MercyCare Health Plans
MercyCare HMO, Inc.
PO Box 550
Janesville, WI 53547
(800) 895-2421 • (877) 908-6027
mercycarehealthplans.com

EMPLOYER GROUP APPLICATION

ILLINOIS

For coverage consideration by MercyCare HMO, Inc.

UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR NOTICE OF APPROVAL BY THE UNDERWRITING DEPARTMENT.

YOU, the Employer (Policyholder), intend to establish and sponsor an Employee Benefit Plan, the terms of which are set forth in the applicable MercyCare HMO, Inc. policy.

YOU understand and agree that the Policyholder is not an insurer with respect to paying claims for benefits under the Policy.

For YOU to remain eligible under the policy, the following participation requirements must be maintained. Failure to maintain participation requirements may result in termination of YOUR coverage under the policy. Other termination provisions are stated in the policy.

YOU must meet the following participation requirements:

a. For groups with more than 10 employees, 70% participation of employees eligible for medical insurance benefits.
b. For groups with less than 11 employees:

Eligible Employees	Participating Employees
2 to 4	2
5 to 6	3
7	4
8 to 9	5
10	6

The following employees do not count as eligible employees for determining minimum participation requirements:

(a) Employees with continuous coverage under YOUR prior health insurance policy; or
(b) Employees with qualifying coverage (unless the group has 10 or less eligible employees and the qualifying coverage is another plan you sponsor).

Qualifying coverage means a group health plan; health insurance; Medicare; Medicaid; a medical care program of the armed forces of the United States, the federal Indian health service, or an American Indian tribal organization; a state health benefits risk pool; a health insurance program for federal government employees and their dependents; a public health plan as defined by the federal department of health and human services; and the health coverage plan for Peace Corps volunteers.

Creditable coverage does not include the limited or special purpose coverage excluded by law, such as accident-only, disability income, workers compensation, auto medical payment, credit-only, dental or vision benefits offered separately, specified illness, hospital or other fixed indemnity, and Medicare supplement.

YOU are required to contribute at least 50% of single coverage and 25% of all other coverage.

Please print in black/blue ink.

SECTION A – GENERAL EMPLOYER INFORMATION

1. Exact legal name of Employer (Policyholder): _____
2. Name of D/B/A (doing business as): _____
3. County: _____ Federal Tax ID #_____
4. Street Address: _____City: _____State: _____ Zip Code: _____
5. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
6. Phone Number: ( ) _____ Fax Number: ( ) _____
7. Website:_____
8. Is this group associated or affiliated with any other group insured by us? ☐NO ☐YES

   If Yes, List name (s) and how affiliated: _____
9. Is this coverage part of a union negotiated agreement? ☐NO ☐YES If YES, Expiration Date:: _____
10. Nature of Business: _____SIC Code: _____
11. How long has this legal entity been doing business? _____
12. Employer Administrative Contact Person: _____ Title: _____
13. Contact email address: _____
14. Employer Corporate Contact Person: _____ Title: _____
15. **Group Size Determination** – Average number of full-time, part-time, and seasonal/temporary employees employed during the preceding calendar year? _____
16. **For Medicare Coordination of Benefits** – In the previous calendar year did you have:
    a) 100 or more employees during 50% of the business days? ☐NO ☐YES
    b) 20 or more employees during 20 or more weeks? ☐NO ☐YES

SECTION B – PLAN INFORMATION

1. Requested effective date: _____ Please note: Coverage will only be effective upon written notification from MercyCare HMO, Inc..
2. Active employees who work on a permanent basis and with a normal workweek of 30 or more hours are eligible. Persons who work on a temporary, seasonal (temporary) or substitute basis are not eligible for coverage.

   Number of eligible employees: _____ Total number of employees on payroll: _____
3. If your hourly requirement varies from 30 hours or more per week and you have 15 or more employees selecting medical coverage, you may reduce the hourly requirement to not less than 20 hours per week.

   Indicate hourly requirement: _____
4. Probationary Period for new employees: ☐0 Days ☐30 Days ☐60 Days ☐90th day* ☐Other (May not exceed 90 days) _____
5. Effective Date for new employees:

   ☐First day of the month following the probationary period. *Not an option if selecting 90th day for probationary period
   ☐First day following the probationary period. *Not an option if selecting 90th day for probationary period
   ☐Date of Hire
6. Do you want the probationary period waived for the initial group enrollment? ☐YES ☐NO

SECTION B – PLAN INFORMATION (*Continued*)

7. Do all classes of employees serve the same probationary period? ☐YES ☐NO

   If NO, please list each class and their probationary period requirements: _____

   _____

   Is the probationary period the same for employees in the following situations?

