EMPLOYER GROUP APPLICATION

Dean Health Plan, Inc. / Dean Health Insurance, Inc.
1277 Deming Way, Madison, WI 53717 (608) 836-1400 or (800) 356-7344

Section I – Group Information

1 Legal name of business requesting coverage:

2 Doing business as (dba):

3 Legal form of business:
☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Other: _____

4 Street address for billing and administrative purposes:
City: County: State: ZIP Code:

5 If physical address is different from the address listed above, please indicate it here:
City: County: State: ZIP Code:

6 Telephone number:

7 Nature of business:

8 Years in business:

9 Federal tax ID number:

10 Website:

11 List names of ALL owners and their percentage of ownership in this company:

a. Do any of the owners, either individually or in combination, own 50% or more of this company and 50% or more of any other company? ☐ Yes ☐ No
b. Does the business above own any other companies or is the business above owned by any other company or legal entity? ☐ Yes ☐ No

12 If answered yes to 11a or 11b, please provide the company details below.

Company Name	Company Address (Street, City, State)	Number of Employees	Does this company have a different Tax ID than the company applying for coverage?	Will this company also be offered Dean coverage?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

13 Administrative Contact Name, Title, Phone Number and E-mail Address:

14 Premium Billing Contact Name, Title, Phone Number and E-mail Address:

15 Are you currently a member of a Dean partner Association or Chamber? ☐ Yes ☐ No
If "yes", please list which one:

Section II – Current Plan Information

16 Please list your current group health insurance carrier: _____
Number of years with this carrier: _____ Renewal date: _____
Please submit a copy of your health carrier's most recent billing statement.

17 Is this group currently self funded? ☐ Yes ☐ No **If "yes", please submit the most recent three years of claims, enrollment, and shock loss data.**

18 Type of current coverage: ☐ HMO ☐ POS ☐ PPO

Deductible: **$**	In-Network: **$**	Out-of-Network: **$**
Co-insurance: **%**	In-Network: **%**	Out-of-Network: **%**
Office visit copay: **$**		Out-of-Network: **$**

Prescription Drug Plan *(please indicate if the amount is $ or %):*

19 Current group premium information:
a. Current total monthly premium: _____ b. Upcoming renewal monthly premium amount or renewal increase %: _____

20 Tier Structure *(all groups with 2-10 subscribers will receive age/gender rates)*:
☐ 2 Tier (Single & Family) ☐ 3 Tier (Single, Employee + 1 & Family)
☐ Special 3 Tier (Single, Employee+Spouse or Child(ren) & Family) ☐ 4 Tier (Single, Employee + Spouse, Employee + Children & Family)

EMPLOYER GROUP APPLICATION *(continued)*

Section III – Eligibility Information

Who is considered an eligible employee?

An employee who: **(a)** appears on the policyholder's or designated employer's payroll records; **(b)** is active at work/active status performing his/her duties on the date his/her coverage is to become effective; **(c)** works at least the minimum number of hours per week required under the Group Master Policy; and **(d)** has completed any waiting period required before coverage is effective. Eligible employees also include commissioned salespeople for whom the policyholder or designated employer is paying Workers' Compensation, premiums, unemployment taxes, and social security.

What are the minimum participation requirements?

Number of eligible employees	Participation Requirements	Number of eligible employees	Participation Requirements
2 through 4	2 participants	5 or 6	3 participants
7	4 participants	8 or 9	5 participants
10	6 participants	11 through 25	50%
26 or more	50% (20% if a large group that is dual choice with another carrier)		

When determining participation, "eligible employees" do not include those with other creditable health coverage (except those employees with other creditable coverage through this employer group); those with group continuation coverage (or any other non-working class of employees); or those serving their waiting period.
Dean may terminate or decline to renew this agreement if the minimum participation requirements are not met.

Our standard dependent termination is to the end of the month the dependent turns 26.

