DeanHealthPlan by Medica

Employer Group Application

Complete this application to apply for group coverage. Large employers with at least 51 total employees complete all sections of the application. Sections D and E are not required for Small employers with 2 to 50 total employees.

Section A Group Information

Requested Effective Date:

1) Legal name of business requesting coverage	2) Doing business as (dba)

3) Physical address – use this as mailing address (if different from billing address below)? ☐ Yes ☐ No

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

8) Billing address – use this also as mailing address? ☐ 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):

Company Name	Company Address (Street, City, State)	Number of Employees	Federal Tax ID Number	Owner Name (50% or more of business)	Applying for Coverage

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) Will you require separate invoices for multiple locations? ☐ Yes ☐ No

25) Current group health insurance carrier (Please submit a copy of your most recent billing statement.)	26) Current renewal date	27) Years with Carrier

28) Do you currently have a Third Party Administrator (TPA) that administers benefits for a qualified HRA plan(s)? ☐ Yes ☐ No
If yes, please list the name of your current TPA: ______________________________
An additional authorization form will need to be completed to allow an electronic claims feed to be sent from Dean Health Plan to a TPA for your qualified HRA plan(s). Please speak to your Dean Health Plan Sales Executive for more information.

29) 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

30) 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.)* ▶ ______________________

31) Current employee information:

a.	Total number of active Fulltime employees (who work at least 130 hours per month)
b.	Total number of active Fulltime equivalent employees (FTE)* (who work less than 120 hours per month):
c.	Total number of current employees:
d.	Of the number listed in "c", the number of employees eligible for health insurance:
e.	Of the number listed in "c", the number of employees NOT eligible for health insurance:
f.	Of the number listed in "c." how many are waiving insurance:
g.	The amount in letter "f." subtracted from letter "d.": ***This should equal the amount of applications that are submitted for coverage.***

*If you need assistance determining the number of FTE's, please contact your Dean Health Plan Sales Executive.

32) 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

Section C Eligibility Information

33) Coverage must be offered to all eligible employees with a normal work week of 30 hours. Please indicate what your hourly requirement is if it is less than 30 hours per week. (Small Employers may only request down to a minimum of 20 hours per week. The hourly requirement for Large and Small Employers may not exceed 30 hours per week by law.):

34) Waiting period for new employees to obtain health insurance coverage: *(please note this cannot exceed 90 calendar days)*

a.	First of the month following: ☐ 0 days ☐ 30 days ☐ 60 days
b.	Immediately following: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
c.	Other:

35) In the following situations, are employees required to serve the waiting period?
a. Return from Layoff ☐ Yes ☐ No b. Return from Leave ☐ Yes ☐ No c. Rehire ☐ Yes ☐ No d. Part time to Full time ☐ Yes ☐ No
If NO is marked for any of these situations please indicate when the employee will be eligible for coverage if not immediately after the employee returns to work:

36) Late enrollee provision: Please select one of the 2 following options:
☐ Our policy 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.
☐ Our policy will have a 90 day waiting period for non-covered employees and dependents before coverage begins.

37) Employee termination is effective: End of the Month is the standard provision for all groups.

38) Dependent maximum age termination is effective: ☐ End of the year ☐ End of the month ☐ End of the day

39) Do you have an additional orientation period for new employees? ☐ Yes ☐ No *If yes, please indicate the length (must not exceed 30 days):*

40) Are you requesting Domestic Partner coverage? ☐ Yes ☐ No *(Please provide your policy information) (If yes, a signed Domestic Partner Addendum is required.)*

41) Are you requesting retiree coverage? *(available to employers with 20 or more enrolled employees)* ☐ Yes ☐ No *(Please provide your policy information)*

a.	Total number of retirees:
b.	Minimum age requirement:
c.	Years of service requirement:

Section D Large Employers Only (Not Required for Small Employers)