   Changing from Part-time to Full-time:

   ☐YES ☐NO If NO, please explain eligibility guidelines: _____

   Return from leave of absence:

   ☐YES ☐NO If NO, please explain eligibility guidelines: _____

   Return from layoff:

   ☐YES ☐NO If NO, please explain eligibility guidelines: _____

   Rehire:

   ☐YES ☐NO If NO, please explain eligibility guidelines: _____

8. Termination Date for Terminated Employees: ☐Last day of the month of termination date
   ☐Date of termination

9. Do you currently have any former employees who have elected and are covered under COBRA – Consolidated Omnibus Budget Reconciliation Act/State Continuation? ☐NO ☐YES If YES, indicate names of individuals and their expiration dates: _____

10. Do you currently have a Workers' Compensation Policy? ☐NO ☐YES If YES, please provide name of carrier and the expiration date of the policy: _____

11. Do you wish to have 24 hour coverage for owners or partners not covered by Workers' Compensation? ☐NO ☐YES

    If YES, please provide name(s): _____

12. Is this a replacement of your current group coverage? ☐NO ☐YES

    If YES, you must furnish the following information:

    a) Name of current group carrier: _____

    b) Include your most recent billing statement.

    If NO, have you requested medical coverage in the last 12-months? ☐NO ☐YES If YES, from whom? _____

    _____

13. Percentage (%) of premium contributed by Employer: (YOU are required to contribute at least 50% of single coverage and 25% of all other coverage.)

    Single _____% Employee/Spouse _____% Employee/Child(ren) _____% Family _____%

14. Are you requesting domestic partner coverage?: ☐YES ☐NO

15. Are you requesting coverage for retired employees (Only for large groups with more than 50 total employees and at least 20 employees enrolled for medical coverage)?:

    ☐YES ☐NO If YES, please attach a copy of your eligibility requirements for retiree coverage.

16. Is there a current HRA or HSA plan in place? ☐YES ☐NO If YES, please provide a copy of this plan.

17. Do you require a claims feed to a third party vendor? ☐YES ☐NO If YES, please provide name of vendor and contact information.

SECTION C – BENEFITS

HMO	POS
☐Full Pay with $_____ Copay	☐Full Pay with $_____ Copay ☐dual choice
☐CO-90 with $_____ Deductible	☐CO-90/70 with $_____ Deductible ☐dual choice
☐CO-80 with $_____ Deductible	☐CO-80/60 with $_____ Deductible ☐dual choice
☐CO-70 with $_____ Deductible	☐CO-70/50 with $_____ Deductible ☐dual choice
☐CO-60 with $_____ Deductible	☐CO-60/40 with $_____ Deductible ☐dual choice
☐CO-50 with $_____ Deductible	☐CO-50/50 with $_____ Deductible ☐dual choice
☐H.S.A. with $_____ Deductible	☐H.S.A. with $_____ Deductible ☐dual choice
☐Other _____	☐Other _____

PRESCRIPTION DRUG BENEFIT			
☐4 Tier - $10/$25/$50/50%	☐4 Tier - $20/$40/$75/50%	☐4 Tier - $20/$50/$100/50%	☐Other _____

PLEASE ALSO ATTACH THE QUOTE SHEET WITH THE CHOSEN PLAN CIRCLED AND INITIALED.

SECTION D – EMPLOYER AGREEMENT

I, the employer (Policyholder), understand and agree that the first month's estimated premium (for groups of less than 51 lives), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is take on the application. Insurance coverage is not in effect unless and until you receive written notification from us. ***UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR NOTICE OF APPROVAL BY MERCYCARE HMO, INC.***

As an official representative for this employer, I further attest and certify that all statements included in this application are true and accurate to the best of my knowledge.

Dated On: _____ By: _____
(Month, Date, Year) (Employer signature)

Dated At: _____ _____
(City and state) (Title)

SECTION E – AGENT/AGENCY INFORMATION

To be completed by agent only. Please print.

AGENT OF RECORD (Agent/Agency to receive commissions)

National Producer Number (NPN)/Tax ID Number: _____

Agency: _____ Email address: _____

Agent completing application: _____

Phone: _____ Fax: _____

Street: _____ Mailing: _____

City: _____ State: _____ Zip Code: _____

I certify that I have met with the employer submitting this application and have fully explained its contents. I have discussed coverage, eligibility, the effect of intentional misrepresentations, and termination provisions. I understand that I have no authority to alter this application and that any alterations will invalidate this contract. I have no authority to bind MercyCare HMO, Inc. by making any promises and/or representation, to waive or change terms, conditions, and/or provisions of the plan or any requirement imposed by MercyCare HMO, Inc.

DATE: _____ **AGENT'S NAME:** _____
(*Please print)*

AGENT'S SIGNATURE _____