ConnectiCare

Large Group (51+) Employer Application

Thank you for your interest in ConnectiCare. Our award-winning customer service begins with setting up your account properly. Please complete this application.

Part 1: Employer Information

Parent Company Name

Effective Date of Coverage

Group Name (if different)

Federal TIN (Tax ID)

HR Benefit Contact Name

ERISA Number

SIC Code

Business Address

HR Contact Email Address

HR Contact Phone Number

HR Contact Fax Number

Employer Portal Users:

Primary Administrator's Name

Email

Phone Number

Administrator's/Secondary Administrator's Name

Email

Phone Number

Part 2: Group Size Certification

Please indicate the total number of full-time equivalents (FTEs). Combine the amounts from number one and two below to get total FTEs.
Total number of working hours for health insurance coverage: _____ *(Required)*

This counting method pertains to the Affordable Care Act (ACA) requirement that employers with 51 or more employees offer a qualified health plan with minimum essential coverage. ConnectiCare will use the number of employees from this calculation to confirm the product options selected for this upcoming plan year. IRS regulations provide detailed rules about this method of calculation; please consult your tax or legal adviser. The following is a general description:

The number of employees is determined by adding (1) and (2) below:

1. The number of full-time employees. Full-time is someone employed an average of at least 30 hours per week or 130 hours per month. **Total number of full-time employees:** _____
2. The number of FTEs, which is a combination of employees. An individual employee may not be full-time because they are not employed an average of at least 30 hours per week. But in combination, such employees are counted as the equivalent of a full-time employee. For example, two employees who each work 15 hours per week make up one FTE. You can also calculate FTEs by aggregating hours worked by non-full-time employees in a month and dividing by 120. **Total number of full-time equivalent employees:** _____

- To determine group size, look to the size of your workforce in the prior calendar year.
- Affiliated employers with common ownership or those under common control must aggregate their employees for purposes of determining group size.
- All employees are included for counting purposes. (For example, union and non-union employees, employees who are covered by another carrier, employees who have waived coverage, or employees located in other states.)
- IRS regulations have special counting rules, such as those for seasonal workers, employees whose hours are difficult to track or whose hours vary, school employers, and companies not in existence in the prior calendar year.

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Part 3: Medical Benefit Selection and Rules:

Please select type of health insurance plan:

☐ Fully Insured ☐ Fixed Funding Solutions* ☐ Level Funded* ☐ ASO*

*Healthcare Reform Act - Public Goods Pool Forms are required.

1. Number of full-time hours required for health insurance eligibility? _____
2. Are part-time employees eligible for health insurance? ☐ Yes, number of hours required _____ ☐ No
3. Are retirees eligible for coverage? ☐ Yes ☐ No
4. Do you have employees that reside in Massachusetts? ☐ Yes ☐ No
   a. If yes, are your current plans considered Massachusetts Minimum Creditable Coverage compliant? ☐ Yes ☐ No
5. Who is your prior health insurance carrier? _____
6. What is your new hire waiting period? *Please choose one option*.
   a. First of the month following _____ days (max. 60) b. ☐ Date of hire
   c. _____ number of days from date of hire (max. 90 days.) d. ☐ Other: _____
7. What is your termination of coverage policy? Please choose one option.
   a. ☐ Date of termination b. ☐ End of month c. Other: _____
8. Do you contribute at least 50% of the Employee medical premium? ☐ Yes ☐ No
   9a. What is your contribution to Employee ($ or %) _____ and Dependent ($ or %) _____
9. Do you offer coverage to domestic partners? ☐ Yes ☐ No
   a. ConnectiCare's policy: 18 yrs. or older residing together for at least six months.
   b. If you do not subscribe to ConnectiCare's domestic partner policy, please indicate your policy: _____
10. HealthEquity Health Reimbursement Account (HRA)/Health Savings Account (HSA) integration?
    ☐ No ☐ Yes HRA ☐ Yes, post-deductible HRA ☐ Yes, HSA
    a. HRA employer-funded amount: Single _____ / Family _____
    b. HSA employer-funded amount: Single _____ / Family _____
    c. Does group currently use HealthEquity as their administrator? ☐ Yes ☐ No

☐ By checking this box, your company is partnering with HealthEquity, and you authorize ConnectiCare to automatically send eligibility and paid claims to HealthEquity for the purpose of opening HSA accounts for your covered employees.

11. HRA/HSA through a vendor other than HealthEquity? ☐ Yes ☐ No
    a. HRA administration:
       i. Name of HRA administrator: _____
       ii. HRA funded amount: Single _____ / Family _____
       iii. Do you want ConnectiCare to integrate enrollment and claims with the HRA administrator? ☐ Yes ☐ No

       Note: By checking Yes, you authorize ConnectiCare to automatically send eligibility and paid claims to your designated third-party administrator for the purpose of opening HRA accounts for your covered employees.
    b. HSA administrator (no claim integration):
       i. Name of HSA bank: _____
       ii. HSA funded amount: Single _____ / Family _____

Part 4: COBRA Administration

1. Number of current COBRA participants: _____
2. Do you use a COBRA administrator? ☐ Yes ☐ No
   a. If yes, please list COBRA administrator company name, contact name, and address:

   _____
3. Who should receive the COBRA invoice from ConnectiCare?
   ☐ Group/Client ☐ Cobra administrator ☐ Bill member directly (2% increase in COBRA member rate)

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Part 5: Billing Information and Format

Premium billing level: *Please note that billing level/format cannot be changed once setup is complete.*

☐ **Group level/single invoice —** one bill separated out and sub-totaled by subgroups

Billing contact name: _____ Phone: _____

Billing contact email: _____ Fax: _____

☐ **Subgroup level/multiple invoices —** individual bill sent to each subgroup/location:

Please add subgroup, contact person, and billing address in the space below. If more space is needed, please attach additional documentation.

Part 6: Electronic Data Interchange (EDI) Vendor Information

Do you plan to use an EDI vendor? ☐ Yes ☐ No

If yes, please list EDI vendor name, contact name, and email:

EDI vendor name: _____ EDI vendor contact name/email: _____

Using a third-party EDI vendor will require a completed Designation of Administration (DOA) form. You will receive this form from **cci-electronic_enrollment@connecticare.com** to complete.

IMPORTANT: *The employer acknowledges responsibility for setting plan eligibility rules, and for accurately communicating eligibility to ConnectiCare. The employer certifies that its eligibility rules are compliant with all applicable laws and regulations, including federal waiting period and orientation period rules and other similar requirements.*

Other third-party relationships: A Designation of Authority (DOA) form is required if any of the following apply:

a. Client is using a third party for billing.

b. Client is using a third party for HRA reimbursement that requires a claim feed.

c. Trading Partner Agreement (TPA) is required between ConnectiCare and vendor of choice if this a new relationship with ConnectiCare.

Employer Signature

Printed Name

Title

Date

Broker Name

Broker Signature

Broker Firm

Date:

Pay to: ☐ Agency ☐ Agent

Questions? Please contact your ConnectiCare sales representative or broker.