# New Group Checklist

## 30 days prior to the effective date, the following Group information is required:

- ❖ Group Policy Application completed and signed.
- ❖ Enrollment forms; be sure to complete any applicable COB information.
  - Include waivers for all eligible employees
- ❖ MESC/Quarterly Wage Detail Report (most current) – if enrollee is **NOT** on wage detail – please provide *proper tax returns* **&/or** copy of W4 and most recent pay stub.
  - **S Corporation –**
    - ✓ IRS Form 1120S (U.S. Income Tax Return for an "S" Corporation) and Schedule K-1 (Shareholders Share of Income, Credits, Deductions, etc.)
  - **Partnership/LLC –**
    - ✓ IRS Form 1065 (U.S. Partnership Return of Income) and Schedule K-1 (Shareholders Share of Income, Credits, Deductions, etc.). A Partnership Agreement is also acceptable with all partners names listed.
  - **Sole Proprietorship** –
    - ✓ Schedule C from proprietor's IRS form 1040
- ❖ Previous detailed carrier bill. *(if not applicable – will NEED tax returns)*
- ❖ HRA/HSA/FSA Attestation
- ❖ New Business Group Size Determination Form
- ❖ Group Pediatric Dental Attestation form – *small group only*

When completing forms:

- ❖ Each Enrollment Form requires both employee and group contact signatures.
- ❖ Social Security numbers are required for all.
- ❖ Street address is required if employee uses a POB for mailing address.
- ❖ Please write legibly.

## After PHP receives the initial materials above:

- ❖ The Final Rates page will be developed using the census information gathered from the member enrollment forms.
  - Once generated, PHP will send the Final Rates page back to the group contact/agent.
  - When signed by the agent or group contact it is to be sent back to PHP.
  - After the final rates are signed, the group will send a binder check to PHP for the first month of premium.
- ❖ Verify if employee packets or open enrollment meetings are required.
- ❖ Member ID cards.
  - It takes approximately three days for members to be enrolled in PHP's system.
  - Cards will be sent to the member's homes approximately 10 days after being entered into the system.

Physicians Health Plan

PHP Insurance Company

# SMALL GROUP POLICY APPLICATION

**HMO EXC** ____ **POS** ____ **PPO** ____

*( initital please )*

Company name to be listed on Policy

Effective Date of Coverage

Contact Person

Employer Taxpayer ID # _____

SIC Code _____

Street Address

City State Zip

**County:**

Phone Fax

( ) ( )

Mailing Addess (if different from Street Address)

City State Zip

**MANDATORY**

**Email address:** _____

Billing Contact Person (if different from above)

Street Address

City State Zip

Phone Fax

( ) ( )

## Eligibility/Participation

How many total employees do you have_____
(including those who may not be eligible for coverage)

Total number of enrollees _____

Total number of waivers + _____

Total number of eligible employees = _____

## Company Legal Status; *(i.e. S Corp, LLC, Partnership, etc)*

## Premium Contribution

Indicate the % of premium, or the dollar amount, the employer contributes toward employee premium:

_____ **%**

## Union Contract

Are any employees covered by a union contract? _____

Local # _____ Contract Exp. Date _____

Is the group currently a member of a sponsored association or chamber? _____

If yes, please indicate name of association or chamber: _____

## Previous insurance coverage

Did your company have previous health insurance coverage? Yes _____ No _____

If yes, please indicate the name of the previous carrier _____

Is your current plan grandfathered under Health Care Reform? Yes _____ No _____

## Dependent Age 26 Coverage Termination

End of Calendar Month: _____

End of Calendar Year: _____

## DEDUCTIBLE ROLLOVER from PRIOR CARRIER

**YES** _____ **NO** _____

***Must have information 21 days after effective date***

## Benefit Selection

| **Medical Benefit:** | **Rx Benefit:** | **Delta Dental:** Yes No |
|---|---|---|
| | | |

