Medica

2023 IOWA SMALL EMPLOYER GROUP APPLICATION
(Employers with 1 to 50 employees)

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, a minimum of 75 percent of eligible employees must be enrolled under the contract. Employees may waive coverage if covered under another group plan, Medicare, or Medical Assistance; these waivers will not count against the minimum participation level.
- 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.

Submit all information either via BrokerLink or upload 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).

Mailed submissions are also accepted. Send all 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**.

SECTION A

EMPLOYER INFORMATION

Company Legal Name *(including dba)*	Federal Tax I.D. Number	SIC Code

Address (Must be a physical address, no P.O. Boxes)

Street			
City	**State**	**ZIP Code**	**County**

Billing Address (If different than above, P.O. Box accepted)

Street			
City	**State**	**ZIP Code**	**County**

Contact Information

Name	Email Address

Type of Ownership:

❑ Sole Proprietorship ❑ Partnership ❑ C Corporation ❑ S Corporation ❑ Political Subdivision ❑ Other

Phone Number (and extension)	Fax Number	Date Business Began

Current Group Carrier *(a copy of your most current Group bill must be submitted)*

SECTION B

EMPLOYER REPRESENTATION | PLEASE READ CAREFULLY

- 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 *(Owner or Officer)* Date

SECTION C

AGENT/REPRESENTATIVE INFORMATION

Agent Signature **X**	Date	Agent Number
Agent Name	Phone Number	Fax Number
Address		
Sales Representative Name		

SECTION 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 the requested coverage effective date**? _____
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? ❑ Yes ❑ No
   If Yes, please complete Medica Controlled Group form.
4. Does your company have a contract with a Professional Employee Organization (PEO)? ❑ Yes ❑ 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 Iowa).

   _____ 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 (including 1099s and seasonal working less than 9 months a year).

SECTION **D** **ELIGIBILITY INFORMATION**

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: _____ %

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

Which Medica Benefit Plan(s) are you selecting?

Plan Selection(s):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

❑ Choice National ❑ Medica with CHI Health

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