maryland health connection

Maryland Health Connection for Small Business - 2023 Direct Enrollment Employer / Carrier Enrollment Application

(not an Employer Eligibility Application)

		Group Number	

Company Information

Legal Company Name		**Doing Business As (if Applicable)**	
Physical Street Address (PO Box not acceptable)	**City**	**State**	**ZIP**
Billing Address (if different from physical)	**City**	**State**	**ZIP**
Mailing Address (if different from physical or billing)	**City**	**State**	**ZIP**
Phone Number	**Fax Number**		

Does this business have multiple locations? If so, please attach sheet with all locations with Street Address, City, State and ZIP and number of employees at each broken down by Full-time, Part-time, Retired, COBRA or State Continuees, 1099, Union, Seasonal, Other.

Company Group Contact: Name and Title		**Email**	**Phone Number**
Billing Contact: Name and Title (if different from above)		**Email**	**Phone Number**
Enrollment Contact: Name and Title (if different from above)		**Email**	**Phone Number**

Chief Executive Officer	**Organization type: (C-Corp, S-Corp, Non-Profit, Partnership, Sole Proprietor, LLC, LLP, Other):**

SIC Code	**Nature of Business**	**Federal Tax ID**	**Date Established**

Group Information

Is your company under 50 full-time equivalent employees (FTEs)? If so, number of FTEs?		
	Yes	**No**
Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company? **Details:**	☐	☐
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	☐	☐
Are there any associated companies to be included with this group that are commonly owned?	☐	☐
Is your company a branch of another company, or does your company have branch offices?	☐	☐
Do you use the services of a payroll company? If "Yes", provide the name of the payroll company: **Payroll Company:**	☐	☐

Prior Insurance Information

Please list any coverage with any carrier in the past 12 months

[redacted]	Name of Carrier (Corporate Name)	Policy # (if available)	Coverage Begin Date (MM/DD/YY)	Coverage End Date (MM/DD/YY) (write current, if current)
Medical Carrier				
Dental Carrier				

	Yes	**No**
Does your group have Worker's Comp: If Yes, what is the Carrier Name:	☐	☐
Are all employees covered by Worker's Compensation? If No, explain below:	☐	☐
Is Health Plan Primary and Medicare Secondary? **If your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, than your health plan is primary and Medicare is Secondary. Otherwise, Medicare is primary.**		

Medical Loss Ratio (MLR) Classification

		Yes	**No**
Subject to ERISA?	**(If no, please indicate why):**	☐	☐
Non-Federal Government Group?		☐	☐

For Non-ERISA and non-government groups, you may be subject to additional addendums dependent on carriers which would be provided to you.

Plan Selection

For Employer Choice: Please select one participating insurance carrier for your company. All metal levels will be available for the chosen carrier.

For Employee Choice: Please select plans across participating insurance carriers for your company. No more then two consecutive metal levels are allowed.

Requested Effective Date:			

Please select the desired method of Plan selection

Employee Choice	☐							**Employer Choice**	☐		
Bronze	☐	**Silver**	☐	**Gold**	☐	**Platinum**	☐				