42) Type of current coverage: ☐ HMO ☐ POS ☐ PPO ☐ Fully Insured ☐ Self-Funded Renewal Date____________________________
If your coverage includes High Deductible Plans, do you fund any of the deductible for your employees? ☐ Yes ☐ No
If yes, what amount?_______________________

43) Current total monthly premium:	a) Upcoming renewal monthly premium or % of increase:

44) Please select the tier structure you prefer:
☐ 2 Tier (Single, Family)
☐ Special 3 Tier (Single, Employee+Spouse or Child(ren), Family)
☐ 3 Tier (Single, Employee+1, Family)
☐ 4 Tier (Single, Employee+Spouse, Employee+Child(ren), Family)

45) Please choose ONE benefit accumulation option: ☐ Plan Year ☐ Calendar Year

46) Will your company offer another health insurance carrier alongside Dean Health Plan ("Dean")? ☐ Yes ☐ No
If yes, please list the carriers offered:

47) **Employee Classes:** Do you want to offer different benefits by class of employee? ☐ Yes ☐ No
If yes, please select which classes you have:
☐ Hourly ☐ Salaried ☐ Union ☐ Non-Union ☐ Part-Time ☐ Full-Time ☐ Management ☐ Non-Management ☐ Executives
☐ Other:____

List any classes you are ***excluding*** from coverage:

48) Question 34 required you to select a waiting period for new employees. If you would like different waiting periods by class of employee or you allow different plan provisions by class of employee, please list that information here (or submit a list with this application):

49) Do you have different hourly requirements for different classes of employees? ☐ Yes ☐ No If yes, please list them here:

50) Do you have variable-hour employees? ☐ Yes ☐ No

If yes, request the variable-hour employee language template from your sales representative and submit with this application.

Section E Large Employers Medical Questions

Large employers with at least 51 total employees must complete all questions of this section. Small employers with 2 to 50 total employees are not required to complete this section.

51) To the best of your knowledge, is there any employee or dependent to be insured:

a. Who is 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

b. Who has informed you that they have been advised to have treatment, surgery or be hospitalized in the next six months? ☐ Yes ☐ No

c. Becoming eligible or receiving disability benefits of any type related to a disability or End Stage Renal Disease? ☐ 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	# of 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.

Section F Employer/Agent Certification

If any application information changes during review of this application please contact Dean 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 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. Dean may delay/void this request for coverage due to incomplete, inaccurate, or untimely information.

c. Coverage is not in effect until the final acceptance is given by Dean. I should not cancel my current coverage until I have received confirmation in writing from Dean.

d. 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.)

e. An agent, agency or broker, acting in any capacity, has no authority to alter this application to bind Dean 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.

f. I agree to contribute a minimum of 25% of the single policy premium amount to all covered employees.

g. No employer may require employees to work more than 30 hours per week to be eligible for insurance coverage.

h. Dean may decline to issue Small Employers (except during the annual one-month guaranteed enrollment period) or terminate existing Large or Small Employer coverage if minimum participation requirements are not met. Dean may not impose more stringent minimum participation than the following list:

	Number of Eligible EEs (without Retirees, Cobra and Waivers	Participation Requirements
Dean Health Plan Only Coverage (Small and Large Groups)	2–4	2 insured
	5–6	3 insured
	7	4 insured
	8–9	5 insured
	10	6 insured
	11+	Number of insured must be 50% of eligible EEs
Dual Choice Coverage (Large Groups Only)	2–50	Number of insured must be 50% of eligible EEs
	51–99	Number of insured must be 30% of eligible EEs
	100+	Number of insured must be 20% of eligible EEs

EMPLOYER AND AGENT SIGNATURES ON FOLLOWING PAGE

Section F *(Continued)* Employer/Agent Certification

Employer Representative's Signature: ______________________________ Date of Signature: ______________

Title of Employer Representative: ____

Section G 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 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: ______________________________ Date: ______________________

Printed Agent Name: ______________________________ Agency Name: ______________________