

2024 Small Employer Group Application

Wisconsin



Requirements

- Group Application completed by employer shall disclose all pertinent information.
- Group size is an average of one (not including a sole proprietor) to 50 employees.
- Except for coverage obtained during group open enrollment from November 15 to December 15 each year, minimum participation requirements are:

Number of Employees*	Participants
More than 10	70%
10	6
8 - 9	5
7	4
5 - 6	3
2 - 4	2

* Eligible employees who have other creditable coverage, other than employees who have creditable coverage under another health benefit plan sponsored by the employer, will not count against the minimum participation.

- Except for coverage obtained during group open enrollment from November 15 to December 15 each year, the employer must contribute a minimum of 50 percent towards the employee's monthly premium rate for health coverage.
- Medica provides your employees access to key health insurance documents electronically. If you want your employees to receive paper copies, please notify your Medica representative.

Checklist

- Medica Insurance Company Small Employer Group Application form fully completed and signed by employer and broker
- Enrollment information on the Medica Spreadsheet or entered directly into BrokerLink. Please include:
 - Newly hired employees in their waiting period
 - Former employees on State Continuation or COBRA (including those in the State Continuation or COBRA eligibility period)
 - Any covered retirees
 - Employees waiving coverage (if using the enrollment spreadsheet, complete the Waiver Reason column)
- A copy of the most recent billing statement from the current carrier
- Wage/tax and/or other tax documentation indicating employee status (i.e. full time, part time, seasonal, etc. and new hires) is required for all groups

Medica may request additional information as deemed necessary.

All of the above information can be uploaded in the Documents section in BrokerLink or uploaded to Small Group Submissions in the broker portal on medica.com. The Medica enrollment spreadsheet can be found on the broker portal of medica.com, under Quote and Renew (Example Census XLS).

Emailed or mailed submissions are also accepted. Email completed submissions to your Medica Small Group team or send completed new groups to the **Medica Sales Department** at:

Mail Route CP275
PO Box 9310
Minneapolis, MN 55440-9310

Medica is committed to protecting and maintaining the privacy and confidentiality of our members' personal information. To see our privacy notice, please visit [Medica.com](https://medica.com).

Small Employer Group Application (1-50 employees)

Please type or print clearly.

A	EMPLOYER INFORMATION		
Company Legal Name (including dba):		Federal Tax ID Number:	SIC Code:
Address (must be a physical address, no PO Boxes)			
Street:			
City:	State:	ZIP Code:	County:
Billing Address (if different than above, PO Box accepted)			
Street:			
City:	State:	ZIP Code:	County:
Contact Information			
Name:		Email Address:	
Type of Ownership:			
<input type="radio"/> Sole Proprietorship <input type="radio"/> Partnership <input type="radio"/> C Corporation <input type="radio"/> S Corporation <input type="radio"/> Political Subdivision <input type="radio"/> Other			
Phone Number (and extension):	Fax Number:	Date Business Began:	
Current Group Carrier (<i>a copy of your most current Group bill must be submitted</i>):			

B	EMPLOYER REPRESENTATION PLEASE READ CAREFULLY
<ul style="list-style-type: none"> The employer understands and agrees that, (1) no coverage will become effective until the date specified by Medica after this application has been approved, (2) the information provided in this application is complete and true to the best of my knowledge and is the basis for the coverage to be issued, and that material misrepresentations of facts could result in termination of coverage, (3) Medica must receive application for each eligible employee and dependent before coverage becomes effective, and (4) no coverage will be effective until the first monthly premium has been paid in full. The employer agrees that any deposit is refundable and will be applied to the first monthly premium due if this application is approved. If this application is not approved, the full deposit will be refunded. The employer agrees to allow Medica to review any of the employer's records that Medica reasonably deems necessary to approve this application. It is also agreed that no agent can approve this application, set an effective date, or waive or alter any provision of this application or any contracts issued. It is agreed that the employer will remit monthly charges for all covered employees and that failure to remit the required charges by the due date may result in termination of coverage. 	
X _____	
Employer Signature (<i>Owner or Officer</i>)	Date

C AGENT/REPRESENTATION INFORMATION		
Agent Signature: X	Date:	Agent Number:
Agent Name:	Phone Number:	Fax Number:
Address:		
Sales Representative Name:		

