



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 | <input type="radio"/> Yes | <input type="radio"/> No | If no, please explain eligibility guidelines: _____ |
| Return from leave of absence | <input type="radio"/> Yes | <input type="radio"/> No | If no, please explain eligibility guidelines: _____ |
| Return from Layoff | <input type="radio"/> Yes | <input type="radio"/> No | If no, please explain eligibility guidelines: _____ |
| Rehire | <input type="radio"/> Yes | <input type="radio"/> 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	2025 Plan #	2026 Plan #		Plan Type	Plan Name	2025 Plan #	2026 Plan #	
HMO	\$0 Co-payment Plan	2561501	2661501	<input type="radio"/>	HMO	\$2,500 High Deductible Health Plan - 0%	2561525	2661525	<input type="radio"/>
HMO	\$10 Co-payment Plan	2561502	2661502	<input type="radio"/>	HMO	\$2,500 High Deductible Health Plan with Rx - 0%	2561526	2661526	<input type="radio"/>
HMO	\$20 Co-payment Plan	2561503	2661503	<input type="radio"/>	HMO	\$2,500 High Deductible Health Plan with Rx - 20%	2561527	2661527	<input type="radio"/>
HMO	\$30 Co-payment Plan	2561504	2661504	<input type="radio"/>	HMO	\$5,250 High Deductible Health Plan - 0%	2561528	2661528	<input type="radio"/>
HMO	\$30 Co-payment Plan No Rx	2561505	2661505	<input type="radio"/>	HMO	\$5,250 High Deductible Health Plan with Rx - 0%	2561529	2661529	<input type="radio"/>
HMO	\$20 Co-payment Plan with \$100 ER Co-payment	2561506	2661506	<input type="radio"/>	HMO	\$20 Co-payment Plan	2561530	2661530	<input type="radio"/>
HMO	\$30 Co-payment & \$100 ER Copayment Plan	2561507	2661507	<input type="radio"/>	HMO	\$15 Co-payment Plan	2561531	2661531	<input type="radio"/>
HMO	\$40 Co-payment with \$100 ER Plan	2561508	2661508	<input type="radio"/>	HMO	\$1,700 High Deductible Health Plan - 20%	2561532	2661532	<input type="radio"/>
HMO	\$500 Deductible \$20 Co-payment Plan	2561509	2661509	<input type="radio"/>	PPO	\$0 Deductible \$10 Co-payment PPO Plan	2563501	2663501	<input type="radio"/>
HMO	\$500 Deductible Plan	2561510	2661510	<input type="radio"/>	PPO	\$0 Deductible \$20 Co-payment PPO Plan	2563502	2663502	<input type="radio"/>
HMO	\$1,000 Deductible \$30 Co-payment Plan	2561511	2661511	<input type="radio"/>	PPO	\$0 Deductible \$30 Co-payment PPO Plan	2563503	2663503	<input type="radio"/>
HMO	\$1,000 Deductible Plan	2561512	2661512	<input type="radio"/>	PPO	\$500 Deductible, \$20 Co-payment PPO Plan	2563504	2663504	<input type="radio"/>
HMO	\$1,500 Deductible Plan	2561513	2661513	<input type="radio"/>	PPO	\$500 Deductible 80/20 Co-insurance PPO Plan	2563505	2663505	<input type="radio"/>
HMO	\$2,000 Deductible \$40 Co-payment Plan	2561514	2661514	<input type="radio"/>	PPO	\$1,000 Deductible, \$30 Co-payment PPO Plan	2563506	2663506	<input type="radio"/>
HMO	\$2,000 Deductible Plan	2561515	2661515	<input type="radio"/>	PPO	\$1,000 Deductible 70/30 Co-insurance PPO Plan	2563507	2663507	<input type="radio"/>
HMO	Consumer Driven \$500 Deductible Plan	2561516	2661516	<input type="radio"/>	PPO	\$2,000 Deductible, \$40 Co-payment PPO Plan	2563508	2663508	<input type="radio"/>
HMO	Consumer Driven \$1,000 Deductible \$30 Co-payment Plan	2561517	2661517	<input type="radio"/>	PPO	\$1,500 Deductible 70/30 Co-insurance PPO Plan	2563509	2663509	<input type="radio"/>
HMO	Consumer Driven \$1,000 Deductible Plan	2561518	2661518	<input type="radio"/>	PPO	Consumer Driven \$1,000 Deductible \$30 Co-pay PPO Plan	2563510	2663510	<input type="radio"/>
HMO	Consumer Driven \$1,500 Deductible Plan	2561519	2661519	<input type="radio"/>	PPO	Consumer Driven \$2,000 Deductible \$40 Co-pay PPO Plan	2563511	2663511	<input type="radio"/>
HMO	Consumer Driven \$2,000 Deductible \$40 Co-payment Plan	2561520	2661520	<input type="radio"/>	PPO	\$1,700 PPO High Deductible Health Plan w/ Rx - 0%	2563512	2663512	<input type="radio"/>
HMO	Consumer Driven \$2,000 Deductible Plan	2561521	2661521	<input type="radio"/>	PPO	\$1,700 PPO High Deductible Health Plan w/ Rx - 20%	2563513	2663513	<input type="radio"/>
HMO	\$1,700 High Deductible Health Plan - 0%	2561522	2661522	<input type="radio"/>	PPO	\$2,500 PPO High Deductible Health Plan w/ Rx - 0%	2563514	2663514	<input type="radio"/>
HMO	\$1,700 High Deductible Health Plan with Rx - 0%	2561523	2661523	<input type="radio"/>	PPO	\$2,500 PPO High Deductible Health Plan w/ Rx - 20%	2563515	2663515	<input type="radio"/>
HMO	\$1,700 High Deductible Health Plan with Rx - 20%	2561524	2661524	<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