Connecticut Small-Group Employer Application

Directions and Checklist

IMPORTANT: Directions

1. In order to ensure that your group receives its ID cards/member materials for the requested effective date, we require a 15th of the month submission date. If a case submission is not complete and received in a timely manner, we will require the completion of a Late Submission Form. Groups submitted after the 15th of the month are not guaranteed approval for the requested effective date.
2. Participation:
   - Groups of 2-9, 75% minimum participation is required of all eligible employees.
   - Groups of 10-50, 65% minimum participation is required of all eligible employees.
   - POS and FlexPOS plans require 70% of eligible enrollees to live in the ConnectiCare service area.
     – Waiver Forms are used in conjunction with Enrollment Forms to calculate participation.
3. Small Group Application:
   - Employer is required to read, complete, date, and sign the Application indicating Medical Plan Option, Pharmacy Option and Dental Plan Option choices. Subsequent plan changes are available only on group renewal date.
   - Please select a new hire waiting period (can select zero.)
   - Agent Information must be completely filled out, including the tax ID #'s. Agents must be licensed and appointed with ConnectiCare.
4. Each enrolling employee must fully complete, date, and sign all sections of the ConnectiCare Enrollment/Change Form. Please indicate a PCP; please remember to complete the date of birth.
5. Each enrolling employee must complete, date and sign the "Family Health Statement."
   - All "yes" answers must be explained (on front and back).
   - Number of hours worked and date of hire must be completed on Family Health Statement
6. Employers are required to submit proof of employment for all employees wishing to enroll in the group plan. Acceptable proof of employment includes:
   - Employee is listed on the quarterly tax-and-wage report; or
   - Proof of income paid via copies of cleared checks issued by the employer.
7. Tax documents: Please submit the most recent tax information described below. NOTE: Payroll journals are not acceptable. Please indicate employees' status (full-time, part-time, waiving, etc.) on this form. Everyone on tax documentation must be accounted for: # of waivers + # of enrollment forms = total eligibles.
   A. Sole proprietor and single owner LLC: Schedule C. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
   B. Multiple owners/Partnership(s): 1065 with K-1's for all partners totaling 100% ownership. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
   C. Corporation: Form 1120C or 1120S. If employees; most recent state quarterly earnings report (UC-5A/UC-2.)
   D. Non-Profit with employees: most recent state quarterly earnings report (UC-5A/UC-2.)
   E. New Business: New Business Certification Statement with a copy of federal EIN notification letter or Sales & Use Tax Permit (if applicable).
8. Please submit first month's premium, payable via *business* check, to ConnectiCare.

Small-Group Case Submission Checklist (1-50 lives)

❑ Small-Group Employer Application **dated and signed** with
  – Medical Plan Option
  – Pharmacy Option
  – Dental Plan Option
  – New Hire Waiting Period Option
❑ Waiver form: Waivers must indicate number of hours worked and date of hire. (Please submit on ConnectiCare's Waiver Form.)
❑ ConnectiCare Enrollment/Change Forms **dated and signed**
❑ Completed Family Health Statements for every eligible enrolling employee **dated and signed**
❑ Copy of **most recent Tax Filing State Quarterly Wage & Tax Form.**
Please indicate employee's status (full-time, part-time, waiving, etc.) on this form.
❑ Copy of the current carrier bill
❑ Copy of complete quote with employee census
❑ First Month's Premium — **Please make business check payable to ConnectiCare.**
❑ Coinsurance Funding Attestation

Submit all paperwork to: ConnectiCare Small-Group Sales, P.O. Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050.
Please do not mail your application directly to your Sales Representative's attention; doing so will delay your application.

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Part 1 Application

Company Information

1. Desired Effective Date _____ Small Group # _____ (ConnectiCare use only)

2. Legal Business Name _____

3. DBA/Doing Business As (if applicable) _____

4. Physical Address _____ P.O. Box _____

City _____ State ____ ZIP _____ Phone ( ) _____ Fax ( ) _____

5. Nature of Business _____ Billing/Contact Person _____

6. Organization Type ❑ Corporation ❑ Partnership ❑ Sole Proprietorship ❑ Other _____

7. Federal Tax Identification Number _____ Business Effective Date _____ Current Ownership Date _____

8. Do you offer health coverage to employees working 20-29 hours? ❑ Yes ❑ No

9. Are you affiliated with any other company? ❑ Yes ❑ No If yes, relationship type _____

Name of affiliated company _____ Relationship effective date _____ Total number of employees _____

