ConnectiCare

Small Group (5-50) Employer Application

Fixed Funding Solutions

Thank you for your interest in ConnectiCare small group Fixed Funding Solutions (FFS). 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 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 FFS Application Checklist

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

- ☐ Employer Application
- ☐ Stop Loss Application
- ☐ New York Public Goods Pool forms
- ☐ 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 the prior carrier invoice or renewal notice
- ☐ Copy of complete quote with employee census indicating plan(s) selected
- ☐ Initial premium payment (business check only). Please complete the Electronic Binder Submission form and mail binder payment to:

ConnectiCare, Inc.
P.O. Box 21852
New York, NY 10087-1852

Submit all paperwork (except for the binder form and payment) to: ConnectiCare Small Group Installation Unit, 175 Scott Swamp Road, P.O. Box 4050, Farmington, CT 06034-4050 or fax: 860-678-5272.

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Part 1: Employer Information

Employer Name	Effective Date of Coverage
Doing Business As (if applicable)	Federal Tax ID
Benefits Administrator Contact Name and Title	Benefits Administrator Contact Email and Phone Number
Additional Contact Name and Title	Additional Contact Email and Phone Number
Business Address	Billing Address (if different from business address)
Prior Health Insurance Carrier	

Part 2: Group Size Certification

Please indicate the total number of full-time equivalent employees (FTEs). Combine the amounts from number one and two below to get total FTEs. **Total number of full-time and full-time equivalent employees: __________ (required)**

This counting method pertains to the ACA requirement that employers with 51 or more full-time 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 to you for 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.
   Total number of full-time employees: __________.
2. The number of FTEs, which is a combination of employees. An individual employee may not be full-time because they are 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. **Total number of full-time equivalent employees: __________.**
   - 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.

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Part 3: Employer Eligibility

Number of Waivers With Other Coverage	Number of Waivers Without Other Coverage
Number of COBRA Participants	Do you offer coverage to domestic partners? ☐ Yes ☐ No (Defined as two people, 18 years of age or older, residing together for at least six months.)

Is your company part of or affiliated with another company? ☐ Yes ☐ No

If yes, name of affiliated company: ______________________ Number of employees at affiliated company: ____________

New hire waiting period: First of the month following ☐ Date of hire ☐ 30 days ☐ 60 days

Employer contribution toward monthly rates. Employee ($ or %): ______________ Dependents ($ or %): ______________

Part 4: Plan Selection

Groups may choose up to five (5) plans:

HSA Compatible Plans	
☐ FlexPOS HSA $6,800 40% ☐ FlexPOS HSA $5,000 50%	☐ FlexPOS HSA $3,300 25%
Copay/Coinsurance Plans	
☐ FlexPOS $40/$80 $5,000 20% ☐ FlexPOS $35/$50 $4,000 35% ☐ FlexPOS $40/$80 $2,750 20%	☐ FlexPOS $30/$50 $3,500 20% ☐ FlexPOS $30/$50 $2,000 ☐ FlexPOS $30/$45 $500

Part 5: Health Savings Account/Health Reimbursement Arrangement

1. Would you like to set up a health savings account (HSA) or a health reimbursement arrangement (HRA) integration with HealthEquity? ☐ Yes, HSA ☐ Yes, HRA ☐ No

   ☐ By checking this box, you authorize ConnectiCare to automatically send eligibility and paid claims to HealthEquity for the purpose of opening employee HSA accounts or an employer HRA account.

2. Do you currently use an HRA administrator? other than HealthEquity? ☐ Yes ☐ No

   a. Name of HRA administrator: ________________________________

   b. ConnectiCare has an integrated relationship with some third-party administrators. Please contact your broker or ConnectiCare account executive to find out if we can integrate eligibility and claims with your administrator.

   Note: By checking "Yes," you authorize ConnectiCare to automatically send eligibility and paid claims to your designated third-party administrator for the purpose of opening an HRA account for your covered employees.

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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 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. 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 to verify eligibility.

Employer Signature	Broker Signature
Employer Printed Name	Broker Printed Name
Title	Agency Name
Date	Date

Questions? Please contact ConnectiCare sales at ffssales@connecticare.com or call 800-723-2986, option 3.

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