

Product Application

Vermont Small Groups



Complete all pages of this application. Some sections may not apply to your specific group.
Please print, and include the Group/Business Name and Tax ID No. on all pages.

Section 1: Group Information

(*Required Information)

Group/Business Name (or DBA Name, if applicable)	Legal Entity Name (if different than Group Name)	SIC Code*
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Nature of Business or Organization	Tax ID No.*	Effective Date of Coverage
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Business Physical Street Address	City	State	Zip Code
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County	Phone No. ()	Fax No. ()
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Company Headquarters Street Address <input type="checkbox"/> Same as above	City	State	Zip Code
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County	Phone No. ()	Fax No. ()
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Group Health Benefits Administrator (HBA) Name	Group HBA Title
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Group HBA Street Address <input type="checkbox"/> Same as above	City	State	Zip Code
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Group HBA Email	Group HBA Phone No. ()
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Who sponsors the group health coverage? Employer Union Association Other: _____

Organization Type <input type="checkbox"/> C Corp <input type="checkbox"/> S Corp <input type="checkbox"/> Partnership <input type="checkbox"/> Nonprofit <input type="checkbox"/> Local Government <input type="checkbox"/> State Government <input type="checkbox"/> Church Group <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____	List Owner(s)/Partner(s) of this Organization
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Are the owners and their spouses the only policy holders on the group sponsored coverage? Yes No

How is the company organized?
 Stand Alone Parent Subsidiary Local Plant/Office/Division Other: _____

Do you, as an employer, offer a group medical plan in addition to the products offered through MVP Health Care?
 Yes, the plan carrier is: _____ No

Company Name	Tax ID No.
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Section 2: Billing Information

Premium invoices should be sent to the Group Contact at the Address provided in Section 1 (Proceed to Section3)

Billing Contact Name		Title		
Billing Contact Street Address	City	State	Zip Code	County
Billing Contact Email	Billing Contact Phone No. ()		Billing Contact Fax No. ()	

Section 3: Regulatory Employer Information

Do you employ at least one employee who lives, works, or resides in the MVP service area? Yes No

Do all employees who are offered coverage work at least 17.5 hours per week? Yes No

Is there at least one common law employee enrolled as a contract holder? Yes No

If owners are enrolling in MVP coverage, do they all work at least 20 hours per week? Yes No

Are more than 50% of your enrolled employees within the MVP service area? Yes No

If you are unsure which states and counties are covered within the MVP regional service area, contact your broker or HBA Account Representative.

Section 4: Group Administration

Solely for purposes of determining whether an employer is a large or small employer, the employer is required to calculate the number of Full-Time Equivalents (FTE) it employed **during the most recent rolling 12 months**, and count each such FTE as one full-time employee. Refer to the employee definitions below.

Common Law Employees are eligible for health Insurance coverage. Common law employees are defined as anyone who performs services for an employer as long as the employer has financial and/or behavioral control for these employees. Leased employees, 1099 employees, and union employees are considered employees under this definition and should be included in the group size count.

Part-Time Employees are those who work less than 30 hours per week and are counted using the FTE counting method. To convert the number of part-time employees to an FTE number, the average monthly aggregate number of hours worked for part-time employees is divided by 120. Part-time hours are capped at 120 hours per employee, per month.

Retirees are not “employees” and are not counted in group size.

COBRA participants are not included in the FTE calculation for determining group size.

To assist you in calculating your group’s part-time FTEs, visit irs.gov/affordable-care-act and select *Employers*, then *Determining if an Employer is an Applicable Large Employer*.

Total Number of Full-Time Employees	+	Total Number of Part-Time FTE* Employees	=	Total Number FTE Employees
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*The full-time equivalent employee counting method in 26 U.S. Code § 4980H(c)(2) must be utilized to determine group size. This method is the same calculation used to determine employer liability under the Shared Responsibility for Employers provisions of the Affordable Care Act (ACA) and Internal Revenue Code.

<p>New Hire Eligibility Policy</p> <p><input type="checkbox"/> Date of hire <input type="checkbox"/> First of the month following date of hire</p> <p><input type="checkbox"/> First of the month following _____ day(s) of employment (not to exceed 90 days)</p>	<p>Contribution to Premium (Dollar Amount or Percentage)</p>
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Company Name	Tax ID No.
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Section 5: Product Selection

Health Plans

Standard Non-Standard

Plan Name (e.g., Gold 4 HDHP) _____

Vision Plans

MVP Vision 1 MVP Vision 2 MVP Vision 3

Section 6: Information About Individuals Not Listed on the Vermont Employers Quarterly Wage & Contribution Report

List below the individuals eligible for coverage who are not listed on the Vermont Employers Quarterly Wage & Contribution Report (C-101). Eligible individuals include partners or owners of the business if actively engaged in the business, new employees, retirees, and spouses of retirees when it is the consistent policy of the business owner to cover retirees and spouses of retirees.

The group attests that the individual(s) listed below work at least 17.5 hours per week at the employer named on page 1 or are otherwise eligible for coverage under a group health insurance plan to be issued by MVP. For each employee listed below, indicate their employment status.

Name _____

New Employee (Date of hire: _____)

Partner Business Partner Retiree

Other (explain): _____

Name _____

New Employee (Date of hire: _____)

Partner Business Partner Retiree

Other (explain): _____

Name _____

New Employee (Date of hire: _____)

Partner Business Partner Retiree

Other (explain): _____

Name _____

New Employee (Date of hire: _____)

Partner Business Partner Retiree

Other (explain): _____

Name _____

New Employee (Date of hire: _____)

Partner Business Partner Retiree

Other (explain): _____

Name _____

New Employee (Date of hire: _____)

Partner Business Partner Retiree

Other (explain): _____

Class Description
(Example, All employees working more than 17.5 hours per week)

Separate Class/Subgroup (If Group requires one)

Medicare Salary COBRA Union

Hourly Other: _____

Section 7: Broker Information

Broker Name _____

Street Address _____

Billing Contact Email _____

Agency Name _____

City _____	State _____	Zip Code _____
Billing Contact Phone No. () _____	Billing Contact Fax No. () _____	

<i>Company Name</i>	<i>Tax ID No.</i>
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Section 8: MVP Representative Attestation

The information provided in this application is true to the best of my knowledge.

MVP Representative Signature

MVP Representative Name (print)

Date

Section 9: Authorization

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I have read and agree to the details outlined in the MVP Electronic Disclosure, which is available at mvphealthcare.com/privacy-notices or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

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, and shall also be subject to a civil penalty.

I have read and agree to this authorization.

Signature

Date

Name (print)

Title
