Health Plan Application
for Vermont Small Group Plans

Please complete both sides of this form.

Section 1: Group Information *(please print, and include Company Name and Tax ID No. on page 2)*

Company Name

Street Address	City	State	Zip Code	County

Tax ID No. *(required)*	SIC Code	Phone ( )	Fax ( )

Additional Office Locations

Group Type ☐ Employer Group or Employer Trust ☐ Association or Chamber ☐ Multiple Employer Trust _____
☐ Taft Harley Trust ☐ Labor Union ☐ Member of Controlled Group or Corporation

Group Contact Name	Group Contact Title

Group Contact Email *(this individual will receive an MVP online account login)*	Phone ( )	Fax ( )

Section 2: Billing Information

☐ Same as Group Contact listed above.

Billing Contact Name	Billing Contact Title

Billing Contact Email	Phone ( )	Fax ( )

Street Address	City	State

Section 3: Other Group Contact Information *(if applicable)*

Name	Title

Email	Phone ( )

Name	Title

Email	Phone ( )

Section 4: Product Selection

☐ Standard ☐ Non-Standard ☐ Plan Name *(e.g. Gold 4 HDHP)* _____

Continued on page 2

Company Name | *Tax ID No.*

Section 5: Group Administration

Total Number of Part-Time and Full-Time Employees
(to determine Certification of Benefits for members 66 and older)

Total Number of Full-Time Equivalent Employees[1]
(to determine if Small or Large Group)

Note: Retirees[2] and COBRA participants are not considered *employees* and should not be counted to determine group size.

[1] The *full-time equivalent* (FTE) employee counting method in 26 U.S.C. 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.

To convert the number of part-time employees to a full-time equivalent, the 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.

[2] Exceptions will be made if the retiree population is more than 25 percent of the group. If the retiree population makes up more than 25 percent of the group, then the retirees will be included in the group size count.

New Hire Eligibility Policy

☐ Date of hire ☐ First of the month following date of hire

☐ First of the month following _____ days of employment (may not exceed 90 days)

Contribution to Premium

$

Section 6: Other Group Coverage in Addition to MVP

1 Name of Other Insurer | Type of Coverage and Plan Design *(metal level)* | Effective Date of Policy

2 Name of Other Insurer | Type of Coverage and Plan Design *(metal level)* | Effective Date of Policy

Section 7: Enrollment Class/Subgroup Assignment

Class Description *(example: All employees working more than 20 hours per week)*

Billing Contact Title

Select a separate Class/Subgroup, if your Group requires one

☐ Medicare Gold ☐ Salary ☐ COBRA ☐ Union ☐ Hourly ☐ Other _____

Section 8: Authorization *(Your Signature is Required for Enrollments)*

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

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 may also be subject to a civil penalty.

By including an email address on this Enrollment/Change form, I agree to accept electronic communication unless otherwise required by law.

I have read and agree to this authorization.

Name *(print)* Signature

Title Date

Section 9: MVP Representative Administration

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

Name *(print)* Signature Date

Was a Broker involved in this sale? ☐ Yes MVP Broker No. _____ ☐ No

Questions? We're here to help. Call **1-844-865-0250** Or visit **mvphealthcare.com**