21 In order to determine the small employer group status of your business, what was the average number of employees working at your business during the most recent calendar year (January through December)? _____ *(Small employer is defined as 2-50 total employees. Please use the numbers reported on your quarterly contribution report(s), including all commonly owned businesses, for the most recent calendar year to determine this number).*

22 Current employee information:

a. _____ Total number of permanent active employees currently on your payroll
b. _____ Number of permanent employees eligible for health insurance
c. _____ Number of permanent employees NOT eligible for health insurance
d. _____ Number of employees who are seasonal or temporary

23 Of the number of employees reported in Question 22b, list the number that are waiving Dean due to other creditable health coverage. _____

24 Employees not actively at work: please provide the following details for all employees that are not actively at work. For each employee choose from the following to indicate the reason they are not actively at work:

a. Currently on COBRA or State Continuation, within election period
b. Laid Off
c. Medical Leave of Absence
d. Non-Medical Leave of Absence
e. Military Leave
f. Health Coverage through Severance Agreement
g. Receiving Worker's Compensation

Name	Last Day at Work	Anticipated Return to Work or Coverage End Date	Reason Code

25 Employer contribution percentage: Single: _____ Employee/Child(ren): _____ Employee/Spouse: _____ Family: _____

Please note: Employers are required to contribute a minimum of 25% of the single premium for all employees.

26 If you are a large employer group (51 or more total employees), will your company offer more than one health insurance option, other than Dean to your employees?

☐ Yes ☐ No
If "yes" please explain: _____

27 If you will be insuring 100 or more employees, do you want to request an annual open enrollment where non-covered employees and dependents may enroll in the plan without late enrollee penalties? (This request is subject to underwriting approval.) ☐ Yes ☐ No ☐ N/A

28 Are you requesting domestic partner coverage? ☐ Yes ☐ No (Underwriting review and approval is required.)

EMPLOYER GROUP APPLICATION *(continued)*

Section IV – Requested Plan Information

29 For large groups with over 51 or more total employees only. Do you want to offer benefits by class? ☐ Yes ☐ No

If "yes," please select which classes you have: ☐ Hourly ☐ Salaried ☐ Union ☐ Non-Union ☐ Part-Time ☐ Full-Time ☐ Management ☐ Non-Management ☐ Executives ☐ Direct Bill

Or, please list the classes your company uses: _____

30 If you are a large employer group, are you excluding any classes of employees from coverage? ☐ Yes ☐ No

If "yes," please list the excluded classes: _____

31 Regardless of group size, coverage must be offered to all permanent employees with a normal work week of 30 or more hours, as defined by the Wisc. State Stat. 632.745
If your hourly requirement is less than 30 hours per week, please indicate your requirement here: _____

Does this hourly requirement apply to all classes of employees? ☐ Yes ☐ No

If "no," please list each class and their hourly requirement: _____

32 Probationary Period for new employees to obtain health insurance coverage (please note for small employer groups the probationary period cannot exceed 180 days).
☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days ☐ Other: _____

After the probationary period is served, coverage becomes effective: ☐ First of the month following the probationary period
☐ Immediately following the probationary period
☐ Other: _____

Do all classes of employees serve the same probationary period? ☐ Yes ☐ No

If "no," please list each class and their probationary period requirements: _____

33 Does the probationary period above apply to the employee in the following situations?

☐ Yes ☐ No Return from layoff: If "no," please advise when coverage would become effective and if you have different requirements for different classes of employees: _____

☐ Yes ☐ No Return from leave of absence: If "no," please advise when coverage would become effective and if you have different requirements for different classes of employees: _____

☐ Yes ☐ No Rehire: If "no," please advise when coverage would become effective and if you have different requirements for different classes of employees: _____

☐ Yes ☐ No Changing from part time to full time: If "no," please advise when coverage would become effective and if you have different requirements for different classes of employees: _____

34 Employee termination is effective: ☐ End of day the employee terminates ☐ End of month the employee terminates ☐ Other: _____

Does this termination requirement apply to all classes of employees? ☐ Yes ☐ No

If "no," please list each class and their termination requirement: _____

35 Are you requesting retiree coverage? ☐ Yes ☐ No

(Retiree coverage is available only if you have 20 or more employees enrolled for medical coverage. Underwriting review and approval is required.)

