Medica Group Application / Employer Health Questionnaire

Medica

Employee Counting Guidelines by State:

Iowa, North Dakota, South Dakota, Wisconsin
If you are a continuing business, how many individuals did you employ, on average, during the calendar year preceding the requested coverage effective date? Include all employees of your company and all employees of entities related to your company as part of a controlled group of corporations; trades or businesses under common control; and/or members of an affiliated service group. (See Section 414 of the Internal Revenue Code for additional information).

Minnesota
If you are a continuing business, how many individuals did you employ, on average, working a minimum of 20 hours per week during the calendar year preceding this application? Include all employees of your company and all employees of entities related to your company as part of a controlled group of corporations; trades or businesses under common control; and/or members of an affiliated service group. (See Section 414 of the Internal Revenue Code for additional information). Also include a sole proprietor or a partner in a partnership, if such individuals are included under the health benefit plan. Do not include individuals who work on a temporary, seasonal or substitute basis.

Nebraska
If you are a continuing business, how many individuals did you employ, on average, working a minimum of 30 hours per week during the calendar year preceding this application? Include all employees of your company and all employees of entities related to your company as part of a controlled group of corporations; trades or businesses under common control; and/or members of an affiliated service group. (See Section 414 of the Internal Revenue Code for additional information). Also include a sole proprietor or a partner in a partnership, if such individuals are included under the health benefit plan. Do not include individuals who work on a temporary, seasonal or substitute basis.

I attest the group applying for coverage is considered a Large Group (51+ employees).

_____
Signature

_____
Printed name

_____
Title and Company

_____
Date

Medica is committed to protecting and maintaining the privacy and confidentiality of our members' personal information. To see Medica's privacy notice, please visit **Medica.com.**

A GROUP INFORMATION (EMPLOYER COMPLETES THIS SECTION)

Company Name	Federal Tax I.D. Number	Plan ID^

Address (Must be a physical address, no P.O. Boxes)

Street			
City	**State**	**ZIP Code**	**County**

Billing Address (If different than above, P.O. Box accepted)

Street			
City	**State**	**ZIP Code**	**County**

Organization Type: ❍ Sole Proprietorship ❍ Partnership ❍ C Corporation ❍ S Corporation

❍ Non-Profit ❍ LLC/LLP ❍ Independent Contractor ❍ Other

Contact Information

Name	Title	
Email	**Fax**	**Work Phone**
Additional Contact Name	Work Phone	
Additional Contact Name	Work Phone	

B COVERAGE INFORMATION

Requested Effective Date of Coverage	Basis for Accumulation of Deductibles (Check)	Year Company Incorporated
__ __ / __ __ / __ __ __ __	☐ Calendar Year ☐ Contract Year *(Specify commencement date: __ __ /__ __ /__ __ __ __)*	

Nature of Business	Industry Code (SIC)	Multi-location Group?	# Locations
		❍ Yes ❍ No	

^ 3-digit number used by the Department of Labor, IRS, and ERISA to identify one employee welfare plan from another among a company's benefit offerings. For example 501, 502, 503. Please provide if applicable. Groups under 100 employees and non-ERISA groups may not have a Plan ID.

Location Addresses (Must be a physical address, no P.O. Boxes) *Add additional addresses on a separate piece of paper*			
Street	**City**	**State**	**ZIP Code**

Number of hours worked/week to be eligible	Employer Contribution _____ Single / _____ Dependent(s)

Number of Employees		
Total # of Employees (Please refer to instructions on cover page to determine the counting methodology for the state in which the group is sitused).	Total # of Employees eligible for health plan	Total # of Employees currently enrolled

# of Employees on State or COBRA Continuation	Annual Employee Turnover Rate

Current Carrier			
Carrier Name	Current Rates	Renewal Rates	Original Effective Date __ __ / __ __ / __ __ __ __

Previous Carriers *(List previous 5 years)*	**Effective Dates** *(List previous 5 years)*

Workers' Compensation Carrier Name	**Are employees/owners excluded from Workers' Comp. Coverage?**
	❍ Yes ❍ No If yes, list names below
Has Medica insured the group in the last 12 months? ❍ Yes ❍ No	
If yes, list date coverage was terminated __ __ / __ __ / __ __ __ __	

Eligible New Hire Effective Date (*Check)*	**Retiree Health Plan Eligibility**
❍ Date of hire: __ __ / __ __ / __ __ __ __ ❍ First of the month after (check one): ❍ 30 day waiting period ❍ 60 day waiting period (unless this results in a waiting period longer than 90 days; then coverage will become effective 90 days following the date of hire) Effective date for status change: __ __ / __ __ / __ __ __ __ Effective date for rehire: __ __ / __ __ / __ __ __ __	Are retirees able to participate in your health plan? ❍ Yes ❍ No If yes, how many retirees are eligible? How many retirees enrolled? Employer contribution toward retiree coverage Retiree eligibility criteria *(or list on additional sheet of paper)*

