



## NEW BUSINESS CHECK LIST

**CHECK FOR FIRST MONTH'S PREMIUM**

**EMPLOYER GROUP APPLICATION**

Note: Any special considerations must be noted under the Comment section.

**COPY OF QUOTE SOLD**

**COPY OF MOST CURRENT QUARTERLY UNEMPLOYMENT WAGE & TAX REPORT**

On the report, next to the employee's name, indicate if the employees are:

- Not Eligible for coverage = NE (part-time, have not met eligibility requirements yet, etc.)
- Terminated = T

All other employees will need to complete an Enrollment Application either electing or waiving coverage.

**EMPLOYEE ENROLLMENT APPLICATIONS**

Employers can elect to enroll on-line through Digital Health Plan (DHP), submit paper enrollment applications or both.

DHP:

- If an employer elects DHP, contact GPB for enrollment details.

Paper Enrollment Application:

- If enrollee is electing coverage, then enrollee must complete and sign the Sanford Health Plan Authorization Form for Pre-Enrollment Uses and Disclosures of Member Information form along with the application.
- If enrollee would like to waive coverage, then enrollee must complete and sign section 1 and section 2 of the application.
- If enrollee is currently on COBRA, 1) on the enrollment application print COBRA in the box entitled Date-of-Hire and 2) attach a copy of prior carrier's COBRA Election Form.
- If an enrollee is currently covered under another Sanford Health Plan fully-insured plan, the enrollee must choose between the two plans. Sanford Health Plan will not coordinate benefits with another Sanford Health Plan fully-insured plan.

**COPY OF PRIOR CARRIER'S BILLING**

Note: For ease of identifying creditable coverage, copies of the prior carrier's monthly billing statements will assist in the process. Please obtain the monthly billing statement for one year prior to the requested effective date and the second billing statement for the current billing period. (i.e. group effective 7/1/06, need copy of prior carriers billing for 7/1/06 and 7/1/05.) The employees who show on both billings will receive credit for preexisting waiting period. The remaining employees will need to supply Sanford Health Plan with Certificate of Creditable Coverage from their prior carrier(s). If you are unable to obtain the billing statements Sanford Health Plan will need the Certificate of Creditable Coverage for all eligible employees.

**DEDUCTIBLE CREDIT FOR BUSINESS WRITTEN OTHER THAN 1/1.**

Note: Sanford Health Plan deductible runs calendar year. Sanford Health Plan will give deductible credit from January 1<sup>st</sup> to effective date. Sanford Health Plan will only give the group deductible credit IF they receive the prior carrier deductible report or copy of member's EOB's within 60-days of the group's original effective date.

Reminder: To ensure timely delivery of ID cards, please submit completed information prior to the requested effective date.



# EMPLOYER APPLICATION

## EMPLOYER INFORMATION

Employer Legal Name \_\_\_\_\_

D/B/A \_\_\_\_\_

Type of Entity:  Corporation  Sole Proprietor  Non Profit  Partnership  Other \_\_\_\_\_

Employer Street Address \_\_\_\_\_

Employer Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Tax I.D. Number \_\_\_\_\_ Business Description \_\_\_\_\_

CEO/President \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

CFO \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Owner \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Billing contact \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Benefits contact \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Business telephone number \_\_\_\_\_ Business fax number \_\_\_\_\_

Email Address \_\_\_\_\_

Billing Address (if different than above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you currently have a Health Reimbursement Arrangement?  Yes  No If yes, administered by \_\_\_\_\_

Do you currently have an Employee Assistance Program?  Yes  No If yes, administered by \_\_\_\_\_

Do you currently subsidize COBRA premiums?  Yes  No If so, for whom \_\_\_\_\_, subsidized: \_\_\_\_\_%

Other Policies: (i.e. retiree or alternate benefit in lieu of health insurance.) If yes, please attach a copy of the policy.  Yes  No

## ENROLLMENT INFORMATION

Effective Date: \_\_\_\_\_

Open Enrollment Period: From \_\_\_\_\_ To \_\_\_\_\_

Total Number of Employees: \_\_\_\_\_ Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_ # of Eligible Employees: \_\_\_\_\_

Employer Contribution: \_\_\_\_\_ % of Single, \_\_\_\_\_ % of Family

Total Number of COBRA Continuees: \_\_\_\_\_

### Eligible Employees:

- All Employees
- All Employees who customarily work at least \_\_\_\_\_ hours/week or at least \_\_\_\_\_ hours/year
- Retirees—if yes, please provide roster of names and retiree policy
- Other: \_\_\_\_\_

### Internal Waiting Period/Eligibility Date:

1<sup>st</sup> day of the month following \_\_\_\_\_ days of eligible service.