Total number of retirees: _____ Minimum age requirement: _____ Years of service: _____

Is retiree coverage available to all classes of employees? ☐ Yes ☐ No

If "no," please list the classes that are eligible for retiree coverage: _____

36 If you will be insuring less than 26 employees or you are a small employer group, a pre-existing clause is mandatory for adults age 19 or older.
If you will be insuring 26 or more employees, do you want a pre-existing clause applied for newly hired employees? ☐ Yes ☐ No ☐ N/A

EMPLOYER GROUP APPLICATION *(continued)*

Section V – Medical Questions — Not Required for Small Employer Groups

37 Has your company ever been declined, canceled, non-renewed, or not quoted by any health or life insurance carrier, including Dean? ☐ Yes ☐ No

38 Are any employees/dependents currently totally disabled, handicapped, confined to a hospital or chemical dependency unit, on sick leave, medical leave of absence, or working less than full time due to a medical condition? ☐ Yes ☐ No

39 Have any employees/dependents been treated for a serious illness, been hospitalized or had surgery in the past 12 months which has resulted in claims in excess of $5,000? ☐ Yes ☐ No

40 Are any employees/dependents currently pregnant? ☐ Yes ☐ No

41 Have any employees/dependents been treated or been advised treatment in the past 2 years for:

a. Cancer	☐ Yes	☐ No	f. Immune system disorder	☐ Yes	☐ No
b. Diabetes	☐ Yes	☐ No	g. Kidney disorder	☐ Yes	☐ No
c. Drug/alcohol	☐ Yes	☐ No	h. Lung disorder	☐ Yes	☐ No
d. HIV/AIDS	☐ Yes	☐ No	i. Psychological disorder	☐ Yes	☐ No
e. Heart conditions	☐ Yes	☐ No	j. Organ transplant	☐ Yes	☐ No

42 If you answered "yes" to any of the above questions in section V (HIV testing and genetic test results need not be revealed), or if you are aware of any other health condition that may exist with the employees of this business, please explain below (if you need additional space, please attach a separate sheet of paper). Should more information need to be obtained, Dean may need to contact the person(s) listed below. Use letter codes from question 41 to indicate type of treatment.

Name and Contact Number	Condition - Use Letter Code	Type of Treatment	Date of Diagnosis

Section VI – Employer Certification

If any application information changes during Dean's review of this application, please contact Dean for approval.

All Employers: By signing this application I understand and agree that:

a. All statements and answers I give are complete and true to the best of my knowledge and belief.

b. Dean will rely in part on the information recorded in this application as the basis for their decision on whether to approve this application and issue coverage.

c. Dean may delay/void this request for coverage due to incomplete, inaccurate, or untimely information.

d. Coverage is not in effect until the final approval is given by Dean. I should not cancel my current coverage until I have received such approval in writing from Dean.

e. An employee not actively at work on his/her assigned effective date will not be eligible until he/she has returned to work on a full-time basis (with the exception of vacation time or medical leave/sick day).

f. An agent, agency or broker, acting in any capacity, has no authority to (i) alter this application to bind Dean by making any promise and/or representation, or (ii) waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Dean.

Employer Representative's Signature: _____ Date of Signature: _____

Title of Employer Representative: _____

Section VII – Agent's Certification

I, as writing agent, certify that I have actively participated in the solicitation and placement of this insurance. I understand that I have no authority to alter this applicaiton to bind Dean by making any promise and/or representation, or to waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Dean.

Writing Agent's Signature: _____ Printed Name: _____ Date of Signature: _____