



Minnesota Group Application - Small Employer

Submission Information

Group submissions do not begin processing until all the information in the checklist below is included. Submissions received after the 10th of the month cannot be guaranteed an effective date of the first of the following month. HealthPartners will request additional information as deemed necessary.

Please complete these forms and attach the following:

- Completed Small Group Employer Application.
 - Information regarding any NEW HIRES AND OWNERS not listed on the Minnesota Quarterly Wage Report on page 2 of this form.
- Minnesota Quarterly Wage Report (from the most recent quarter which should list each employee and the hours they worked); including the following:
 - Indication of status of all employees; full time, part-time, union, seasonal and terminated.
- Copy of most recent bill from current HEALTH insurance carrier
- All completed employee enrollment forms. Enrollment forms MUST be completed in their entirety.
- All eligible employees must be accounted for with an application or waiver.

EMPLOYER ELIGIBILITY INFORMATION

Today's Date _____ Requested Eff. Date _____ HealthPartners Sales Executive _____

Full Legal Group Name _____ DBA (if applicable) _____

Address _____ County _____ Phone _____

City, State, ZIP _____ Fax _____

Contact Person _____ Title _____ email _____

Is Contact Person an eligible employee? YES NO If NO, please explain: _____

Owners and percentage of ownership for each _____

Are they eligible for coverage? YES NO If NO, please explain: _____

YES NO 1. Is this organization in any way related to other companies (such as a national corporation) as a wholly or partially owned subsidiary, or does this organization own any other companies or have wholly or partially owned subsidiaries?

If YES, please provide the HealthPartners Controlled Group form, found on healthpartners.com.

2. Corporate headquarters location (City and State and/or County): _____

YES NO Do you have any other locations or sites? If yes, list the State and/or County: _____

3. Number of years in business and Group's Federal Tax ID number _____ Industry _____

4. TYPE OF ENTITY: S Corporation C Corporation Sole Proprietorship Partnership Non-Profit
 LLC (circle one to the right: C Corporation Sole Proprietorship Partnership)

5a. On average, how many individuals did this organization employ (in all locations), working a minimum of 20 hours per week, throughout the preceding calendar year (January to December)? _____

5b. Currently, how many employees had a normal work week of 20 or more hours?

(Excluding seasonal,* temporary and union employees covered under a collective bargaining agreement)

Some employees who do not work a full twelve months may be covered under their employers plan. These employees must work a minimum of nine months in a calendar year. If providing coverage for these employees, the employer must complete the Small Employer Contribution Agreement Form. Contact your HealthPartners Sales Representative for details.

If you are going to cover employees working for a minimum of 9 months, how many will you be covering? _____

6. How many employees reside outside of Minnesota? (Submit Quarterly Wage Report for each state)

YES NO 7. If you elect coverage, will you be offering a Medical Expense Reimbursement plan? (such as an HRA or similar arrangement)

YES NO 8. Does this organization currently have any leased employees? If YES, please explain: _____

YES NO 9. Does this organization currently have, intend to have, or ever had a Professional Employer Organization (PEO) agreement?
If YES, please provide a copy of the agreement

Please provide the name and termination date of the PEO agreement: _____

YES NO 10. Does this organization intend to offer domestic partner coverage? Same gender Opposite gender
Please refer to Domestic Partner Form on www.healthpartners.com for eligibility.

PARTICIPATION/EMPLOYEE ELIGIBILITY INFORMATION

Number of hours all eligible employees must work per week

Classification(s) of Employees Excluded from Coverage: Union covered by a collective bargaining agreement Part-time
 Union not covered by a collective bargaining agreement Salaried
 Other (explain): _____ Hourly
_____ Owners

YES NO Are retirees eligible for coverage? If yes, define policy _____

Waiting Period for New Employees: Date of Hire OR

First of the month following: 30 days 60 days 90 days Other, explain: _____

_____ Total number of eligible employees

_____ Total number of eligible employees that are applying for coverage

_____ Total number of employees that are waiving coverage

_____ Total number of employees in their waiting period (application or waiver required) See page 2.

_____ Number of former employees on COBRA continuation (application required for all COBRA participants)

Employer Contribution: Minimum 50% of single coverage, or Medical: ___ Single ___ Family Dental: ___ Single ___ Family (if applicable)

EMPLOYEES AND OWNERS NOT ACCOUNTED FOR ON QUARTERLY WAGE AND DETAIL REPORT

Please use this space to account for Employees and Owners NOT included on the Minnesota State Employer's Quarterly Wage and Detail Report (Form MDES-1D). Additional documentation may be required regarding owners.

