ConnectiCare

2022 CT Small Group Employer Application

Thank you for your interest in ConnectiCare Small-Group Health Insurance. Now that you have found the right plan(s) for your group, here's how to apply for coverage:

1. **Participation:**
   There must be a minimum of 75% participation after Spousal, Medicare, Medicaid, Parental, and Individual Coverage waivers. Every eligible employee must complete an enrollment form or waiver form indicating the reason for waiving coverage.
2. **Tax Documents:**
   Please submit a copy of the most recently filed tax information as described below:
   A. **Groups with employees (including those residing outside of Connecticut):** Submit the most recently filed state *Employee Quarterly Earnings Report* for each state as applicable (e.g., CT Form UC-5A/UC-2). Indicate status next to each employee name (full-time, part-time, waiving coverage, seasonal, terminated). For any new employees not listed on the Quarterly Report, please submit copies of two canceled pay stubs as proof of employment.
   B. **Multiple Owners/Partnership(s):** Form 1065 with K-1 for all partners totaling 100% ownership
   C. **Not-for-Profit Company Exempt from Income Tax Under Section 501(c):** Form 990
   D. **Newly Formed Business:** ConnectiCare New Business Certification Statement Form with a copy of Federal EIN Notification Letter or Sales and Use Tax Permit (if applicable)
   E. **Group that has Filed for Tax Extension:** Copy of filed Application for Automatic Extension of Time (Form 4868) along with a copy of prior year's Tax Filing

Small-Group Case Submission Checklist:

Please use the checklist below as a guide to ensure the timely processing of your application:

- ☐ Small-Group Employer Application completed and signed
- ☐ ConnectiCare Enrollment/Change Forms completed by each enrolling employee or Excel Spreadsheet Template. For COBRA participants, employer must indicate the effective date that the employee became eligible for COBRA.
- ☐ If enrolling a Domestic Partner, an Affidavit of Domestic Partnership must be included with the Enrollment/Change Form.
- ☐ Copy of most recent Tax Filing. Please indicate each employee's status: (full-time, part-time, waiving, terminated, seasonal, etc). Refer to number 2 above for required tax documents.
- ☐ Copy of complete quote with employee census indicating plan(s) selected
- ☐ Initial premium payment (business check only) made payable to CBIA Service Corp. Personal checks will not be accepted

Submit all paperwork to: ConnectiCare Small-Group Administration c/o CBIA Service Corporation 350 Church Street, Hartford, CT 06103 or fax it to: 1-860-278-0883.

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Company Information (all fields required)

Desired Effective Date: _____ Small-Group #: _____
ConnectiCare Use only

Legal Business Name: _____

DBA/Doing Business As (if applicable): _____

Physical Address: _____

City: _____ State: _____ ZIP: _____

Mailing Address/PO Box: _____

City: _____ State: _____ ZIP: _____

Benefits Administrator/Billing Contact: _____

Benefits Administrator Email Address: _____

Phone: _____ Fax: _____

Nature of Business: _____ SIC _____

Federal Tax ID Number: _____

Do you offer coverage to Domestic Partnerships? ☐ YES ☐ NO

Are you affiliated with another company? ☐ YES ☐ NO

If YES, relationship type: _____ Number of employees at that location: _____

Organization Type: ☐ Corporation ☐ Partnership ☐ Other: _____

Business Effective Date: _____ Current Ownership Date: _____

# of eligible employees: _____ # enrolling employees: _____ # of COBRA enrollees: _____

# of waivers with other coverage: _____

Total Number of Full-Time and Full-Time Equivalent Employees _____ (REQUIRED)
*Refer to page 3 for counting method instructions

Check #: _____ Amount: $ _____

New Hire Waiting Period: First of the month following: ☐ 0 days ☐ 30 days ☐ 60 days

Will coverage be transferring from another carrier? ☐ YES ☐ NO

If YES, prior carrier name: _____ Proposed termination date: _____

If the prior carrier is ConnectiCare, provide the Group #: _____ Total Replacement? ☐ YES ☐ NO

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Group Membership Information

Calculating the total number of full-time and full-time equivalent employees

This counting method pertains to the ACA requirement that employers of 51+ offer a qualified health plan with minimum essential coverage. ConnectiCare will use the number of employees from this calculation to determine the product options available starting with the upcoming plan year (Small or Large group). IRS regulations provide detailed rules about this method of calculation; please consult your tax or legal adviser. The following is a **general** description:

The number of employees is determined by adding (1) and (2) below:

1. The number of full-time employees. Full-time is someone employed an average of at least 30 hours per week or 130 hours per month.

2. The number of full-time equivalents (FTEs), which is a combination of employees. An individual employee may not be full-time because he/she is not employed an average of at least 30 hours per week. But in combination, such employees are counted as the equivalent of a full-time employee. *For example, two employees who each work 15 hours per week make up one FTE.* You can also calculate FTEs by aggregating hours worked by non-full-time employees in a month and dividing by 120.

    - To determine group size, look to the size of your workforce in the **prior** calendar year.
    - Affiliated employers with common ownership or those under common control must aggregate their employees for purposes of determining group size.
    - All employees are included for counting purposes—for example, union and non-union employees, employees who are covered by another carrier, employees who have waived coverage, or employees located in other states.
    - The IRS regulations have some special counting rules, such as those for seasonal workers, employees whose hours are difficult to track or whose hours vary, school employers, and companies not in existence in the prior calendar year. Please consult your tax or legal advisor if there are questions or special circumstances.

