



## Employer Group Application

Dean Health Plan, Inc.  
Dean Health Insurance, Inc.  
1277 Deming Way, Madison, WI 53717  
(608) 836-1400 or 1-800-356-7344

For underwriting purposes, we may request additional information from an employee or dependent in the form of an updated application, a questionnaire or a telephone interview.

### 1. Are you a Small Employer Group?

If you had a total number of employees (part-time, full-time, seasonal, temporary etc.) from 2 through 50 over the last calendar year, you are a Small Employer Group. Please read the listed information below to assist you in answering the enclosed questions.

- The hourly requirement for eligible employees is 30 hours per week. (Question #31)
- All classes of employees must be offered coverage. (Question #32)
- The probationary period cannot be greater than 180 days. (Question #33)
- New hires after the initial enrollment period will be subject to a 12 month pre-existing period (As of 10/1/2010 does not apply to children through the age of 18). (Question #37)
- An open enrollment provision is not allowed. (Question #38)
- Dual choice with other carriers is not allowed. (Question #39)

The information below pertains to both Small Employer Groups and Large Employer Groups and will assist you in answering the questions enclosed.

### 2. What are the minimum contribution requirements? (Question #30)

All groups                      25% for Single Coverage

### 3. Who is considered an eligible employee? (Question #23b)

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 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.

### 4. What are the minimum participation requirements? (Question #23 and Question #24)

<u>Number of eligible employees</u>	<u>Participation Requirements</u>
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 dual choice and Large Employer Group)

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.

### 5. How are special provisions approved? (Questions #25 through #29)

- Retiree, Domestic Partner, Layoff, Rehire, Leave of Absence, Military Leave and Severance Agreements or any other provision where group coverage is continued for those not actively at work are subject to Underwriting review and approval. We require that you submit copies of any written policies.
- Union Agreement-Please submit a copy of the agreement to Underwriting for review and clarification of union provisions.

### 6. When is a pre-existing clause applied? (As of 10/1/2010 does not apply to children through the age of 18) (Question #37)

- **Large Employer Groups (2-25 employees applying)**-New hires after the initial enrollment period will be subject to a 12 month pre-existing period.
- **Late enrollee**-Those eligible employees or dependents of an eligible employee who did not request coverage during the initial enrollment period and are not eligible for a special enrollment will be subject to an 18 month pre-existing period.
- **Portability**-The pre-existing time period may be reduced or waived depending upon previous creditable coverage.

### 7. What are the PPO guidelines?

No more than 50% of the population enrolling with Dean may elect the PPO coverage. Employee eligibility for the PPO product is determined by their personal address.

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Requested Effective Date: \_\_\_\_\_  
 Requested Plan(s): \_\_\_\_\_ HMO  
 \_\_\_\_\_ POS  
 \_\_\_\_\_ PPO

*The contents of this Application will be kept strictly confidential and not released to any unauthorized source.*

### Section I – Group Information

1. Legal Name of Business Requesting Coverage: \_\_\_\_\_
2. Legal Form of Business:  Sole Proprietor     Partnership     Corporation     Other: \_\_\_\_\_
3. Street Address for Billing and Administrative Purposes: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. If physical address is different from the address listed above, please indicate it here: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
5. Telephone Number: (    ) \_\_\_\_\_ 6. Fax Number: (    ) \_\_\_\_\_
7. Federal Tax ID Number: \_\_\_\_\_ 8. Website Address: \_\_\_\_\_
9. Nature of Business: \_\_\_\_\_ 10. Years in Business: \_\_\_\_\_
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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

13. Administrative Contact Person's Name, Title, Phone Number, and E-Mail Address: \_\_\_\_\_
14. Premium Billing Contact Person's Name, Title, Phone Number, and E-Mail Address: \_\_\_\_\_

### Section II – Current Plan Information

15. Current Worker's Compensation Carrier: \_\_\_\_\_
16. Please list your current group health insurance carrier: \_\_\_\_\_  
 a. Number of years with this carrier: \_\_\_\_\_ b. Renewal Date: \_\_\_\_\_
17. Please attach a copy of your health carrier's most recent billing statement.
18. Is this group currently self funded?  Yes  No **If Yes, please attach the most recent 3 years of claims, enrollment, and shock loss data.**
19. Type of current coverage:  HMO     POS     PPO  

Deductible	\$ _____	In Network \$ _____	Out of Network \$ _____
Coinsurance	_____ %	In Network _____ %	Out of Network _____ %
Office Visit Copay	\$ _____	In Network \$ _____	Out of Network \$ _____
Prescription Drug Copay	_____/_____/_____ (Please indicate if amount is \$ or %)		
20. Current group premium information: a. Current Total Monthly Premium: \_\_\_\_\_  
 b. Upcoming renewal monthly premium amount or renewal increase %: \_\_\_\_\_
21. Current Rates: Effective Date: \_\_\_\_\_ Medicare Eligible:  

