ConnectiCare

2023 MA 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 Massachusetts):** Submit the most recently filed state *Employee Quarterly Earnings Report* for each state as applicable (e.g., MA form WR-1). Indicate status next to each employee name (full-time, part-time, waiving coverage, seasonal, terminated). For any new employees not listed on the taxes, 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.
- ☐ 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: 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.

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

Binder Payment

Check #: _____ Amount $ _____

Electronic Payment Amount $ _____ (Copy of voided check required)

☐ Included ☐ Mailed Signature Required _____

Coverage is provided by and services are administered as follows: In Massachusetts, Group HMO & POS coverage is underwritten by ConnectiCare of Massachusetts, Inc. CBIA Service Corp. provides certain administrative services to ConnectiCare Insurance Company, Inc. and its affiliates for a fee.

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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+ employees 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 they are 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.
- **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.

Groups may choose up to five (5) plans.

CMI Small-Group Plans
Gold
☐ Choice Mass HMO Copay $30 Calendar Year
☐ Choice Mass POS Copay $30 Calendar Year
☐ Choice Mass HMO Copay $2,000/$4,000 Contract Year
Silver
☐ Choice Mass HMO Copay $2,500/$5,000 ded. Contract Year
☐ Choice Mass POS Copay $3,000/$6,000 Contract Year
☐ Choice Mass POS HSA $2,500/$5,000 Contract Year
☐ Choice Mass POS HSA $4,500/$9,000 Contract Year

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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 HealthEquity to provide this service for our customers. Benefits include a full integration of enrollment and claims payment.

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

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 that are not covered by the company's selected standard insurance plan. ConnectiCare has partnered with HealthEquity to provide this service for our customers. Benefits include a full integration of enrollment and claims payment.

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

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

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

If yes: TPA Name _____

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 Massachusetts. 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.

- Federal Medical Loss Ratio for calendar year 2021 for ConnectiCare of Massachusetts, Inc. (CMI): Individual/Small-Group: N/A

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MASSACHUSETTS NON-DISCRIMINATION CERTIFICATION

_____ (hereafter, Employer), hereby certifies that as of _____ , Employer is in
(Name of employer) Insert date of issue or renewal of group contract

compliance with the provisions of Chapter 58 of the Massachusetts Acts of 2006 that require Massachusetts employers to offer their group health benefit plans on a non-discriminatory basis to employed Massachusetts residents. Specifically, Employer certifies the following:

1. Employer offers the ConnectiCare of Massachusetts (CMI) health benefit plan(s) it has chosen to all of its full-time employees living in Massachusetts.

It is acknowledged that Employer is not required to offer the CMI health benefit plan(s) to retirees or part-time, temporary, or seasonal employees as defined within regulations promulgated by the Massachusetts Division of Health Care Finance and Policy regarding the so-called "employer fair share contribution." Further, it is acknowledged that:

- A full-time employee is an employee who is scheduled or expected to work at least the equivalent of an average of 35 hours per week over the applicable base period who is not a temporary employee or a seasonal employee.
- A temporary employee is an employee who is expected to work 12 consecutive weeks or fewer.
- A seasonal employee is an employee who is so recognized by the Massachusetts Department of Unemployment Assistance.

2. Employer does not make a smaller premium contribution percentage for each CMI health benefit plan that it offers to any full-time employee living in Massachusetts than the employer makes to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. It is acknowledged that this provision does not apply to any separate contribution percentages for employees covered by collective bargaining agreements. Employer acknowledges that it is permitted to make premium contributions in accordance with the following rules:

- Employer may establish a fixed dollar amount contribution to premium regardless of salary for all full-time employees living in Massachusetts.
- Employer may establish different percentage contributions or fixed dollar contributions for different plan choices, as long as the contributions made with respect to each plan on behalf of full-time employees living in Massachusetts do not differ based on the salary level of those employees.
- Employer may establish greater contribution levels for increasing lengths of service, as long as the schedule of contribution levels is part of a formal employee benefit plan and is designed as a reward for longevity rather than as a pretext for providing better health insurance contributions to more highly paid employees.
- Employer may establish greater contribution levels for employees who participate in company-sponsored health and wellness programs.
- Employer may establish contribution levels for dependents of covered full-time employees living in Massachusetts that differ from contribution levels for full-time employees, provided that the contribution level is the same for all dependents of said full-time employees living in Massachusetts and does not differ based on the salary level of those employees.

Name of employer	
Print name of person signing	Title
Signature	Date

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

Coverage is provided by and services are administered as follows: In Massachusetts, Group HMO & POS coverage is underwritten by ConnectiCare of Massachusetts, Inc. CBIA Service Corp. provides certain administrative services to ConnectiCare Insurance Company, Inc. and its affiliates for a fee.

ConnectiCare of Massachusetts, Inc.