Multiple Waiting Periods?  Yes  No If yes, please specify: \_\_\_\_\_

Are any divisions/subsidiaries to be covered?  Yes  No

If yes, attach a list that includes the division/subsidiaries name, location, relationship and number of employees.

Do you want one billing separated by location?  Yes  No, or

Do you want multiple billings sent to each location?  Yes  No

Are employees residing outside the Sanford Health Plan service area?  Yes  No

If yes, attach a list that includes the number of employees in each city and state.

NOTE: Any employee's residing outside the Sanford Health Plan service area will be required to utilize the out of area network.

Is an IRS form 5500 required?  Yes  No

If yes, Plan Year: from \_\_\_\_\_ through \_\_\_\_\_  
month/day month/day

**BENEFIT INFORMATION**

**Plan Design**

SD  IA  MN

Deductible: \$ \_\_\_\_\_

Office Visit: \$ \_\_\_\_\_

Emergency Room: \$ \_\_\_\_\_

Out of Pocket Maximum: \$ \_\_\_\_\_

Coinsurance: \$ \_\_\_\_\_

Pharmacy Copay: \$ \_\_\_\_\_

Oral Contraception (SD only)  Yes  No

Available Riders: Employee Assistance Program:  Yes  No

Lab & X-Ray:  Yes  No

Vision:  Yes  No

**NOTE: Attach copy of quote sold.**

**Additional Services:**

- Premium Conversion  Flex Spending Account
- Health Reimbursement Account  Health Savings Account

**SD/IA**

**High Deductible – HSA qualified**

Aggregate	Embedded
<input type="checkbox"/> \$1,250 – 80%	<input type="checkbox"/> \$2,500 – 80%
<input type="checkbox"/> \$1,500 – 80%	<input type="checkbox"/> \$3,000 – 80%
<input type="checkbox"/> \$2,000 – 80%	<input type="checkbox"/> \$3,000 – 100%
<input type="checkbox"/> \$2,500 – 80%	<input type="checkbox"/> \$5,000 – 100%
	<input type="checkbox"/> \$7,500 – 100%

**IA State Mandated Small Group Options<sup>1</sup>:**

Basic  Standard<sup>2</sup>

<sup>1</sup>Includes drug benefit, <sup>2</sup>Lab & X-ray not available

**MN**

**High Deductible – HSA qualified**

Aggregate	Embedded
<input type="checkbox"/> \$1,250 – 80%	<input type="checkbox"/> \$2,500 – 80%
<input type="checkbox"/> \$1,500 – 80%	<input type="checkbox"/> \$3,000 – 80%
<input type="checkbox"/> \$2,000 – 80%	<input type="checkbox"/> \$3,000 – 100%
	<input type="checkbox"/> \$5,000 – 100%
	<input type="checkbox"/> \$7,500 – 100%

**MN State Mandated Small Group Options<sup>1</sup>:**

Copay Select  DeductibleSelect<sup>2</sup>

<sup>1</sup>Includes drug benefit, <sup>2</sup>Lab & X-ray not available

Digital Health Plan Enrollment On-line:  Yes  No

Date of employee meeting: \_\_\_\_\_ # of Enrollment Packets: \_\_\_\_\_ # of Applications: \_\_\_\_\_

Special agreements/comments: \_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE**

Authorized Group Representative \_\_\_\_\_ Print Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Agent \_\_\_\_\_ Agency \_\_\_\_\_ Print Agent Name \_\_\_\_\_ Date \_\_\_\_\_

**Internal Use Only:**

CM \_\_\_\_\_ OR \_\_\_\_\_ Initial contract period: from \_\_\_\_\_ to \_\_\_\_\_  
Billing method: \_\_\_\_\_ Employer SF cobra rates: \_\_\_\_\_ Pre-existing exceptions: \_\_\_\_\_