



Maryland Health Connection for Small Business - 2022 Direct Enrollment Employer / Carrier Enrollment Application
(not an Employer Eligibility Application)

Group Number

Company Information

Legal Company Name		Doing Business As (if Applicable)	
Physical Street Address (PO Box not acceptable)		City	State ZIP
Billing Address (if different from physical)		City	State ZIP
Mailing Address (if different from physical or billing)		City	State ZIP
Phone Number		Fax Number	
Does this business have multiple locations? If so, please attach sheet with all locations with Street Address, City, State and ZIP and number of employees at each broken down by Full-time, Part-time, Retired, COBRA or State Continuees, 1099, Union, Seasonal, Other.			
Company Group Contact: Name and Title		Email	Phone Number
Billing Contact: Name and Title (if different from above)		Email	Phone Number
Enrollment Contact: Name and Title (if different from above)		Email	Phone Number
Chief Executive Officer		Organization type: (C-Corp, S-Corp, Non-Profit, Partnership, Sole Proprietor, LLC, LLP, Other):	
SIC Code	Nature of Business	Federal Tax ID	Date Established

Group Information

Is your company under 50 full-time equivalent employees (FTEs)? If so, number of FTEs?			Yes	No
Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?		Details:		
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?				
Are there any associated companies to be included with this group that are commonly owned?				
Is your company a branch of another company, or does your company have branch offices?				
Do you use the services of a payroll company? If "Yes", provide the name of the payroll company:			Payroll Company:	

Prior Insurance Information

Please list any coverage with any carrier in the past 12 months

	Name of Carrier (Corporate Name)	Policy # (if available)	Coverage Begin Date (MM/DD/YY)	Coverage End Date (MM/DD/YY) (write current, if current)
Medical Carrier				
Dental Carrier				

Does your group have Worker's Comp: If Yes, what is the Carrier Name:			Yes	No
Are all employees covered by Worker's Compensation? If No, explain below:				
Is Health Plan Primary and Medicare Secondary? If your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, then your health plan is primary and Medicare is Secondary. Otherwise, Medicare is primary.				

Medical Loss Ratio (MLR) Classification

Subject to ERISA?	(if no, please indicate why):	Yes	No
Non-Federal Government Group?			
For Non-ERISA and non-government groups, you may be subject to additional addendums dependent on carriers which would be provided to you.			

Plan Selection

For Employer Choice: Please select one participating insurance carrier for your company. All metal levels will be available for the chosen carrier.

For Employee Choice: Please select plans across participating insurance carriers for your company. No more than two consecutive metal levels are allowed.

