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 so that we can provide a seamless transition to ConnectiCare.

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: _____

Business address: _____

HR Contact Email Address: _____

_____

HR Contact Phone Number: _____

_____

HR Contact Fax Number: _____

Employer Portal User: Name, email & phone (Primary Administrator): _____

Employer Portal User: Name, email & phone (Administrator): _____

Part 2: Group Size Certification

Total Number of Full-Time and Full-Time-Equivalent Employees: ☐ REQUIRED

This counting method pertains to the ACA requirement that employers of 51+ 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.
2. The number of full-time equivalents (FTEs), which is a combination of employees. An individual employee may not be full-time because he/she is 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.

- 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.
- The IRS regulations have some 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: Your Rules About Offering Coverage

1. How many full-time employees do you have? _____ # FT hours required for health insurance eligibility? _____
2. How many part-time employees do you have? _____ Are part time employees eligible for health insurance? ☐ Yes ☐ No
   a. If yes, how many hours do you require a part-time employee to work to be eligible for health insurance? _____
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. Do you offer coverage to domestic partners? ☐ Yes ☐ No
   a. ConnectiCare's policy: 18 yrs. or older residing together for at least 6 months.
   b. If you do not subscribe to ConnectiCare's domestic partner policy, please indicate your policy: _____
7. 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. _____ # days from DOH (max 90 days.) d. ☐ Other: _____
8. What is your termination of coverage policy? Please choose one option.
   a. _____ date of termination b. _____ end of month c. Other: _____
9. Employer contribution to medical premiums: Employee _____ Dependent _____
10. HealthEquity HRA/ HSA Integration? ☐ No ☐ Yes HRA ☐ Yes Post-deductible HRA ☐ Yes HSA
    a. HRA ER funded amount: Single _____ / Family _____
    b. HSA ER 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 & claims with HRA administrator? ☐ Yes ☐ No

       Note: By checking Yes, you authorize ConnectiCare to automatically send eligibility and paid claims to your designated TPA 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 utilize a COBRA Administrator? ☐ Yes ☐ No
   a. If yes, please list COBRA Administrator company name, contact name and address of administrator:

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

Continued

Part 5: Billing Information and Format

Premium Billing Level: *Please note — 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

If Subgroup Level/Multiple invoices, please add subgroup, contact person and billing address in the space below. If more space is needed, please attach additional documentation.

Part 6: EDI Vendor Information

Plan to use an EDI vendor: ☐ Yes ☐ No

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

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: *Employer acknowledges responsibility for setting plan eligibility rules, and for accurately communicating eligibility to ConnectiCare. 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 applies:

a.If client is using a third party for billing.

b. If 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.