Physicians Health Plan

PHP Insurance Company

## Enrollment/Eligibility Criteria

**Eligible for coverage:**

**ACTIVE:** _____ Employee working a minimum of _____ hours per week.

_____ Other: _____

**RETIREES:** _____ *(not to exceed 10% of the active enrolled population)*

**Excluded:**

_____ Part time
_____ Temporary
_____ Seasonal
_____ Other _____

**Effective Date for New Hires:**

*(NOT to exceed 90 days from date of hire)*

____ Date of Hire

____ First of the month following _____ day waiting period

____ Date of completion of _____ day waiting period.

**Effective Date for Return to Employment:**

*(NOT to exceed 90 days from date of return)*

____ Date of Return

____ First of the month following _____ day waiting period

____ Date of completion of _____ day waiting period.

**Effective Date for Status Change:**

*(NOT to exceed 90 days from date of change)*

____ Date of Change

____ First of the month following _____ day waiting period

____ Date of completion of _____ day waiting period.

**Effective Date for Termination of employment:**

_____ Date of termination of employment

_____ Last day of the month in which termination occurs

The enrolling Group understands and agrees that if it signs this application and this application is accepted in writing by PHP, the Enrolling Group will be considered a Policyholder, and will be bound by the terms of such agreement, the provisions of PHP and the provisions of this application. The Enrolling Group acknowledges that these documents constitute the entire agreement between PHP, and the Enrolling Group, and supersede all prior or contemporaneous negotiations, representations, or agreements (whether written or oral) between the parties. PHP may, at its discretion, request supplemental information from any individual or company, including but not limited to information service agencies, medical or credit information bureaus.

The Enrolling Group certifies that the information contained in this application is accurate and agrees that issuance of coverage is based on this application, which shall become a part of the Policy. Any material omissions, misrepresentations or misstatements in the information requested on this form can result in voiding or reformation of insurance. By applying, the Enrolling Group agrees to all of the terms and conditions of this application, and all of the terms and provisions of the group insurance policy, as amended from time-to-time. Coverage will not become effective unless this application is accepted in writing by PHP.

Name of Producer _____ Agency _____

Printed Applicant Name _____ Applicant Signature _____

Applicant Title _____ Date _____

## For Physicians Health Plan Use Only

Group Number _____ Sub Grp Number _____ Policy Effective Date _____ Sales Executive _____

Class _____ Description _____ Class _____ Description _____

Class _____ Description _____ Class _____ Description _____

Binder Check _____ Check Amount _____ Received _____

Send completed form to:
PHP
PO Box 853936
Richardson, TX 75805-3936
Or Fax to: 517.364.8416
ATTN: Enrollment Dept.

# ENROLLMENT FORM

Physicians Health Plan

PLEASE PRINT LEGIBLY

| **Application for**: ☐ Medical ☐ Dental | Waiver of Coverage: I decline coverage for: ☐ Employee & all dependents ☐ Spouse Only ☐ Dependents Only Reason: ☐ Covered under another health plan Other (specify): |
|---|---|

## A. EMPLOYEE & FAMILY INFORMATION

| Employee's Last Name | First Name | Middle Initial | Social Security Number | |
|---|---|---|---|---|
| Street Address | City | | State | Zip |
| Phone | Work Phone | Email | Language | |
| Date of Birth | Gender | Ethnicity | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | |
| Independent Contractor? ☐Yes ☐No | Primary Care Physician Last Name First Initial City Phone | | | Current Patient? ☐Yes ☐No |

**Please list family members to be covered under this policy. Please attach additional forms if needed. Write name as it should appear on ID Card. Dependent may not be eligible if other medical coverage is available to them through their employer.**

| | First Name M. I. Last Name | Social Security Number | Relationship | Gender | Date of Birth | Medical Ins. available from employer? | Primary Care Physician | Current Patient? |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | ☐Yes ☐No | | ☐ Yes |
| 2 | | | | | | ☐Yes ☐No | | ☐ Yes |
| 3 | | | | | | ☐Yes ☐No | | ☐ Yes |
| 4 | | | | | | ☐Yes ☐No | | ☐ Yes |
| 5 | | | | | | ☐Yes ☐No | | ☐ Yes |