Requested Effective Date: _____

Please select the desired method of Plan selection

Employee Choice		Employer Choice	
Bronze	Silver	Gold	Platinum

MEDICAL PLAN CHOICES



Aetna Health, Inc.	Aetna Bronze HNOption 8000 70/50 INT	Aetna Silver HMO 3500 100% HSA T	Aetna Gold HMO 1000 100% E Value	Aetna Life Insurance Company	Aetna Bronze PPO 7500 70/50 INT Value	Aetna Gold OAEPO 1500 80%	Aetna Silver OAEPO 2500 100% Value	
CareFirst BlueChoice, Inc.	BlueChoice HMO 1000 (Gold)	BlueChoice HMO HSA/HRA 2400 (Silver)	BlueChoice HMO Gold 1500	BlueChoice HMO Referral HSA/HRA 6200 (Bronze)	BlueChoice HMO HSA/HRA Silver 1500	BlueChoice HMO HSA/HRA Silver 3000	BlueChoice HMO Silver 5000	BlueChoice HMO Value Bronze 6000
	BlueChoice HMO Referral Bronze 8250	BlueChoice Advantage Gold 1000	BlueChoice Advantage HSA/HRA Bronze 6100	BlueChoice Advantage HSA/HRA Silver 3000	BlueChoice Advantage HSA/HRA Gold 1500	BlueChoice Advantage Silver 5000	BlueChoice HMO HSA/HRA Bronze 6100	
Group Hospitalization and Medical Services, Inc.	BluePreferred PPO 1000 90%/70% (Gold)	BluePreferred PPO HSA/HRA 6200 (Bronze)	BluePreferred PPO HSA/HRA 2400 80%/60% (Silver)	CareFirst of Maryland, Inc.	BluePreferred PPO HSA/HRA 6200 (Bronze)	BluePreferred PPO 1000 90%/70% (Gold)	BluePreferred PPO HSA/HRA 2400 80%/60% (Silver)	
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	KP MD Platinum 0/10/Vision	KP MD Platinum 500/20/Vision	KP MD Gold 0/20/Vision	KP MD Gold 1000/20/Vision	KP MD Gold Virtual Forward 2000	KP MD Gold 1400/0%/HSA/Vision	KP MD Bronze 6850/0%/HSA/Vision	
	KP MD Silver 1850/40/Vision	KP MD Silver 2500/40/Vision	KP MD Silver Virtual Forward 3000	KP MD Silver 2000/30/HSA/Vision	KP MD Bronze 6150/30/HSA/Vision	KP MD Bronze 6500/50/Vision		
UnitedHealthcare of the Mid Atlantic, Inc.	UHC Core Essential HSA Bronze 7000-2	UHC Core Essential HSA Gold 2250-2	UHC Navigate HSA Bronze 7000-2	UHC Navigate HSA Gold 1600-2	UHC Core Essential HSA Silver 2500-2	UHC Navigate HSA Silver 2500-2	UHC Core Essential Gold 750-2	
	UHC Core Essential Silver 3500-2	UHC Navigate Gold 750-2	UHC Navigate Silver 3500-2					
UnitedHealthcare Insurance Company	UHC Choice Plus HSA Bronze 7000-2	UHC Choice Plus HSA Gold 1600-6	UHC Choice Plus HSA Silver 2500-2	UHC Choice Plus Gold 750-2	UHC Choice Plus Gold 1500-4	UHC Choice Plus Silver 5000-3	UHC Choice Plus Silver 3500-2	
	UHC Choice Plus Platinum 0-4							
Optimum Choice, Inc.	UHC OCI HSA Bronze 7000-2	UHC OCI HSA Gold 2250-2	UHC OCI HSA Silver 2500-2	UHC OCI Gold 3500-2	UHC OCI Gold 750-2	UHC OCI Gold 1500-3	UHC OCI Silver 5000-3	
	UHC OCI Silver 2000-2	UHC OCI Platinum 0-2	UHC OCI Platinum 0-4					
MAMSI Life and Health Company	UHC Choice HSA Bronze 7000-2	UHC Choice HSA Gold 1600-2	UHC Choice HSA Gold 2250-2	UHC Choice HSA Silver 2500-2	UHC Choice Gold 1500-2	UHC Choice Platinum 0-2	UHC Choice Platinum 0-4	
	UHC Choice Gold 1500-4	UHC Choice Silver 5000-4	UHC Choice Silver 3500-2	UHC Choice Plus Platinum 0-2				
Employer Contribution								
Employer Contribution	Medical (Percentage Contribution)	Medical (Fixed Dollar Contribution)		Dental (Percentage Contribution)	Dental (Fixed Dollar Contribution)			
For Employee		% \$			% \$			
For Dependents		% \$			% \$			
Employer POS Option								
Employer wants medical POS Option offered to its employees						Yes	No	
Employer wants dental POS Option offered to its employees								
Employee Eligibility								



Eligibility date for enrollment will be the first day of the policy month following the waiting period, unless date of hire or 90 days following date of hire option. Policy month refers to the contract effective date of the 1st of the month. Date of Hire or 90 days following date of hire option would result in an effective date on the date of hire or exactly 90 days from the employee's date of

		Yes	No
Waive the waiting period for present employees enrolling with the group? (YES/NO)			
Waiting Period for future Employees: (Please pick one)	First day of policy Month following:	0 Days	
		30 Days	
		60 Days	
or immediately after 90 Days			
Waive waiting period for rehires? (YES/NO)			

Employer Eligibility

Full-Time Equivalent Employees

The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H(2) must be utilized to determine group size for health coverage.