10. Number of full-time eligible employees working 30 hours or more per week _____ Number of enrolling employees _____

Number of spousal/applicable waivers _____ Number of "other" waivers _____

Number of part-time employees working 20-29 hours per week _____ Number of part-time employees working less than 20 hours per week _____

Number of seasonal employees _____ Number of former employees on COBRA/state continuation _____

Total number of employees (including owners, part-time and seasonal) _____

11. New Hire Waiting Period ❑ 0 ❑ 30 ❑ 60 ❑ 90 ❑ 180 Days ❑ First of month following new hire waiting period selected

12. Will coverage be transferring from another carrier? ❑ Yes ❑ No

If yes, prior carrier name _____ Proposed termination date _____

(Please include a copy of the current premium bill with this carrier.)

If prior carrier is ConnectiCare, provide group #: _____ Total replacement? ❑ Yes ❑ No

Has the group been uninsured for three or more months prior to the requested effective date? ❑ Yes ❑ No

13. Small Employer Certification: *Pursuant to state law, carriers need information from an employer to determine if the employer qualifies as a small employer under the law. Guaranteed issue and renewability and ConnectiCare's underwriting guidelines are contingent upon this criteria being met. Certification of eligibility is required herein and prior to renewal. Your group health plan will become effective only as approved by ConnectiCare.* I hereby certify the employer applying for coverage is a small group under applicable state law. I certify that the information herein is true and complete to the best of my knowledge. I also certify that all eligible employees are covered by Workers' Compensation insurance except when exempt under applicable law and all eligible employees have equal access to ConnectiCare coverage. I agree to immediately notify ConnectiCare of any changes to the information provided herein. On behalf of the employer, I also agree to the terms and conditions of the Group Membership Agreements, including any riders and addendums, that govern the plans issued by ConnectiCare to the employer. I understand that false and/or incomplete responses or statements may result in cancellation or rescission of coverage. I acknowledge that ConnectiCare reserves the right to request any reasonable documentation from the employer, its affiliates, subscribers or dependents in order to verify eligibility.

Employer Signature X _____ Title _____ Date _____

E-mail Address _____

Agent Information

14. Agency Name _____ Agent Name _____

15. Address _____ City _____ State _____ ZIP _____

Phone ( ) _____ Fax ( ) _____ Commission Paid to: ❑ Agency ❑ Agent

Social Security # or Tax ID # _____ (Must be completed to ensure proper commission payment.) ConnectiCare Appointment ❑ Yes ❑ No

Contact Person _____ Agent E-mail Address _____

16. I have reviewed the answers on all applications and forms and I am not aware of any additional information that would affect the underwriting of this case. I agree to immediately notify ConnectiCare of any changes to the information provided herein or if I become aware of any information that could affect the underwriting of this case. I certify that each employee has completed and signed all forms, and selected a PCP.

Agent Signature X _____ Date _____

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Part 2 Plan Choice

Connecticare, Inc. (CCI): Connecticut Domiciled Only

Pharmacy Options (RX)

Please select a plan and indicate the appropriate Pharmacy option.
A. $15/$30/$40/20% ($300 script); or
B. $15/$30/$40/20% ($300 script) $200 Ded Tier 2, 3, 4

Hospital Copayment Plans (Contract Year Plans)

❑ FlexPOS 15 Copay CNT	RX	❑ A	❑ B
❑ FlexPOS 30 Copay CNT		❑ A	❑ B

Hospital Deductible Plans (Contract Year Only Plans)

❑ FlexPOS HD 1500 CNT		❑ A	❑ B
❑ FlexPOS HD 2250 CNT		❑ A	❑ B
❑ FlexPOS HD 3000 CNT	RX	❑ A	❑ B
❑ FlexPOS HD 4000 CNT		❑ A	❑ B
❑ FlexPOS HD 5000 CNT		❑ A	❑ B

Upfront Deductible Plans (Contract Year Only Plans)

❑ FlexPOS UPD 1000 30PCP 25% CNT		❑ A	❑ B
❑ FlexPOS UPD 2500 30PCP 25% CNT		❑ A	❑ B
❑ FlexPOS UPD 1000 30PCP 50% CNT		❑ A	❑ B
❑ FlexPOS UPD 2500 30PCP 50% CNT	RX	❑ A	❑ B
❑ FlexPOS UPD 3500 30PCP 50% CNT		❑ A	❑ B
❑ FlexPOS UPD 750 50% CNT		❑ A	❑ B

Upfront Deductible Plans (Calendar or Contract Year Plans)