D ELIGIBILITY INFORMATION	
When answering Question 1 or 2, as applicable, include all employees of your company and all employees of entities related to your company as part of a controlled group of corporations, trades or businesses under common control, and/or members of an affiliated service group (see Section 414 of the Internal Revenue Code for additional information).	
1.	If you are a continuing business, how many individuals did you employ, on average, during the calendar year preceding this application ? _____
2.	If you are a new business, how many individuals do you reasonably expect to employ on average in the current calendar year? _____
3.	Does your company have common ownership/control in or with any other company? <input type="radio"/> Yes <input type="radio"/> No If Yes , complete Medica Controlled Group form.
4.	Does your company have a contract with a Professional Employee Organization (PEO)? <input type="radio"/> Yes <input type="radio"/> No If Yes , please list which PEO firm and specify how many of these employees are applying for coverage. _____
5.	Please list any employees that may be residing out of area in other states. _____
6.	Requested effective date: ____ / ____ / ____ Please allow adequate time for processing. Employer should not cancel existing coverage until employer receives Medica's written notice of approval of this application.
_____	A. Total number of current employees (including all new hires in their waiting period, all part-time employees, owners, partners and those working outside of Wisconsin).
_____	B. How many hours per week does an employee have to work to be considered eligible for coverage?
_____	C. Which classifications of employees are eligible for coverage (i.e., all full-time employees, non-union, etc.)
_____	D. Total eligible employees (including new hires in their waiting period) that are applying for coverage .
_____	E. Total eligible employees that are waiving coverage .
_____	F. Total number of individuals covered under State Continuation/COBRA.
_____	G. Total ineligible employees.

D ELIGIBILITY INFORMATION (CONTINUED)

7. New hire coverage begins:

- Date of hire
- First of the month after completion of waiting period.
Please specify waiting period: N/A 30 days 60 days*
**Note: In no event may a waiting period be longer than 90 calendar days.*
- Immediately following waiting period.
Please specify waiting period: N/A 30 days 60 days*
**Note: In no event may a waiting period be longer than 90 calendar days.*
- Return to work or rehire waiting period if other than New Hire (please specify): _____

Annual open enrollment will be the 1st through the 15th of the month prior to the effective date of coverage unless otherwise noted below.

Other _____

8. Employer Contribution Amount: Employee: _____% Dependent: _____%

E BENEFIT SELECTION | PLEASE INDICATE THE DESIRED PRODUCT(S)

Which Medica Benefit Plan(s) are you selecting?
Plan Selection(s):

Passport Medica CompleteHealth Essentia Choice Care with Medica

Deductible and Out-of-Pocket Accumulators: Calendar Contract

Note: High-deductible plans may have either Calendar or Contract year accumulators. Traditional plans may only have Calendar year accumulators. If offering more than one benefit plan, both plans must have the same accumulator period.

These benefit plans do not include coverage of pediatric dental services as described under the Affordable Care Act. Standalone dental coverage is available through the insurance market.

Are you purchasing Medica OneSource administration? *Note: Additional paperwork is required.*

- Health Savings Account Flexible Spending Account
- Health Reimbursement Account Limited Purpose Flexible Spending Account

MEDICA INSURANCE COMPANY - SMALL GROUP NOTIFICATION

In compliance with state small group disclosure requirements, Medica is mandated to advise small employer group clients of the following general guidelines for coverage issued by Medica to small employers.

- Rates in the small employer market may vary only on the following basis: geographic rating area; age (within certain parameters); tobacco use (within certain parameters); benefit plan design and whether individual or family coverage is selected.
- Medica may increase rate in accordance with applicable law, including at the time of coverage renewal.
- Medica rating methods are in compliance with generally accepted actuarial principles, policies and procedures.
- Any contracts issued may not be canceled by Medica prior to the contract renewal date and guaranteed renewal of the contract is required, except for the following reasons:
 - a. Failure to pay a premium when due.
 - b. Fraud or intentional misrepresentation of material fact by the employer.
 - c. There is no longer any member who lives in the service area or any active employees who are members.
 - d. Wisconsin small employer requirements are no longer met.
 - e. The employer fails to comply with Medica's minimum contribution or participation requirements.
 - f. Medica ceases to offer the particular product in the small group market.
 - g. Medica withdraws from the Wisconsin small group market.
 - h. The employer ceases to do business.

The following signatures acknowledge receipt of this information. Please remit the signed original to Medica Insurance Company.

Group Name _____

Employer Signature **X** _____ Date _____

Agent's Signature **X** _____ Date _____



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