ConnectiCare Small Group Administration c/o CBIA Service Corp.
350 Church Street, Hartford, CT 06103-1126 • Fax: 860-278-0883

Small Group Enrollment/Change Form

Please print clearly. Complete in full using ballpoint pen.

EMPLOYER: Complete this section. Form cannot be processed without this information.

Group Name	Employee Work Location	Group Number

Date of Hire (mm/dd/yy)	Hours Per Week	Coverage Effective Date (mm/dd/yy)	Coverage End Date (mm/dd/yy)	COBRA ☐ Yes ☐ No COBRA Start Date / /	Length of coverage: ☐ 30 months ☐ 36 months ☐ Other

Employer Signature	Title	Date

EMPLOYEE: Complete the following sections, sign at bottom, and read information on reverse side.

Please check appropriate item: ☐ New Enrollment ☐ Terminate Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Change Plan ☐ COBRA Election
☐ Other (Name change, address change, etc. Indicate reason for change.) _____

First Name	Middle Name	Last Name

Street Address	City	State	ZIP Code

Primary Phone Number ☐ Home ☐ Cell ☐ Work	Secondary Phone Number ☐ Home ☐ Cell ☐ Work	Email Address	Primary Language (optional)

Marital Status: ☐ Single ☐ Married/Civil Union ☐ Domestic Partner ☐ Legally Separated ☐ Separated ☐ Divorced ☐ Widowed

2023 Small Group Plans:

Hospital Copayment Plans (Calendar Year): ☐ Choice Mass HMO Copay $30 ☐ Choice Mass POS Copay $30

Upfront Deductible Copay or Coinsurance Plans (Contract Year):
☐ Choice Mass HMO Copay $2,000/$4,000
☐ Choice Mass HMO Copay $2,500/$5,000 ded.
☐ Choice Mass POS Copay $3,000/$6,000

HSA Compatible Plans (Contract Year):
☐ Choice Mass POS HSA $2,500/$5,000
☐ Choice Mass POS HSA $4,500/$9,000

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number (required)	Sex	Date of Birth (mm/dd/yy)	Primary Care Provider	ConnectiCare Provider ID Number (optional)	Existing Patient
Employee	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Spouse/Civil Union/Domestic Partner	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 1	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 2	☐	☐		☐ M ☐ F				☐ Yes ☐ No
Dependent 3	☐	☐		☐ M ☐ F				☐ Yes ☐ No

Are you currently using tobacco? Employee ☐ Yes ☐ No Spouse/Civil Union/Dom. Partner ☐ Yes ☐ No Dependent 1 ☐ Yes ☐ No Dependent 2 ☐ Yes ☐ No Dependent 3 ☐ Yes ☐ No

Race/Ethnicity (Required): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating, or claim payment.

Employee:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Spouse/Civil Union/Domestic Partner:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 1:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 2:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 3:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

☐ Check if enrolling a disabled dependent age 26 or over and contact CBIA Service Corp. to obtain a form for submitting proof of disability.

Other health care coverage: Will you have other health insurance in addition to this ConnectiCare plan, under a Group, HMO, or Medicare plan? ☐ Yes ☐ No

If yes, name of person covered	Employer	
Insurance Co. Name and Address (Please attach a copy of your group medical insurance card.)	Policy Number	Medicare (Please attach a copy of your Medicare card.) ☐ Part A ☐ Part B ☐ Retired

IMPORTANT: EMPLOYEE/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare of Massachusetts, Inc. (CMI), or a CMI affiliate or other organization or person having records, data, or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data, or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CMI's Privacy Notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the Privacy Notice prior to signing this consent. I understand that CMI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CMI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan and for one year thereafter. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CMI as long as CMI or others have not taken action relying on this authorization. I acknowledge that I have retained a copy of this authorization. I authorize payroll deduction, if any, for the coverage I have elected.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment, and restitution depending on applicable laws.

Important: By signing here, you are indicating that you have read and understand the information on the front and back of this form. This authorization is valid as long as you are enrolled in a ConnectiCare health plan, and for one year after enrollment in the plan ends. I certify that the information supplied in the form is correct. I agree to the consent on this form. I understand that the phone numbers I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me, or my health benefit plan or related programs.

► Employee's Signature _____ Date _____

ConnectiCare collects race/ethnicity data solely for the purposes of developing quality improvement programs, education, training, and marketing purposes. This data will not be used for determining eligibility, premium rate, or claim payment.

INSTRUCTIONS: DID YOU REMEMBER TO...

- ☐ **Print clearly, complete all sections, and sign at the bottom of page 1?**
- ☐ **Select your primary care provider and include the ConnectiCare Provider ID number? (Can be found in the Provider Directory or on our website.)**
- ☐ **Attach a copy of your Medicare card if you are Medicare-eligible?**
- ☐ **Attach a copy of your group medical insurance card if you have other coverage?**
- ☐ **Insert Social Security number for each dependent?**
- ☐ **Retain a copy of this form for your records?**