EMPLOYEE / OWNER NAME	SOCIAL SECURITY NUMBER	HIRE DATE	TERMINATION DATE	# OF HOURS WORKED

FORMER EMPLOYEES ENROLLED WITH COBRA COVERAGE

Please use this space to account for former employees covered by COBRA continuation. Indicate either the notification date if the individual is currently under COBRA or the cancellation date if an individual's COBRA coverage is terminating. **Employers must also complete the Small Employer Verification of Terminated Employees form (HP490016), found on healthpartners.com.**

FORMER EMPLOYEE NAME	SOCIAL SECURITY NUMBER	NOTIFICATION DATE	COBRA TERMINATION DATE

CURRENT CARRIER INFORMATION

Current **MEDICAL Insurance Carrier** _____ Type of Coverage (circle one) **GROUP** **INDIVIDUAL**

Please list ALL medical carriers for the previous 5 years (if needed, attach additional pages):

NAME OF CARRIER	RENEWAL DATE	DATES OF COVERAGE	REASON FOR TERMINATION

Renewal Rates: _____ **Single** _____ **Family** **Renewal Plan (product) Name:** _____

Current **DENTAL Insurance Carrier** _____ **Renewal Date** _____

AGENT / BROKER INFORMATION

Agent Name _____ Phone _____

Address _____ Fax _____

City, State, ZIP _____ Broker Number _____

email Address _____

x _____
 Agent of Record signature _____ Printed Name and Company _____ Date _____
 (if applicable)

EMPLOYER SIGNATURE

I hereby certify that the information provided in this document, and any additional information submitted to support this application, is accurate and complete.

I understand that errors or omissions regarding this information may result in premium adjustments and/or termination of the contract as permitted by Minnesota law.

x _____
 CEO/Owner/Authorized Company Representative _____ Printed Name _____ Date _____

PRODUCT SELECTION

MEDICAL PRODUCTS: HealthPartners HealthPartners Insurance Company (available to groups outside the HMO service area)

<p>Choice Copay Plans Copayment options: <input type="checkbox"/> 15-100% <input type="checkbox"/> 15-80% <input type="checkbox"/> 25-80% <input type="checkbox"/> 45-80% <input type="checkbox"/> 20-100% <input type="checkbox"/> 20-80% <input type="checkbox"/> 35-80%</p>	<p>DistinctionsSM <input type="checkbox"/> \$15-\$30-\$50 <input type="checkbox"/> \$20-\$40-\$60</p>
<p>Empower Plans (High Deductible Health Plan) <input type="checkbox"/> \$1,100/100 <input type="checkbox"/> \$1,500/100 <input type="checkbox"/> \$2,000/100 <input type="checkbox"/> \$2,700/100 <input type="checkbox"/> \$1,100/80 <input type="checkbox"/> \$1,500/80 <input type="checkbox"/> \$2,000/80 <input type="checkbox"/> \$2,700/80</p> <p>Benefit Administration: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year (If offering more than one product, benefit administration must match.)</p>	<p>Deductible Plan <input type="checkbox"/> Choice 1000</p> <p>Compliance Plans <input type="checkbox"/> Copayment Plan <input type="checkbox"/> Deductible Plan</p>
<p>Empower Embedded Deductible Plans <input type="checkbox"/> \$2,200/100 <input type="checkbox"/> \$2,700/100 <input type="checkbox"/> \$2,700/80</p>	<p>Deductible / Copay Plans <input type="checkbox"/> 300/15 <input type="checkbox"/> 300/25 <input type="checkbox"/> 300/35 <input type="checkbox"/> 500/15 <input type="checkbox"/> 500/25 <input type="checkbox"/> 500/35 <input type="checkbox"/> 500/45 <input type="checkbox"/> 750/25 <input type="checkbox"/> 750/35 <input type="checkbox"/> 750/45 <input type="checkbox"/> 1000/25 <input type="checkbox"/> 1000/35 <input type="checkbox"/> 1000/45 <input type="checkbox"/> 2000/35 <input type="checkbox"/> 2500/35</p>
<p>Empower Tiered Network Plan (underwritten by HealthPartners) <input type="checkbox"/> \$2,000/100/90/80</p>	<p>Deductible / Coinsurance Plan <input type="checkbox"/> 500/50% <input type="checkbox"/> 500/60% <input type="checkbox"/> 500/75%</p>

National Plans are available for groups with out-of-state employees and with more than 5 employees enrolled.

DENTAL PRODUCTS:
May also be purchased on a stand-alone basis.

