Employer Group Enrollment Application

ASPIRUS HEALTH PLAN

INSTRUCTIONS: Please complete the entire application. Please print using black ink.

Section 1 – Employer Demographics

Type of Application ☐ New Group ☐ Change to Existing Group Number _____	Requested Effective Date	Requested Anniversary Date

Employer Legal Name	SIC Code (nature of business)		Federal Tax ID Number (EIN)	
Location/Street Address of Business	**City**	**State**	**Zip Code**	**County**
Billing Address	**City**	**State**	**Zip Code**	**County**
Name of Contact Person	**Title of Contact Person**		**Telephone Number**	
Email Address				
Nature of Business	**Type of Business** *(i.e., S Corp, C Corp, LLC)*			
Name of Subsidiary (ies)/Affiliate(s)			**Federal Tax ID Number** *(if different)*	
Address	**City**	**State**	**Zip Code**	**County**

Section 2 – Eligibility

A. Total Number of Employees: _____ Include all employees (full-time, part-time, and seasonal)
All full-time sole proprietors, corporate officers, directors, and employees are eligible for coverage. Retirees, part-time, temporary, and seasonal employees are not eligible for coverage. Exceptions are subject to the Insurer's Underwriting requirements and guidelines.

B. Actively at Work Requirement:
2-50 Total Employees: 30 hours per week

51 or More Total Employees: _____ hours per week *(not to exceed 30 hours per week)*

C. Are domestic partners and their eligible dependents eligible for coverage? ☐ Yes ☐ No
This question C. does not apply to local government units per Wis. Stat. 66.0137(1)(ae).

D. Are any classes of eligible employees to be excluded from any coverage? ☐ Yes ☐ No

If yes, please explain and identify each coverage: _____

E. Are any employees or dependents currently on or eligible for COBRA or State Continuation? ☐ Yes ☐ No
If yes, please list name, effective date, and termination date:

F. To the best of your knowledge and belief, is any employee or dependent (including spouse) proposed for coverage disabled, unable to work, or not at work because of a current or approaching hospital confinement, leave of absence, absence, or are otherwise incapacitated? ☐ Yes ☐ No
If yes, please provide each person's name and status.

G. Is each coverage applied for subject to or part of a union-negotiated collective bargaining agreement? ☐ Yes ☐ No

If yes, when does that agreement expire? _____

H. Requested Probationary Period:
- ☐ 0 days
- ☐ 1st of the calendar month following full-time employment
- ☐ 1st day of the calendar month following one month of full-time employment
- ☐ 1st day of the calendar month following two months of full-time employment
- ☐ The day following 90 days of full-time employment
- ☐ Other *(Only groups with 51 or more total employees may select this option)*: _____

Does the same probationary period apply to all covered classes? ☐ Yes ☐ No *(Only groups with 51 or more total employees may select 'no')*

If No, Specify:

Section 3 – Plan Information

A. Annual Open Enrollment
2-50 Total Employees: Month prior to renewal date
51 or More Total Employees:
☐ Month prior to renewal date
☐ Other: Dates for open enrollment *(end date must be before renewal date)*

From: _____ To: _____

B. What percentage of the monthly premium is to be paid by the employer for each of the following:
(Minimum Employer Contribution is 50% of the employee premium)

_____ % Employee Only Coverage _____% Limited Family Coverage _____% Family Coverage

C. The applicable benefit options (deductible, coinsurance, annual out-of-pocket limits, preferred/participating provider networks, etc.) are the coverage and corresponding benefit options stated in the final, written quote that was issued by the Insurer and signed by the employer's representative in Section 7 below. If the Insurer approves this application, the actual benefit options for this employer's group medical coverage will be contained in the Certificate of Coverage which is part of the group master policy issued by the Insurer to the employer as the group policyholder.

D. For groups of **100** or more enrolled employees, the following additional classes are eligible for coverage: ☐ Retirees ☐ Part-time employees

E. Other special requests/comments:

F. Do you participate in a Health Reimbursement Arrangement (HRA)? ☐ Yes ☐ No

If Yes, who is your vendor?

G. ☐ Church Plan
☐ ERISA plan (or sponsor of ERISA plan) Plan Number*:
*(*Include the three-digit Plan Number that is included on the plan's Form 5500. If the plan is not required to file a Form 5500, no Plan Number needs to be included.)*
☐ Non-Federal governmental plan
☐ Issuer

Section 4 – Information About Your Current Plan

A. Will/does your company offer other group health coverage? ☐ Yes ☐ No

B. Are you replacing existing group health insurance? ☐ Yes ☐ No

Name of current insurance carrier/administrator _____

Original effective date _____

C. What is the name of your current workers' compensation carrier? _____

Section 5 – Change Information

A. Employer Name Change

Employer Former Name: _____

Employer New Name: _____

B. Employer Address Change

Employer's Former Address: _____

Employer's New Address: _____

C. Employer Coverage Change

Employer's Old Coverage:

Employer's New Coverage:

D. Change probationary period from: _____ to: _____

E. Other Change *(please explain)*

Section 6 – Premium/Billing Information

A check for $ _____ made payable to the Insurer is being submitted with this application as payment by this employer to be applied toward the initial month's premium if this application is approved by the Insurer and the group master policy is issued. The monthly premium billed by the Insurer will be due and payable to the Insurer on the first day of the coverage month.