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Group & Membership Information – continued (all fields required)

Small Employer Certification: *Pursuant to state and federal law, carriers need information from an employer to determine if the employer qualifies as a small-group employer under the law. Guaranteed issue and renewability of group coverage are contingent upon the submission of accurate and complete information, and the applicable guidelines 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 law in accordance with the employee counts provided to ConnectiCare. 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 Worker's 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. If we have opted to submit our employee information on an excel spreadsheet we will collect and maintain the written release that is included on paper enrollments for all initial and new enrollments. 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.

Owner's Name (Please Print): _____

Owner's Email Address _____

Owner's Signature: _____ Date: _____

Broker Information

Agency Name: _____ Broker Name: _____

Address:_____ City:_____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Broker Email Address: _____

Commission Paid to: ☐ Agency ☐ Broker

Social Security or Tax ID #:_____

Contact Person: _____ Contact Phone Number: _____

Contact Person's Email Address: _____

ConnectiCare Appointment: ☐ YES ☐ NO ConnectiCare Sales Rep.: _____

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.

Broker Signature: _____Date: _____

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Benefit Plan Information:

Pharmacy Benefits are included in all medical plans. Refer to benefit summary for plan details.

- Several plans include **Adult Preventive Dental Care** as an embedded benefit. Refer to benefit summary for plan details.
- All plans are contract year plans which reset annual benefits and deductibles on the month in which your policy renews.
- ConnectiCare Benefits, Inc. (CBI) plans use the same network as plans sold through Access Health CT and will follow the small group 4-tier employer sponsored drug formulary.

Groups may choose up to five (5) plans.

Copay/Coinsurance Plans:	
☐ FlexPOS Copay $20 with Dental	
Upfront Deductible Copay or Coinsurance Plans:	
☐ FlexPOS Copay/Coins. $1000 with Dental	☐ FlexPOS Copay/Coins $4000 with Dental
☐ FlexPOS Copay/Coins. $2000	☐ FlexPOS Copay/Coins. $4250 with Dental
☐ FlexPOS Copay/Coins. $2500	☐ FlexPOS Copay/Coins. $5300
☐ FlexPOS Copay $3000	☐ FlexPOS Coins. $7500 with Dental
☐ FlexPOS Copay/Coins. $3500	
HSA Compatible Plans:	
☐ FlexPOS HSA Copay/Coins 3000/6000 ded with Dental	☐ FlexPOS HSA Coins. $5800/$11600 ded. with Dental
☐ FlexPOS HSA Copay/Coins. $3500	☐ FlexPOS HSA Copay/Coins 6400/12800 ded with Dental
Passage Plans*:	
☐ Passage HMO PCP Copay/Coins $2,500	☐ Passage HMO PCP Copay $6500/$13000 ded.
☐ Passage HMO PCP Coins. $8500	
* Members must select a PCP from the Passage network and include the PCP's name on the enrollment form. Referrals are required from your Passage PCP to see a specialist. Find participating Passage network PCPs with the "Find a doctor" tool on connecticare.com	
Compass Plans:**	
☐ Compass HMO Copay/Coins. $2000 with Dental	
**Members pay less in copays, deductibles and/or coinsurance when they visit "preferred" primary care providers (PCPs) and hospitals for covered services. Use "Find a doctor" on connecticare.com to locate Compass preferred providers.	
ConnectiCare Benefits, Inc. (CBI): (network includes providers located in Connecticut)	
☐ Choice Bronze POS	☐ Choice Bronze POS HSA
☐ Choice Silver A POS	☐ Choice Silver POS HSA
☐ Choice Silver B POS	☐ Passage Gold POS PCP

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Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA)* – All Fields Required

An HSA is a tax-free fund that can be used to pay for qualified medical and/or pharmacy expenses. ConnectiCare has partnered with Health Equity to provide this service for our customers. Benefits include a full integration of enrollment and claim payment.

Would you like to open employee HSA accounts with Health Equity? ☐ YES ☐ NO

Health Reimbursement Arrangements (HRAs) are arrangements that allow an employer to reimburse for medical expenses paid by participating employees. HRAs reimburse only those items (copays, coinsurance, deductibles, prescription drugs, and services) agreed to by the employer which are not covered by the company's selected standard insurance plan. ConnectiCare has partnered with Health Equity to provide this service for our customers. Benefits include a full integration of enrollment and claim payment.

Would you like to open an HRA account with Health Equity? ☐ YES ☐ NO

If yes to either of the above, you or your broker should go to cbia.com/connecticare-forms and complete the Health Equity Onboarding form online.

Will you have an HRA account with another third party Administrator? ☐ YES ☐ NO

If yes: TPA Name _____

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

Plan (10+ employees)	**With orthodontia** (10+ employees)
☐ $1,000 benefit maximum	☐ $1,000 orthodontia maximum
☐ $2,000 benefit maximum	☐ $1,500 orthodontia maximum

Plan (2-9 employees) ☐ $1,000 benefit maximum

Disclosure of Medical Loss Ratio

The 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. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs, or other cost containment programs or features. 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 2020 for ConnectiCare, Inc. (CCI): 79.0%
- Federal Medical Loss Ratio for calendar year 2020 for ConnectiCare, Inc. (CCI):
  Individual 91.5%
  Small-Group N/A
  Large-Group 86.7%
- State Medical Loss Ratio for calendar year 2020 for ConnectiCare Insurance Company, Inc. (CICI): 85.8%
- Federal Medical Loss Ratio for calendar year 2020 for ConnectiCare Insurance Company, Inc. (CICI):
  Individual 78.4%
  Small-Group 81.1%
  Large-Group 87.9%
- State Medical Loss Ratio for calendar year 2020 for ConnectiCare Benefits, Inc. (CBI): 76.5%
- Federal Medical Loss Ratio for calendar year 2020 for ConnectiCare Benefits, Inc. (CBI): Individual 81.4%

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