 1000 Ded/3000 MOOP	2642123 <input type="radio"/>	2641123 <input type="radio"/>	2644123 <input type="radio"/>	2643123 <input type="radio"/>
Platinum 1000 Ded/1500 MOOP	2642133 <input type="radio"/>	2641133 <input type="radio"/>	2644133 <input type="radio"/>	2643133 <input type="radio"/>
Platinum 250 Ded/1850 MOOP	2642132 <input type="radio"/>	2641132 <input type="radio"/>	2644132 <input type="radio"/>	2643132 <input type="radio"/>
Gold 1500 Ded/7500 MOOP	2642224 <input type="radio"/>	2641224 <input type="radio"/>	2644224 <input type="radio"/>	2643224 <input type="radio"/>
Gold 3250 Ded/6350 MOOP Primary Care Preferred	2642227 <input type="radio"/>	2641227 <input type="radio"/>	N/A	N/A
Gold 3100 Ded/3100 MOOP HSA	2642223 <input type="radio"/>	2641223 <input type="radio"/>	2644223 <input type="radio"/>	2643223 <input type="radio"/>
Gold 3300 Ded/3300 MOOP	2642234 <input type="radio"/>	2641234 <input type="radio"/>	2644234 <input type="radio"/>	2643234 <input type="radio"/>
Gold 1200 Ded/5600 MOOP	2642207 <input type="radio"/>	2641207 <input type="radio"/>	2644207 <input type="radio"/>	2643207 <input type="radio"/>
Gold 2250 Ded/6250 MOOP	2642226 <input type="radio"/>	2641226 <input type="radio"/>	2644226 <input type="radio"/>	2643226 <input type="radio"/>
Silver 5300 Ded/5300 MOOP HSA	2642373 <input type="radio"/>	2641373 <input type="radio"/>	2644373 <input type="radio"/>	2643373 <input type="radio"/>
Silver 9650 Ded/9650 MOOP Primary Care Preferred	2642376 <input type="radio"/>	2641376 <input type="radio"/>	N/A	N/A
Silver 3300 Ded/9000 MOOP	2642319 <input type="radio"/>	2641319 <input type="radio"/>	2644319 <input type="radio"/>	2643319 <input type="radio"/>
Silver 7000 Ded/8500 MOOP	2642374 <input type="radio"/>	2641374 <input type="radio"/>	2644374 <input type="radio"/>	2643374 <input type="radio"/>
Bronze 7100 Ded/7100 MOOP HSA	2642404 <input type="radio"/>	2641404 <input type="radio"/>	2644404 <input type="radio"/>	2643404 <input type="radio"/>
Bronze No Medical Ded/10400 MOOP	2642430 <input type="radio"/>	2641430 <input type="radio"/>	2644430 <input type="radio"/>	2643430 <input type="radio"/>
Bronze 8700 Ded/8700 MOOP	2642419 <input type="radio"/>	2641419 <input type="radio"/>	2644419 <input type="radio"/>	2643419 <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**

**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