Group Billing Options:

☐ **Automatic Withdrawal.** We electronically transfer your premium directly from your bank account on the first business day of the coverage month. If the first of the month falls on a weekend or holiday, we will withdraw the funds on the first business day. Please complete Section 10. Authorization Agreement for Electronic Fund Transfers.

☐ **Direct Bill.** We send a premium notice directly to your billing address monthly. You return payment to the Insurer by the first business day of the coverage month.

Section 7 – Employer Statement/Certification

The group medical coverage is guaranteed renewable. However, your group medical coverage could be canceled if the Insurer terminates all of the group medical insurance policies for this group class, or if you: fail to timely pay your monthly premium; engage in fraud or misrepresentation; breach the Insurer's group insurance policy; fail to meet minimum participation requirements; or become ineligible as a group due to: (a) ceasing active business operation; (b) losing status as a legal entity; or (c) moving the business to a state where this type of group medical insurance policy is not offered by the Insurer.

The Insurer may investigate the information on this application. Any findings may be used to deny coverage for one or more employees of the group or the entire group. Please indicate the name, title, and telephone number of an employee in your company who can provide necessary clarification of the employee and group information provided on this application.

Name	Title	Telephone Number

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been advised: not to terminate all existing coverage, whether on an insured or self-funded basis, unless and until the Insurer notifies me in writing that coverage has been approved and the agent represents the employer, not the Insurer.

I understand that the Insurer will rely, in part, on the information provided in this application to issue or deny coverage. If the Insurer approves this application, I understand coverage will become effective on the date assigned by the Insurer and no coverage will be in force until that date.

I understand no agent or other person has the authority to alter, bind the Insurer, or waive or change any terms, conditions, and/or provisions of the policy or any other requirement imposed by the Insurer. I understand the employer represents its employees and their dependents, not the Insurer. As the employer's authorized representative and acting on that employer's behalf, I understand, agree with, and approve each and every certification made by the agent in Section 9. Agent Certification of this application.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the insurer may rescind and void any coverage if it determines that you, your spouse, or any named dependent are either listed on the SDN list or associated with an entity listed on the SDN list.

If this application is approved, I understand that the Insurer will not be, and are not, a plan sponsor, plan administrator, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any state or federal law. I understand the employer is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies.

Signature of Employer Representative	Signed at *(City, State)*	Date

Section 8 – Issue Information

The group master policy will be sent directly to the Employer. Identification cards will be mailed directly to each covered employee with instructions on accessing the online member guide.

Important! DID YOU REMEMBER TO INCLUDE:

☐ A copy of the Insurer's quote.

☐ Completed and signed Employee(s) Group Enrollment Application for each eligible employee, both enrolling and waived, if applicable.

☐ A copy of the group's most recent State Quarterly Wage and Tax Report
(Groups with more than 100 total employees should include a census of all full- and part-time employees).

☐ Rating and Renewability Disclosure Form

Section 9 – Agent Certification

I hereby certify and represent all of the following as being true: I asked all questions accurately and fully recorded all information given by the Employer Representative in this application; I advised the Employer Representative not to terminate existing coverage unless and until the Insurer notifies him/her, in writing, that this application has been approved; I used only advertising approved by the Insurer to solicit this application; I told the Employer Representative nothing inconsistent with, or contrary to, the approved advertising about the benefits, group policy, and/or coverage; I didn't guarantee the Insurer's approval of this application or the Insurer's issuance of coverage; and I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and marketing/sales standards maintained by the Insurer.

I hereby certify and represent all of the following as being true: I told the Employer Representative that the Insurer has no liability for anything I said or failed to say before, during, or after the application process, that's not subsequently confirmed in writing by an authorized officer of the Insurer including, but not limited to, answers given by me in response to questions asked by that Representative or anyone else; I told the Employer Representative that the Insurer is not liable for any statement, representation, or other information provided to that Representative or anyone else that is not expressly contained in a written document provided to them and signed by an authorized officer of the Insurer;

I understand that I am liable for my acts and omissions to the extent provided by law; and I understand I have no authority to alter this application, bind the Insurer by making promises and/or representations, or to waive or change the terms, conditions, and/or provisions of the group insurance policy or any requirement imposed by the Insurer.

Writing Agent's Name	Writing Agent's License Number		
Writing Agent's Signature		Date	
Agency Name			
Agency Email	Agency Telephone Number	Agency Tax ID Number	
Agency Address	City	State	Zip Code

Section 10 – Authorization Agreement for Electronic Fund Transfers

Group's Legal Name _____ Group's Number _____

I hereby authorize the Insurer, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my:

(Select one) ☐ Checking Account* ☐ Savings Account

indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name		Branch	
Depository Address	City	State	Zip Code
Transit Number	Account Number		

This authority is to remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

_____ _____

Employer Representative Signature Date

_____ _____ _____ _____

Employer Representative Name Title Telephone Number Fax Number

*IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:
Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *certificate of coverage*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1.866.631.5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بن اعلى رقم الهاتف 1.866.631.5404(رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_: य_द आप ि हंदी बोलते ह_ तो आपके ि लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1.866.631.5404 (TTY:711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.866.631.5404 (TTY:711).