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*

Nature of Business or Organization

Tax ID No.*

Effective Date of Coverage

Business Physical Street Address

City

State

Zip Code

County

Phone No. ( )

Fax No. ( )

Company Headquarters Street Address ☐ *Same as above*

City

State

Zip Code

County

Phone No. ( )

Fax No. ( )

Group Health Benefits Administrator (HBA) Name

Group HBA Title

Group HBA Street Address ☐ *Same as above*

City

State

Zip Code

Group HBA Email

Group HBA Phone No. ( )

Who sponsors the group health coverage? ☐ **Employer** ☐ **Union** ☐ **Association** ☐ **Other:**

Organization Type

☐ **C Corp** ☐ **S Corp** ☐ **Partnership**
☐ **Nonprofit** ☐ **Local Government** ☐ **State Government**
☐ **Church Group** ☐ **Trust** ☐ **Other:**

List Owner(s)/Partner(s) of this Organization

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.*

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.

Retirees are not "employees" and are not counted in group size.

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.

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**

*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.

New Hire Eligibility Policy

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

☐ **First of the month following** _____ **day(s) of employment** (not to exceed 90 days)

Contribution to Premium
(Dollar Amount or Percentage)

Company Name *Tax ID No.*

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

Agency Name

Street Address

City

State

Zip Code

Billing Contact Email

Billing Contact Phone No.
( )

Billing Contact Fax No.
( )

Company Name *Tax ID No.*

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*