Single: _____	Employee/Child(ren): _____	1 over 65: _____
Employee + 1: _____	Family: _____	2 over 65: _____
Employee/Spouse: _____		1 over and 1 under 65: _____

**Section III – Eligibility Information**

22. 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 - December)? \_\_\_\_\_  
*(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)*
23. 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
24. \_\_\_\_\_ Of the number of employees reported in Question 23b list the number that are waiving Dean due to other creditable health coverage.
25. Current Employees that are not active at work, if applicable:
- a. \_\_\_\_\_ Total number that are laid off
  - b. \_\_\_\_\_ Total number that are on a medical leave of absence
  - c. \_\_\_\_\_ Total number that are on a non-medical leave of absence
  - d. \_\_\_\_\_ Total number that are on Military leave
  - e. \_\_\_\_\_ Total number that have health coverage continued through a severance agreement
  - f. \_\_\_\_\_ Total number that are currently receiving Worker's Compensation
  - g. \_\_\_\_\_ Total number currently on COBRA, State Continuation, or within their election period

26. Please provide the following details that correspond to your answers to Question 25:

Applicable Letter (a, b, c, d, e, f, g)	Name	Last Day at Work	Anticipated Return to Work or Coverage End date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

27. Are you requesting Retiree coverage?  Yes  No  
 A retiree class will be considered only if you have 20 or more employees enrolled for medical coverage. Approval of this coverage requires Underwriting review.  
 Minimum Age Requirement: \_\_\_\_\_ Years of Service: \_\_\_\_\_ Eligible Classes of retired employees: \_\_\_\_\_
28. Total number of retirees: \_\_\_\_\_
29. Are you requesting Domestic Partner coverage?  Yes  No  
**\*We require that you submit copies of any written policies or union language that relates to questions 26-29 above.\***

**Section IV – Requested Plan Information**

30. Employer Contribution Percentage:  
 Single: \_\_\_\_\_ Employee/Child(ren): \_\_\_\_\_ Employee/Spouse: \_\_\_\_\_ Family: \_\_\_\_\_
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 St 632.745  
 a. If your hourly requirement is less than 30 hours per week, please indicate your requirement here: \_\_\_\_\_  
 b. Does this hourly requirement apply to all employees?  Yes  No If No, please explain: \_\_\_\_\_
32. If you are not a Small Employer Group what classes of employees are to be excluded?  None  Hourly  Salary  Union  Non-Union  Other \_\_\_\_\_
33. Probationary Period for new employees to obtain health insurance coverage (please note for Small Employer Groups the probationary period cannot exceed 180 days)  
 a.  0 days  30 days  60 days  90 days  Other \_\_\_\_\_  
 b. After the probationary period is served, coverage becomes effective:  
 First of the month following the probationary period  
 Immediately following the probationary period  
 Other: \_\_\_\_\_
34. Does the probationary period above apply to the employee in the following situations?  
 Return from layoff:  Yes  No **If no**, please advise when coverage would become effective: \_\_\_\_\_  
 Return from leave of absence:  Yes  No **If no**, please advise when coverage would become effective: \_\_\_\_\_  
 Rehire:  Yes  No **If no**, please advise when coverage would become effective: \_\_\_\_\_  
 Changing from part-time to full-time:  Yes  No **If no**, please advise when coverage would become effective: \_\_\_\_\_
35. Employee Termination is effective:  end of day the employee terminates  end of month the employee terminates  Other: \_\_\_\_\_
36. Our standard dependent termination is to the end of the month the dependent turns age 26.
37. 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
38. 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
39. If you are not a Small Employer Group, will your company offer more than one health insurance option, other than Dean to your employees?  Yes  No If "Yes" please explain \_\_\_\_\_

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

*Answer the following questions to the best of your knowledge for the persons eligible to be insured.  
Please give details to any questions answered "yes" in this section.*

40. Has your company ever been declined, canceled, non-renewed, or not quoted by any health or life insurance carrier, including Dean? .....  Yes  No
41. 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
42. 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
43. Are any employees/dependents currently pregnant?.....  Yes  No
44. Have any employees/dependents been treated or been advised treatment in the past 2 years for:
- |  |  |
|--|--|
| Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | Immune system disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | Kidney disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Drug/alcohol..... <input type="checkbox"/> Yes <input type="checkbox"/> No     | Lung disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| HIV/AIDS..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | Psychological disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Conditions..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Organ Transplant..... <input type="checkbox"/> Yes <input type="checkbox"/> No       |

45. 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.

Question #	Name and contact information (phone #)	Diagnosis/Treatment/Surgery	Date of Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Section VI – Employer Certification**

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

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 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. The first month's estimated premium must be submitted prior to enrollment. Any premium deposit will be returned if the request for coverage is not approved.

\_\_\_\_\_  
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 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 of Signature

\_\_\_\_\_  
Writing Agent's Name (Please Print)

\_\_\_\_\_  
Agency Name