Additional Questions		
a.	Is your group part of a Multiple Employer Welfare Arrangement (MEWA)?	❍ Yes ❍ No
b.	Are you an employee leasing/professional employee organization (PEO)?	❍ Yes ❍ No
c.	Will your plan use an out-of-state trust?	❍ Yes ❍ No
d.	Does your plan provide coverage pursuant to a collective bargaining agreement? *If yes, please provide pertinent portions of the agreement on separate sheet*	❍ Yes ❍ No
e.	Is your company part of a larger company? *If so, provide details on separate sheet on controlled group status as defined under IRC Section 414.*	❍ Yes ❍ No

C HEALTH QUESTIONNAIRE (EMPLOYER COMPLETES THIS SECTION)

THE PURPOSE OF THIS QUESTIONNAIRE IS TO OBTAIN INFORMATION ON POTENTIAL CLAIMS UTILIZATION FOR RATING PURPOSES. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. (*Attach additional sheet of paper if needed.)*

1 Are you aware of anyone in your group (employees or dependents) that has been diagnosed, consulted with, or been examined or treated by any health care professional for the following conditions?

An underwriter may be phoning the contact named above for clarifications in regard to the medical information listed below.

❍ Cancer	❍ Parkinson's Disease	❍ Blood Disorder*	❍ Immune Disease
❍ Cystic Fibrosis	❍ Crohn's Disease/Ulcerative Colitis	❍ Severe Motor Vehicle Accident	❍ Premature Birth
❍ Diabetes	❍ Congenital/Birth Defects	❍ Cerebral Palsy	❍ Liver Disorder
❍ Chronic Lung Disease	❍ Transplant (Organ/Bone Marrow)	❍ Brain Injury/Paralysis	❍ Multiple Sclerosis
❍ Heart	❍ Complicated Pregnancy/ Multiples Birth	❍ Spina Bifida	❍ Kidney Disease
❍ Stroke	❍ ALS (Lou Gehrig's disease)	❍ Growth hormones	❍ Systemic Lupus

If so, please provide the following information:

Name	Date of Treatment	Type of Treatment	If Cancer, Type/Stage	Cost

2 Are you aware of any employee/dependent not actively at work due to a disability that is currently covered by your medical plan?

❍ Yes
❍ No
❍ No Info Available

If Yes, please provide the following information

Name	Date of Disability	Medical Reason for Disability

3 Has any employee/dependent incurred over $25,000 in medical expenses within the last 24 months? *(if not listed above)*

❍ Yes
❍ No
❍ No Info Available

If Yes, please provide the following information

Name	Date of Treatment	Type	Diagnosis

4	Are there any employees/dependents covered by your insurance that are currently confined to a hospital or treatment facility?					
	❍ Yes ❍ No ❍ No Info Available	*If Yes, please provide the following information*				
		Name	**Age**	**Date of Confinement**	**Diagnosis**	**Current Status or Prognosis**

5	Are you aware of any employees or their dependents who have scheduled hospitalizations or surgeries in the near future?					
	❍ Yes ❍ No ❍ No Info Available	*If Yes, please provide the following information*				
		Name	**Age**	**Date of Confinement**	**Diagnosis**	**Current Status or Prognosis**

6	Are you aware of any employees or their dependents who have been diagnosed, consulted with, or been examined or treated by any health care professional for a health condition, or experienced the worsening of an existing health condition, that would not be reflected in the claims experience provided to Medica?			
	❍ Yes ❍ No ❍ No Info Available	*If Yes, please provide the following information*		
		Name	**Age**	**Diagnosis**	**Current Status or Prognosis**

7	How many COBRA employees and/or dependents do you have? Have they been diagnosed, consulted with, or been examined or treated by any health care professional?					
	❍ Yes ❍ No # of COBRA: _____	*If Yes, please provide the following information*				
		Name	**Date COBRA Began**	**Diagnosis**	**Current Status/Prognosis**	**Type of Treatment**

8	Does your company have a non-smoking environment? ❍ Yes ❍ No

D COMMISSION INFORMATION

Contact Information

Writing Agent Name	Title	
Email	Fax	Work Phone

Address (Must be a physical address, no P.O. Boxes)

Street			
City	State	ZIP Code	County

Requested Commission	Agent Signature	Date __ __ / __ __ / __ __ __ __

E	**FINANCIAL INFORMATION** (EMPLOYER COMPLETES THIS SECTION)	
	1. In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal bankruptcy laws? (Chapter 11 or 7)	❍ Yes ❍ No
	2. In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity to be placed involuntarily into bankruptcy?	❍ Yes ❍ No

THE COMPANY acknowledges that Medica may obtain from Dun & Bradstreet a Credit Scoring Report on the Company.
THE COMPANY acknowledges that Medica is relying on the answers set forth above when extending its offer. Medica reserves the right to revise such offer in the event the information provided by Company is materially inaccurate. THE OFFICER signing below hereby represents and warrants that the answers to the above questions are true as of the date set forth below.