- A. FTEs from full-time employees. Number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a year (even if they are not eligible or enrolling for health coverage).
- B. FTEs from part-time employees (excluding seasonal workers). Number of part-time employees who worked on average less than 30 hours a week. (Add up the total number of hours worked in a week by part-time employees and divide by 30. Example, 10 employees working 20 hours a week: $10 \times 20 = 200 / 30 = 6.66 = 6$ (rounding down to the nearest whole number).
- C. Total number of FTEs = A + B

Participation Determination

Total number of eligible employees based on state law must work a minimum of 30 hours a week. Note: An employer may not set eligibility rules that would require an employee to work more than 30 hours a week to obtain small group coverage. As long as the employee meets the 30 hour a week standard, they are considered full time for purposes of coverage.

Number of employees eligible for coverage (employees working 30 hours per week)		
Number of employees enrolling		Number of employees waiving coverage
Number of full-time employees excluding union employees		Number of employees working outside Maryland List all states:
Number of part-time employees		Number of employees not actively at work
Number of 1099 employees		Number of COBRA continuees
Number of union employees		Number of employees in waiting period and not eligible

General Information		Yes	No
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Cover Part-time (Part-time is defined as more than 17.5 hours and less than 30 hours) Employees?			
Cover Domestic Partners of Employees?			
Cover Employees with Other Coverage?			
Is your employer group required to comply with ERISA? (Most private sector plans are ERISA plans) If no, please indicate appropriate category:	Church	Federal Government	Indian Tribe - Commercial Business
		State, Local or Tribal Gov	Foreign Government / Foreign Embassy
			Non-ERISA Other
Is your employer group required to comply with COBRA regulation or State Continuation? (YES/NO)			
Do you have any present or former employees/dependents on COBRA or State Continuation? (YES/NO)			

If yes, please attach list of people with name, qualifying information, date of eligibility and date of coverage termination

Special Provisions Related to Medical Eligibility
 If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status. (2) No longer than 6 consecutive months if the employee is totally disabled.
 If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision described in the Certificate of Coverage for the carrier(s).

Medicare primary versus secondary

How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year?
 Include: Full-time, part-time, seasonal, temporary, union, owners, partners, officers. Exclude: Self-employed persons, independent contractors 1099), directors. If you employed fewer than 20 employees for 20 weeks in the current or prior year, your group has Medicare as primary.
 If you employed 20 or more employees for 20 weeks in the current or prior year, your group insurance is primary.



FRAUD STATEMENT

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CARRIER STATEMENT

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

PARTICIPATING CARRIER CORPORATE NAMES AND ADDRESSES

Aetna Health, Inc. 1425 Union Meeting Road Blue Bell, PA 19422	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 (844) 241-0209	CareFirst BlueChoice, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	Group Hospitalization and Medical Services, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	CareFirst of Maryland, Inc. dba CareFirst BlueCross BlueShield 1501 S. Clinton Street, 10th Floor Baltimore, MD 21224
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 East Jefferson Street Rockville, MD 20852 (800) 777-7904	Optimum Choice, Inc. MAMSI Life and Health Insurance Company 4 Taft Court Rockville, MD 20850 (301)294-1578	UnitedHealthcare Insurance Company UnitedHealthcare of the Mid-Atlantic, Inc. 4 TAFT COURT ROCKVILLE, MD 20850 (952)992-5878		

EMPLOYER ATTESTATION AND SIGNATURE

Name of Group		Officer Title	
Officer Signature		Date	
Officer Printed Name		Officer Phone Number	
Officer Email		Broker ID	
Broker Name		Date	
Broker Signature		Broker Phone Number	
Broker Email		Carrier ID	
Carrier Name		Date	
Carrier Representative Signature		Carrier Phone Number	
Carrier Email			