<p><input type="checkbox"/> Exceed Choice <input type="checkbox"/> Ortho Plan 750¹ (OPTIONAL) <input type="checkbox"/> Exceed Voluntary² <input type="checkbox"/> Ortho Plan 1000¹ (OPTIONAL) <small>No Ortho with Voluntary plans</small></p>	<p>Open Access– Employer sponsored (select one benefit from each category)</p> <table style="width:100%;"> <tr> <th>Annual maximum</th> <th>Deductible</th> <th>Basic</th> <th>Major</th> </tr> <tr> <td><input type="checkbox"/> \$750</td> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> 50%</td> <td><input type="checkbox"/> 50%</td> </tr> <tr> <td><input type="checkbox"/> \$1,000</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 60%</td> <td><input type="checkbox"/> 60%</td> </tr> <tr> <td><input type="checkbox"/> \$1,250</td> <td><input type="checkbox"/> \$50</td> <td><input type="checkbox"/> 80%</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$1,500</td> <td><input type="checkbox"/> \$75</td> <td></td> <td></td> </tr> </table> <p><small>Not available to employers headquartered in the 7 county metro area. (Hennepin, Ramsey, Anoka, Washington, Scott, Carver and Dakota.)</small></p>	Annual maximum	Deductible	Basic	Major	<input type="checkbox"/> \$750	<input type="checkbox"/> None	<input type="checkbox"/> 50%	<input type="checkbox"/> 50%	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$25	<input type="checkbox"/> 60%	<input type="checkbox"/> 60%	<input type="checkbox"/> \$1,250	<input type="checkbox"/> \$50	<input type="checkbox"/> 80%		<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$75		
Annual maximum	Deductible	Basic	Major																		
<input type="checkbox"/> \$750	<input type="checkbox"/> None	<input type="checkbox"/> 50%	<input type="checkbox"/> 50%																		
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$25	<input type="checkbox"/> 60%	<input type="checkbox"/> 60%																		
<input type="checkbox"/> \$1,250	<input type="checkbox"/> \$50	<input type="checkbox"/> 80%																			
<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$75																				
<p>Select network: <input type="checkbox"/> Classic <input type="checkbox"/> HealthPartners</p> <p>Select plan: <input type="checkbox"/> Basic Choice <input type="checkbox"/> Standard Choice <input type="checkbox"/> Advantage Choice</p> <p>Select Ortho: <input type="checkbox"/> Ortho Plan 750¹ <input type="checkbox"/> Ortho Plan 1000¹ <small>(OPTIONAL)</small></p>	<p>Voluntary Open Access Dental Plan² (select one benefit from each category)</p> <table style="width:100%;"> <tr> <th>Annual maximum</th> <th>Deductible</th> <th>Coinsurance</th> </tr> <tr> <td><input type="checkbox"/> \$500</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/50/0</td> </tr> <tr> <td><input type="checkbox"/> \$750</td> <td><input type="checkbox"/> \$50</td> <td><input type="checkbox"/> 100/50/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,000</td> <td><input type="checkbox"/> \$75</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,250</td> <td></td> <td></td> </tr> </table>	Annual maximum	Deductible	Coinsurance	<input type="checkbox"/> \$500	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/50/0	<input type="checkbox"/> \$750	<input type="checkbox"/> \$50	<input type="checkbox"/> 100/50/50	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$75	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1,250							
Annual maximum	Deductible	Coinsurance																			
<input type="checkbox"/> \$500	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/50/0																			
<input type="checkbox"/> \$750	<input type="checkbox"/> \$50	<input type="checkbox"/> 100/50/50																			
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$75	<input type="checkbox"/> 100/80/50																			
<input type="checkbox"/> \$1,250																					
<p><input type="checkbox"/> Customized Options 1000³ <input type="checkbox"/> Customized Options 1000 (with ortho) <input type="checkbox"/> Customized Options 2000⁴ <input type="checkbox"/> Customized Options 2000 (with ortho)</p>	<table style="width:100%;"> <tr> <td><input type="checkbox"/> \$1,000 (w/ortho)⁵</td> <td><input type="checkbox"/> \$25</td> <td><input type="checkbox"/> 100/80/50</td> </tr> <tr> <td><input type="checkbox"/> \$1,250 (w/ortho)⁵</td> <td><input type="checkbox"/> \$50</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> \$75</td> <td></td> </tr> </table>	<input type="checkbox"/> \$1,000 (w/ortho) ⁵	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/80/50	<input type="checkbox"/> \$1,250 (w/ortho) ⁵	<input type="checkbox"/> \$50			<input type="checkbox"/> \$75												
<input type="checkbox"/> \$1,000 (w/ortho) ⁵	<input type="checkbox"/> \$25	<input type="checkbox"/> 100/80/50																			
<input type="checkbox"/> \$1,250 (w/ortho) ⁵	<input type="checkbox"/> \$50																				
	<input type="checkbox"/> \$75																				

¹ Must have 10 or more employees **enrolled** to be eligible for orthodontic products and currently offer an orthodontia benefit.
² Must have 5 or more employees **enrolled** to be eligible for voluntary plans.
³ Available to groups with 15-200 **enrolled** employees
⁴ Available to groups with 30-200 **enrolled** employees
⁵ Available to groups with 50-100 **eligible** employees

HealthPartners will notify employees covered on HealthPartners plans of the special enrollment periods detailed in 29 CFR Sec. It is the responsibility of the employer to notify those employees who decline HealthPartners coverage of their special enrollment rights.



PO Box 1309
 Minneapolis, MN 55440-1309
 Sales Metro Phone # 952-883-5200 Non-Metro Phone # 800-298-4235
 HP 401012 (5/07)