❑ FlexPOS UPD 1500 Copay CAL		❑ A	❑ B
❑ FlexPOS UPD 1500 Copay CNT		❑ A	❑ B
❑ FlexPOS UPD 2000 Copay CAL		❑ A	❑ B
❑ FlexPOS UPD 2000 Copay CNT	RX	❑ A	❑ B
❑ FlexPOS UPD 3000 Copay CAL		❑ A	❑ B
❑ FlexPOS UPD 3000 Copay CNT		❑ A	❑ B

HSA COMPATIBLE PLANS (Calendar or Contract Year Plans)

- ❑ FlexPOS HSA 1500I/3000F 30/45 CAL
- ❑ FlexPOS HSA 1500I/3000F 30/45 CNT
- ❑ FlexPOS HSA 3500I/7000F 30/45 CAL
- ❑ FlexPOS HSA 3500I/7000F 30/45 CNT
- ❑ FlexPOS HSA 2500I/5000F CAL
- ❑ FlexPOS HSA 2500I/5000F CNT
- ❑ FlexPOS HSA 3000I/6000F CAL
- ❑ FlexPOS HSA 3000I/6000F CNT
- ❑ FlexPOS HSA 4000I/8000F CAL
- ❑ FlexPOS HSA 4000I/8000F CNT
- ❑ FlexPOS HSA 5000I/10000F CAL
- ❑ FlexPOS HSA 5000I/10000F CNT

All HSA Compatible Plans include Pharmacy Benefits

Premium $ _____ Check # _____
❑ Composite Rated (Group 25-50 in Connecticut)

ConnectiCare Dental Plans (for groups with three or more employees)

NETWORK ❑ Value ❑ Plus ❑ Premium

PLAN
❑ $1,000 benefit maximum ❑ $1,500 benefit maximum (10+ ees only.)
❑ Basic Plan (10+ ees) ❑ Basic Plan (3-9 ees) ❑ 3-9 Comprehensive Plan

❑ with orthodontia (10+ ees only.) Not applicable to Basic Plans.

DOMESTIC PARTNER *(Dental only)*
❑ Yes ❑ No Note: Affidavit must be received with paperwork.

SIC CODE:

Please note:
Calendar Year Plans reset annual benefits and deductibles each January.
Contract Year Plans reset annual benefits and deductibles on the month in which your policy renews.

The following information is being provided in accordance with the recent Connecticut State mandate (SB 46, PA 09-46), which requires Medical Loss Ratio (MLR) disclosure by all insurance companies.

Disclosure of Medical Loss Ratio: The State Medical Loss Ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and is calculated in accordance with applicable law.

The Federal Medical Loss Ratio has the same meaning as provided in and calculated in accordance with PPACA, PL 111-148, as amended from time to time, and regulations adopted thereunder.

- State Medical Loss Ratio for calendar year 2011 for ConnectiCare, Inc. (CCI): 81.3%
- Federal Medical Loss Ratio for calendar year 2011 for Connecticare, Inc. (CCI): 85.7%
- State Medical Loss Ratio for calendar year 2011 for ConnectiCare Insurance Company, Inc. (CICI): 73.3%
- Federal Medical Loss Ratio for calendar year 2011 for ConnectiCare Insurance Company, Inc. (CICI): 82.2%

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Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage is underwritten by ConnectiCare, Inc. FlexPOS, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.

ATTESTATION REGARDING EMPLOYER FUNDING OF COINSURANCE PLANS

ConnectiCare is committed to providing clients with affordable health insurance options for their employees. Inherent in the pricing of ConnectiCare's coinsurance plans is an actuarial assumption that the members will be responsible consumers of medical care and will be liable for the *full* member out-of-pocket expenses *without underlying employer funds* being used to offset the exposure.

To maintain the integrity of the pricing of these products, ConnectiCare is requiring that an officer of the company and the company's agent-of-record attest to the fact that there is no underlying funding of the employees' out-of-pocket medical expenses associated with these plans. By signing below you are indicating that you will notify us immediately if you are currently using or if you intend to use an underlying plan to subsidize your employees' cost sharing responsibilities. ConnectiCare reserves the right to adjust rates retroactively, reduce agent commissions, and/or rescind the coverage for non-compliance with this underwriting rule.

Employer	Agent
Group Number	Signature of Agent
Signature of Officer	Date
Title	
Date	

Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage, and Individual HMO coverage is underwritten by ConnectiCare, Inc.; Group coverage for coinsurance plans and Individual POS coverage is underwritten by ConnectiCare Insurance Company, Inc. In Massachusetts: Group HMO and POS coverage is underwritten by ConnectiCare of Massachusetts, Inc. FlexPOS, PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.