To the best of my knowledge and/or belief, the information provided on this application is accurate an complete. The Company understands and agrees that an act or omission that constitutes fraud or an intentional misrepresentation of material fact made by the Company on this application may invalidate any subsequent Policy or Contract.

Employer Representative Signature	Title	Date __ __ / __ __ / __ __ __ __	
Agent Name	Agent Signature	Agent #	Date _ _ / _ _ / _ _ _ _

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

You are not required to disclose the performance of or results of a test to determine the presence of the humanimmunodeficiency virus (HIV) antibody or other blood borne pathogen performed on (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency medical services personnel** at a hospital or medical care facility; or (3) emergency medical services personnel who were tested as a result of performing emergency medical services.*

***DEFINED TERMS: The term "emergency medical services personnel" includes (1) individuals employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves a s an employee or volunteer of an ambulance service as defined by state law or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual's duties; (2) an individual employed as a licensed peace officer under state law; (3) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation; (4) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a good Samaritan as described under state law; and (5) any individual who, in the process of executing a citizen's arrest as defined by state law, may have experienced a significant exposure to a source individual.*

The term "blood borne pathogen" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

The term "source individual" means an individual, living or dead, whose blood tissue or potentially infectious body fluids may be a source of blood borne pathogen exposure to an emergency medical services personnel. Examples include, but are not limited to, a victim of an accident, injury, or illness, or a deceased person.

The term "significant exposure" means contact likely to transmit a blood borne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes (1) percutaneous injury, contact of mucous membrane or non intact skin, or prolonged contact of intact skin; and (2) contact, in a manner that may transmit a blood borne pathogen, with blood, tissue, or potentially infectious body fluids.

F SUBMISSION REQUIREMENTS

Medica greatly appreciates your request for a Commercial Group Proposal. In order to provide you with an accurate, cost-competitive quote, please review the guided outline below for your submission and respond with information applicable to each of the respective areas. If information is missing from your submission this will cause delays in the process and we will check the box, highlight and return this document to you for completion. These key pieces of information will help us provide a strong proposal that aligns with your needs and without delay. We thank you for your business and support of Medica.

RFP

Provide highlights of bid including objectives, current and requested funding type, unusual group circumstances, tenure with current carrier, employer contribution, union bargained status, MEWA status, requested Medica products, broker/consultant commissions.

Completed Employer Group Application Requirements *(for Groups of less than 200 enrolled employees)*

- ❍ Company Name, City, State & Zip Code
- ❍ SIC code and nature of business
- ❍ Total # employees/eligible employees/enrolled employees
- ❍ Health Questionnaire answers for questions 2-8
- ❍ Federal Tax ID #
- ❍ Organization Type *(C-Corp, S-Corp, Non-Profit etc.)*
- ❍ If part of Multiple Employer Welfare Arrangement *(MEWA)*
- ❍ Employer and agent signature with date

Employer Information (*Groups more than 200 enrolled employees)*

Company name, city, state, and zip code, nature of business, employer contribution toward single and family coverage, number of benefit eligible and participating employees, plan eligibility requirements for active and retirees.

Census Requirements per Individual *(Excel format required)*

- ❍ Gender
- ❍ Date of Birth
- ❍ Coverage Information; plan design, coverage tier, waived, eligible retirees, dependents, spouse, child
- ❍ Zip Code (Individual zip code of residency per individual)

Claims & Enrollment Data

- ❍ 12-24 mos. of carrier source claim data *(with incurred & paid date labels)* with paid thru date within 120 days of submission
- ❍ Individual Health Applications if claims data is not available, including waived applicants
- ❍ Renewal rates per plan for the next year if available
- ❍ Current rates per plan (for self-insured groups, include administration fees, stop loss rates, stop loss contract basis, aggregate attachment factors).
- ❍ High Cost Claimant Report based on the same time period of claims data, separately for each data period if more than 12 months, paid claim amount, member status, and diagnosis for each claimant if available.
- ❍ Monthly enrollment (subscriber and member counts) matching dates in paid/incurred claim file

Benefit Plans

- ❍ Current Summary of Benefits and Coverage, including deductible and OOP accumulation period (contract or calendar). Description of prior SBCs if benefits have been modified within the claim experience period.
- ❍ Certificate of Coverage if available

Additional information may be requested in order to provide an accurate quote. Any missing information may delay your quote & cause inaccuracy in the bid. Please check with your broker for documents needed for Medical & Pharmacy Disruptions.

Medica®

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