

IMPORTANT: Directions

1. In order to ensure that your group receives its ID cards/member materials for the requested effective date, we require a 15th of the month submission date. If a case submission is not complete and received in a timely manner, we will require the completion of a Late Submission Form. Groups submitted after the 15th of the month are not guaranteed approval for the requested effective date.
2. Participation:
 - Groups of 2-9, 75% minimum participation is required of all eligible employees.
 - Groups of 10-50, 65% minimum participation is required of all eligible employees.
 - POS plans require 70% of eligible enrollees to live in the ConnectiCare service area.
 - Eligible employees must work a minimum of 35 hours per week.
 - Waiver Forms are used in conjunction with Enrollment Forms to calculate participation.
3. Small Group Application:
 - Employer is required to read, complete, date, and sign the Application indicating Medical Plan Option and Pharmacy Option choices. Subsequent plan changes are available only on group renewal date.
 - Please select a new hire waiting period (can select zero.)
 - Agent Information must be completely filled out, including the tax ID #'s. Agents must be licensed and appointed with ConnectiCare.
4. Each enrolling employee must fully complete, date, and sign all sections of the ConnectiCare Enrollment/Change Form. Please indicate a PCP; please remember to complete the date of birth.
5. Tax documents: Please submit the most recent tax information described below. NOTE: Payroll journals are not acceptable. Please indicate employees' status (full-time, part-time, waiving, etc.) on this form. Everyone on tax documentation must be accounted for: # of waivers + # of enrollment forms = total eligibles.
 - A. Sole proprietor and single owner LLC: Schedule C. If employees; most recent state quarterly earnings report (WR-1.)
 - B. Multiple owners/Partnership(s): 1065 with K-1's for all partners totaling 100% ownership. If employees; most recent state quarterly earnings report (WR-1.)
 - C. Corporation: Form 1120C or 1120S. If employees; most recent state quarterly earnings report (WR-1.)
 - D. Non-Profit with employees: most recent state quarterly earnings report (WR-1.)
 - E. New Business: New Business Certification Statement with a copy of federal EIN notification letter or Sales & Use Tax Permit (if applicable).
6. Please submit first month's premium, payable via business check, to ConnectiCare.

Small-Group Case Submission Checklist (1-50 lives)

- Small-Group Employer Application **dated and signed** with
 - Medical Plan Option
 - Pharmacy Option
 - New Hire Waiting Period Option
- Waiver form: Waivers must indicate number of hours worked and date of hire. (Please submit on ConnectiCare's Waiver Form.)
- ConnectiCare Enrollment/Change Forms **dated and signed**
- Copy of **most recent Tax Filing State Quarterly Wage & Tax Form.**
Please indicate employee's status (full-time, part-time, waiving, etc.) on this form.
- Copy of the current carrier bill
- Copy of completed and signed Massachusetts Non-Discrimination Certification Form
- Copy of complete quote with employee census
- First Month's Premium — **Please make business check payable to ConnectiCare.**

**Submit all paperwork to: ConnectiCare Small-Group Sales, P.O. Box 4050, 175 Scott Swamp Road, Farmington, CT 06034-4050.
 Please do not mail your application directly to your Sales Representative's attention; doing so will delay your application.**



Company Information

1. Desired Effective Date _____ Small Group # _____
ConnectiCare use only
2. Legal Business Name _____
3. DBA/Doing Business As (if applicable) _____
4. Physical Address _____ P.O. Box _____
City _____ State _____ ZIP _____ Phone () _____ Fax () _____
5. Nature of Business _____ Billing/Contact Person _____
6. Organization Type Corporation Partnership Sole Proprietorship Other _____
7. Federal Tax Identification Number _____ Business Effective Date _____ Current Ownership Date _____
8. Are you affiliated with any other company? Yes No If yes, relationship type _____
Name of affiliated company _____ Relationship effective date _____ Total number of employees _____
9. Total number of employees (including part-time and seasonal) _____
Number of full-time eligible employees working 35 hours or more per week _____ Number of enrolling employees _____
Number of spousal/applicable waivers _____ Number of "other" waivers _____
10. New Hire Waiting Period 0 30 60 90 180 Days First of month following new hire waiting period selected
11. Will coverage be transferring from another carrier? Yes No
If yes, prior carrier name _____ Proposed termination date _____
(Please include a copy of the current premium bill with this carrier.)
If prior carrier is ConnectiCare, provide group #: _____ Total replacement? Yes No
Has the group been uninsured for three or more months prior to the requested effective date? Yes No
12. Small Employer Certification: *Pursuant to state law, carriers need information from an employer to determine if the employer qualifies as a small employer under the law. Guaranteed issue and renewability and ConnectiCare's underwriting guidelines are contingent upon this criteria 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 state law. 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. 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 in order to verify eligibility.

