DeanHealthPlan Administrative Services
A member of SSM Health

Level Funded Employer Group Application

Section A — Group Information

Requested Effective Date:

1) Legal name of business requesting coverage

2) Doing business as (dba)

3) Billing Address (Same as Mailing Address? ☐ Yes ☐ No)

4) City | 5) State | 6) ZIP code | 7) County

8) Physical Address – use this as mailing address (if different from billing address above)? ☐ Yes ☐ No

9) City | 10) State | 11) ZIP code | 12) County

13) Phone number ( )

14) Federal Tax ID number

15) List the names of the businesses with common ownership (where an owner owns 50% or more of more than one business) that are applying for coverage as part of this offering:

Company Name	Company Address (Street, City, State)	No. of Employees	Federal Tax ID Number

16) Administrative contact name | 17) Title | 18) Phone number ( ) | 19) Email address

20) Billing contact name (if different than 16) | 21) Title | 22) Phone number ( ) | 23) Email address

24) Current group health insurance carrier (Please submit a copy of your most recent billing statement.)

25) Current renewal date

26) Years with Carrier

27) Type of current coverage: ☐ HMO ☐ POS ☐ PPO ☐ Fully Insured ☐ Self-Funded   Renewal Date: ____________

If your coverage includes High Deductible Health Plans, do you fund any of the deductible for your employees? ☐ Yes ☐ No If Yes, what amount?: ____________

28) Current total monthly premium:

a) Upcoming renewal monthly premium or % of increase:

29) Do you currently have a Third Party Administrator (TPA) that administers benefits for qualified HRA Plan(s)? ☐ Yes ☐ No

If yes, please list the name of the TPA: ____________

An additional authorization form will need to be completed to allow electronic claims feeds to be sent from Dean Health Plan to an eligible TPA for your qualified HRA plan(s).

30) For Medicare coordination of benefits:

a. In the previous calendar year did you have 100 or more employees during 50% of business days? ☐ Yes ☐ No

b. In the previous calendar year did you have 20 or more employees during 50% of business days? ☐ Yes ☐ No

c. Please indicate your employee count: ____________

Section B — Eligibility Information

31) In order to determine the group size classification of your business, what was the average number of employees working at your business during the entire previous calendar year? *(Please use the numbers reported on last year's quarterly contribution reports.)* ▶ ____________

32) Current employee information:

a. Total number of active employees:

b. Number of employees eligible for health insurance:

c. Number of employees NOT eligible for health insurance:

d. Of the number listed in "b." how many are waiving insurance:

e. The amount in letter "d." subtracted from letter "b.":

This should equal the amount of applications that are submitted for coverage.

33) Please provide the following details for any employee that is not currently active at work. For each employee please choose from the following list to indicate the reason they are not actively working: *(If you have policies pertaining to any of the Reasons listed below, please provide a copy)*

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

Reason Codes:

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

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Section C — Eligibility Information

34) Waiting period for new employees to obtain health insurance coverage: *(please note this cannot exceed 90 calendar days)*
First of the month following: ☐ 0 days ☐ 30 days ☐ 60 days

35) In the following situations, are employees required to serve the waiting period?

a.	Return from layoff: ☐ Yes ☐ No	c.	Rehire: ☐ Yes ☐ No
b.	Return from leave: ☐ Yes ☐ No	d.	Part time to full time: ☐ Yes ☐ No

If no is marked for any of these situations, please provide your policy information.

36) Are you requesting Domestic Partner coverage? ☐ Yes ☐ No If yes, a signed Domestic Partner Addendum is required.

Section D — Medical Questions

37) Has your company ever been declined, canceled, non-renewed, or not quoted by any health or life insurance carrier? ☐ 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 24 months which has resulted in claims in excess of $5,000? ☐ Yes ☐ No

40) To the best of your knowledge, is there any employee or dependent to be insured becoming eligible or receiving disability benefits of any type related to a disability or End Stage Renal Disease? ☐ Yes ☐ No

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

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

42) Have any employees/dependents informed you that they have been advised to have treatment, surgery or hospitalization in the next six months? ☐ Yes ☐ No

Provide details for any yes answers from above. If necessary, use additional sheets of paper.

Question Number	Name	Condition	Date of Diagnosis	Current Treatment or Date of Recovery	# Missed work days

Please provide your employee handbook/contract outlining your policies and procedures regarding employee coverage, waiting periods, and other eligibility to assist in the creation of your insurance policy.

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Section E — Employer/Agent Certification

If any application information changes during review of this application please contact Dean Health Plan with the revised information.

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 Health Plan will rely in part on the information recorded in this application as the basis for their decision on whether to accept this application and issue coverage.
c. Dean Health Plan may delay/void this request for coverage due to incomplete, inaccurate, or untimely information.
d. Coverage is not in effect until the final acceptance is given by Dean Health Plan . I should not cancel my current coverage until I have received confirmation in writing from Dean Health Plan .
e. An employee not actively at work on the assigned effective date will not be eligible until they have returned to work on a full-time basis (with exception of vacation time or medical leave/sick time.)
f. An agent, agency or broker, acting in any capacity, has no authority to alter this application to bind Dean Health Plan by making any promise or representation, or waive or change terms, conditions, or provisions of the group insurance policy or any requirement imposed by Dean Health Plan.
g. I agree to contribute a minimum of 25% of the single policy premium amount to all covered employees.
h. No employer may require employees to work more than 30 hours per week to be eligible for insurance coverage.
i. Coverage must be offered to all eligible employees with a normal work week of 30 hours. The hourly requirement for Large and Small Employers may not exceed 30 hours per week by law.
j. The Plan will have an Annual Open Enrollment period upon renewal where non-covered employees and dependents may enroll in the plan. Outside of the Annual Open Enrollment period applications will not be accepted.
k. Employee termination is effective end of the month.
l. Dependent maximum age termination is effective end of the month.
m. Dean Health Plan requires at least 50% participation of all eligible employees.
n. Electronic Fund Transfers are required for monthly funding amounts.

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

Title of Employer Representative: ____________________

Section F — Agent 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 application to bind Dean Health Plan 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 Health Plan .

Writing Agent's Signature: ____________________ Date: ____________________

Printed Agent Name: ____________________ Agency Name: ____________________

Section G — Authorization Agreement of Electronic Fund Transfers

Dean Health Plan offers an easy way to make monthly premium payments by automatically transferring funds from your checking or savings account on a monthly basis to pay your monthly premiums.

Any transfers that are not possible due to insufficient funds will be your responsibility. If you have any questions, please feel free to contact our Customer Care Center at 1-866-234-4516.

This authorization is to remain in full force and in effect until *Dean Health Plan* has received written notification from the employer group of its termination in such time and in such manner as to afford the Insurer and the bank a reasonable opportunity to act on it. On behalf of the employer group listed below, I hereby authorize the Insurer to initiate debit entries to the company account:

Employer Name ____________________ **Group Number**(s) __________ **Month to begin deductions** _____ **Bank Name** ____________________

Checking# ____________________ **or Savings#** ____________________ **Routing#** ____________________

Authorized Signature ____________________ **Date** ____________________

Don't forget to attach a deposit slip or voided check, or if the deduction is to be made from your savings account include the bank name, routing number and account number above. Please return your completed form and voided check/deposit slip to:

DEAN HEALTH PLAN • PO BOX 56099 • MADISON, WI 53705

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