MEDICAL PLAN CHOICES

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Aetna Health, Inc.	☐ Aetna Bronze HNOption 8000 70/50 INT	☐ Aetna Silver HMO 3500 100% HSA T	☐ Aetna Gold HMO 1000 100% E	**Aetna Life Insurance Company**	☐ Aetna Bronze PPO 7600 70/50 INT	☐ Aetna Gold OAEPO 1500 80%	☐ Aetna Silver OAEPO 2500 100%
CareFirst BlueChoice, Inc.	☐ BlueChoice HMO Gold 1000	☐ BlueChoice HMO HSA/HRA Silver 2750	☐ BlueChoice HMO Gold 1500	☐ BlueChoice HMO Referral HSA/HRA Bronze 6200	☐ BlueChoice HMO HSA/HRA Silver 1600	☐ BlueChoice Advantage HSA/ HRA Gold 1500	☐ BlueChoice HMO Silver 6500 / ☐ BlueChoice HMO Value Bronze 6000
	☐ BlueChoice HMO Referral Bronze 8250	☐ BlueChoice Advantage Gold 1000	☐ BlueChoice Advantage HSA/HRA Bronze 6100	☐ BlueChoice Advantage Silver 6500			
Group Hospitalization and Medical Services, Inc.	☐ BluePreferred PPO Gold 1100 90%/70%	☐ BluePreferred PPO HSA/HRA Bronze 6200	☐ BluePreferred PPO HSA/HRA Silver 2750 80%/60%	**CareFirst of Maryland, Inc.**	☐	☐	☐
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	☐ KP MD Platinum 0/10/Vision	☐ KP MD Platinum 500/20/Vision	☐ KP MD Gold 0/20/Vision	☐ KP MD Gold 1000/20/Vision	☐ KP MD Gold Virtual Complete 2000	☐ KP MD Gold 1500/0%/HSA/Vision	☐ KP MD Bronze 7000/0%/HSA/Vision
	☐ KP MD Silver 1800/40/Vision	☐ KP MD Silver 2500/40/Vision	☐ KP MD Silver Virtual Forward 3000	☐ KP MD Silver 2000/30/HSA/Vision	☐ KP MD Bronze 6150/30/HSA/Vision	☐ KP MD Bronze 6500/50/Vision	
UnitedHealthcare of the Mid Atlantic, Inc.	☐ UHC Core Essential Gold 750-2	☐ UHC Core Essential HSA Silver 2500-2	☐ UHC Navigate Gold 750-2	☐ UHC Navigate HSA Gold 1600-2	☐ UHC Navigate HSA Bronze 7000-2	☐ UHC Navigate HSA Silver 2500-2	☐ UHC Navigate Silver 3500-2
UnitedHealthcare Insurance Company	☐ UHC Choice Plus HSA Bronze 7000-2	☐ UHC Choice Plus HSA Gold 1600-6	☐ UHC Choice Plus HSA Silver 2500-2	☐ UHC Choice Plus Gold 750-2	☐ UHC Choice Plus Gold 1500-3	☐ UHC Choice Plus Silver 5000-3	☐ UHC Choice Plus Silver 3900-1
	☐ UHC Choice Plus Platinum 0-4	☐ UHC Choice Plus Platinum 750-4	☐ UHC Choice Plus Gold 2500-2	☐ UHC Choice Plus Silver 6000-3			
Optimum Choice, Inc.	☐ UHC OCI HSA Bronze 7000-2	☐ UHC OCI HSA Gold 2250-2	☐ UHC OCI HSA Silver 2500-2	☐ UHC OCI Gold 2500-2	☐ UHC OCI Gold 750-2	☐ UHC OCI Gold 1500-3	☐ UHC OCI Silver 6700
	☐ UHC OCI Platinum 0-1	☐ UHC OCI Platinum 750-1					
MAMSI Life and Health Company	☐ UHC Choice HSA Bronze 7000-2	☐ UHC Choice HSA Gold 1600-2	☐ UHC Choice HSA Silver 2500-2	☐ UHC Choice Gold 1500-4	☐ UHC Choice Platinum 0-2	☐ UHC Choice Platinum 0-4	☐ UHC Choice Plus Platinum 0-2
	☐						

	Medical (Percentage Contribution)	Medical (Fixed Dollar Contribution)	Dental (Percentage Contribution)	Dental (Fixed Dollar Contribution)
For Employee	%	$	%	$
For Dependents	%	$	%	$

Employer POS Option

	Yes	
Employer wants medical POS Option offered to its employees	☐	☐
Employer wants dental POS Option offered to its employees	☐	☐

Employee Eligibility

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Eligibility date for enrollment will be the first day of the policy month following the waiting period, unless date of hire or 90 days following date of hire option. Policy month refers to the contract effective date of the 1st of the monrh. Date of Hire or 90 days following date of hire option would result in an effective date on the date of hire or exactly 90 days from the employee's date of

			Yes	No
Waive the waiting period for present employees enrolling with the group? (YES/NO)				
Waiting Period for future Employees: (Please pick one)	First day of policy Month following:	0 Days	☐	☐
		30 Days	☐	☐
		60 Days	☐	☐
	or immediately after 90 Days		☐	☐
Waive waiting period for rehires? (YES/NO)			☐	☐

Employer Eligibility

Full-Time Equivalent Employees

The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H©(2) must be utilized to determine group size for health coverage.