Employer Signature _____ Title _____ Date _____
E-mail Address _____

Agent Information

13. Agency Name _____ Agent Name _____
14. Address _____ City _____ State _____ ZIP _____
Phone () _____ Fax () _____ Commission Paid to: Agency Agent
Social Security # or Tax ID # _____ Must be completed to ensure proper commission payment. ConnectiCare Appointment Yes No
Contact Person: _____ Agent E-mail Address _____
15. I have reviewed the answers on all applications and forms and I am not aware of any additional information that would affect the underwriting of this case. I agree to immediately notify ConnectiCare of any changes to the information provided herein or if I become aware of any information that could affect the underwriting of this case. I certify that each employee has completed and signed all forms, and selected a PCP.

Agent Signature _____ Date _____

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Connecticare of Massachusetts, Inc. (CMI): MA Domiciled Only

Hospital Copayment Plans (Calendar Year Plans)

- | HMO | POS |
|---|--|
| 1. <input type="checkbox"/> MAH-OA-15/25-100D-CAL | 6. <input type="checkbox"/> MAP-OA-15/25-100D-CAL |
| 2. <input type="checkbox"/> MAH-OA-20/30-100D-CAL | 7. <input type="checkbox"/> MAP-OA-20/30-100D-CAL |
| 3. <input type="checkbox"/> MAH-OA-20/30-500D-CAL | 8. <input type="checkbox"/> MAP-OA-20/30-500D-CAL |
| 4. <input type="checkbox"/> MAH-OA-30/40-250D-CAL | 9. <input type="checkbox"/> MAP-OA-30/40-250D-CAL |
| 5. <input type="checkbox"/> MAH-OA-30/40-500D-CAL | 10. <input type="checkbox"/> MAP-OA-30/40-500D-CAL |

Hospital Deductible Plans (Calendar and Contract Year Plans)

- | | |
|---|---|
| 11. <input type="checkbox"/> MAH-OA-20/30-1000HospDed-CAL | 17. <input type="checkbox"/> MAH-OA-30/40-3000HospDed-CNT |
| 12. <input type="checkbox"/> MAH-OA-25/35-1500HospDed-CAL | 18. <input type="checkbox"/> MAP-OA-25/35-1500HospDed-CAL |
| 13. <input type="checkbox"/> MAH-OA-30/40-2000HospDed-CAL | 19. <input type="checkbox"/> MAP-OA-30/40-2000HospDed-CAL |
| 14. <input type="checkbox"/> MAH-OA-20/30-1000HospDed-CNT | 20. <input type="checkbox"/> MAP-OA-25/35-1500HospDed-CNT |
| 15. <input type="checkbox"/> MAH-OA-25/35-1500HospDed-CNT | 21. <input type="checkbox"/> MAP-OA-30/40-2000HospDed-CNT |
| 16. <input type="checkbox"/> MAH-OA-30/40-2000HospDed-CNT | |

Upfront Deductible Plans

- | Calendar Year Plans | Contract Year Plans |
|---|---|
| 22. <input type="checkbox"/> MAH-OA-1000Upfront-20/30-CAL | 25. <input type="checkbox"/> MAH-OA-500Upfront-20/30-CNT |
| 23. <input type="checkbox"/> MAH-OA-1500Upfront-25/35-CAL | 26. <input type="checkbox"/> MAH-OA-1000Upfront-20/30-CNT |
| 24. <input type="checkbox"/> MAH-OA-2000Upfront-30/40-CAL | 27. <input type="checkbox"/> MAH-OA-1500Upfront-25/35-CNT |
| | 28. <input type="checkbox"/> MAH-OA-2000Upfront-30/40-CNT |

Pharmacy Options

- A. \$10/\$20/\$35
 B. \$15/\$30/\$40
 C. \$15/\$30/\$40 with a \$200 Deductible
 D. \$15/50%/50% \$200 Deductible T2/T3 \$100 per script max

DOMESTIC PARTNER RIDER

Yes No

Note: Affidavit must be received with paperwork.

DUAL OR TRIPLE OPTION Offering Calendar Year and Contract Year plans side by side is not recommended.

Plan # _____ Rx _____

Plan # _____ Rx _____

Plan # _____ Rx _____

Indicate sold plan number and Rx letter for all MA domiciled plans.

Premium \$ _____ Check # _____

Other plan: _____

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