A. FTEs from full-time employees. Number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a y ear (even if they are not eligible or enrolling for health coverage).	
B. FTEs from part-time employees (excluding seasonal workers). Number of part-time employees who worked on average less than 30 hours a week. (Add up the total number of hours worked in a week by part-time employees and divide by 30. Example, 10 employees working 20 hours a week: 10 x 20 = 200 / 30 = 6.66 = 6 (rounding down to the nearest whole number).	
C. Total number of FTEs = A + B	

Participation Determination

Total number of eligible employees based on state law must work a minimum of 30 hours a week. Note: An employer may not set eligibility rules that would require an employee to work more than 30 hours a week to obtain small group coverage. As long as the employee meets the 30 hour a week standard, they are considered full time for purposes of coverage.

Number of employees eligible for coverage (employees working 30 hours per week)			
Number of employees enrolling		Number of employees waiving coverage	
Number of full-time employees excluding union employees		Number of employees working outside Maryland List all states:	
Number of part-time employees		Number of employees not actively at work	
Number of 1099 employees		Number of COBRA continuees	
Number of union employees		Number of employees in waiting period and not eligible	

General Information	Yes	No
Cover Part-time (Part-time is defined as more than 17.5 hours and less than 30 hours) Employees?	☐	☐
Cover Domestic Partners of Employees?	☐	☐
Cover Employees with Other Coverage?	☐	☐

Is your employer group required to comply with ERISA? (Most private sector plans are ERISA plans) If no, please indicate appropriate category:	Church	Federal Government	Indian Tribe - Commercial Business	State, Local or Tribal Gov	Foreign Government / Foreign Embassy	Non-ERISA Other		
	☐	☐	☐	☐	☐	☐	☐	☐
Is your employer group required to comply with COBRA regulation or State Continuation? (YES/NO)							☐	☐
Do you have any present or former employees/dependents on COBRA or State Continuation? (YES/NO)							☐	☐

If yes, please attach list of people with name, qualifying information, date of eligibility and date of coverage termination

Special Provisions Related to Medical Eligibility

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision described in the Certificate of Coverage for the carrier(s).

Medicare primary versus secondary

How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year? Include: Full-time, part-time, seasonal, temporary, union, owners, partners, officers. Exclude: Self-employed persons, independent contractors 1099), directors. If you employed fewer than 20 employees for 20 weeks in the current or prior year, your group has Medicare as primary. If you employed 20 or more employees for 20 weeks in the current or prior year, your group insurance is primary.	

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FRAUD STATEMENT

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CARRIER STATEMENT

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

PARTICIPATING CARRIER CORPORATE NAMES AND ADDRESSES

Aetna Health, Inc. 1425 Union Meeting Road Blue Bell, PA 19422	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 (844) 241-0209	CareFirst BlueChoice, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	Group Hospitalization and Medical Services, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	CareFirst of Maryland, Inc. dba CareFirst BlueCross BlueShield 1501 S. Clinton Street, 10th Floor Baltimore, MD 21224

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 East Jefferson Street Rockville, MD 20852 (800) 777-7904	Optimum Choice, Inc. MAMSI Life and Health Insurance Company 4 Taft Court Rockville, MD 20850 (301)294-1578	UnitedHealthcare Insurance Company UnitedHealthcare of the Mid-Atlantic, Inc. 4 TAFT COURT ROCKVILLE, MD 20850 (952)992-5878

EMPLOYER ATTESTATION AND SIGNATURE

Name of Group			
Officer Signature		Officer Title	
Officer Printed Name		Date	
Officer Email		Officer Phone Number	
Broker Name		Broker ID	
Broker Signature		Date	
Broker Email		Broker Phone Number	
Carrier Name		Carrier ID	
Carrier Representative Signature		Date	
Carrier Email		Carrier Phone Number	

Maryland Health Connection for Small Business Plans

Broker Information

☐ **I certify that I am not aware of any information not disclosed in this application by the client that may have bearing on this risk, for all products being applied for.**

☐ **I represent that I am licensed and authorized to sell small business program-eligible products in the State of Maryland.**

☐ **I certify that I have advised the client not to terminate any existing coverage until receiving written notice from the carriers that the coverage being applied for by this application is accepted.**

General Agent	**Broker TAX ID Number**
Broker Name	**Broker Email Address**
Broker Office Number	**Broker Cell Phone Number**
Agency Name	**Pay Commissions to the Agency or the Broker**
Agency Contact	**Broker Fax Number**
Broker Street Address	**City State Zip**
National Producer Number	**License Number**

*Your broker is/may be paid commissions and other financial incentives by any of the participating insurance carriers.