## B. COORDINATION OF BENEFITS – Failure to complete this section may result in delays in enrollment or claim payments

On the day your coverage begins, will any family members above be covered by other medical, dental or Medicare insurance? ☐Yes ☐No **If yes, please complete this section and attach a copy of the card.** Please use extra paper if more than one additional policy will be in force.

| Coverage type (please attach copy of other medical insurance care): ☐Medical ☐Dental ☐Prescription Drug ☐Medicare A/B ☐Medicare D | Name of Policy Holder | Policy Holder Date of Birth |
|---|---|---|
| Insurance Company Name & Phone Number | Policy Number and Eff. Date | Policy Holder's Employer |

| Medicare Policy Number | Medicare Part A Eff. date | Medicare Part B Eff. date | Medicare Part D Eff. date | Medicare Part C Eff. date |
|---|---|---|---|---|

| Reason for Medicare: ☐End Stage Renal Disease ☐Disability ☐Over age 65 ☐Over age 65 and working | List everyone covered by other insurance: | Coverage Dates |
|---|---|---|

## C. EMPLOYEE SIGNATURE – this form must be signed by the employee even if waiving coverage

ACCURACY OF INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and or my dependents' coverage. NOTICE OF ENROLLMENT RIGHTS: I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may be able to enroll myself and my dependents in this policy if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing toward my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, I can contact PHP Customer Service at 517.364.8500.

Employee Signature: Date Signed:

## D. FOR EMPLOYER USE ONLY – must be completed in order to process

| Group Name | Group Number | Sub Group Number | Class Number | Effective Date |
|---|---|---|---|---|
| Qualifying event date | Qualifying event reason: | ☐Full-time ☐Part-time | ☐Union ☐Non-Union | ☐Salaried ☐Hourly |

Employer Representative Name: _____ Phone Number: _____

Employer Representative Signature: Date:

For questions regarding this form, please e-mail php.enrollment@phpmm.org or call 517.364.8320

Physicians Health Plan

# Disabled Dependent Verification Form

| Section 1. To Be Completed by Subscriber (Please print clearly) | | |
|---|---|---|
| **PHP Policyholder's Name** | | **PHP ID#** |
| **Dependent's Full Name** | | **Dependent's Date of Birth** |
| **Does dependent reside with you?** ☐ Yes ☐ No | **Do you provide half of the dependent's support?** ☐ Yes ☐ No | **Dependent's Address if different from policyholder** |
| **Is dependent covered by Medicare?** ☐ Yes ☐ No | | **If yes, provide Medicare number** |

| Section 2. To Be Completed by Dependent's Treating Physician | |
|---|---|
| **Diagnosis** | **Date of Diagnosis** |
| ☐ **Permanently Disabled** | ☐ **Temporarily Disabled – Please give estimated timeframe:** |
| **Anticipated course and/or duration of disability (estimate in months or years)** | |
| | |
| **Provide a description of both current and chronic specific symptoms and functional impairments that render the Patient incapable of self-sustaining activities and a clear explanation of how those symptoms and functional impairments in fact render the individual unable to sustain employment.** | |
| | |
| **Is the Patient capable of self-sustaining activities of daily living (ADLs)?** ☐ **Yes** ☐ **No**<br>**Is the Patient capable of self-sustaining instrumental activities of daily living (IADLs)?** ☐ **Yes** ☐ **No** | |
| **PHYSICIAN'S SIGNATURE** | |

**Physician's Name (please print)**

**Physician's Signature** **Date**

**Please note**: It is a crime to provide false, incomplete, or misleading information knowingly for the purpose of defraud. Penalties include imprisonment, fines, and denial of benefits. PHP reserves the right to request this certification on an annual basis.

| For PHP Use Only | |
|---|---|
| **PHP Reviewing Physician** | **Date** |
| ☐ **Approved Permanently Disabled**<br>☐ **Approved Temporarily Disabled**<br>☐ **Denied** | **Length of Approval for Temporary Disability** |

Physicians Health Plan

**GROUP PEDIATRIC DENTAL COVERAGE ATTESTATION**

The Physicians Health Plan or PHP Insurance Company group health benefit plan that you wish to purchase does not include pediatric dental coverage. Because of this, federal and state law provide that you are only eligible to purchase this group health benefit plan if you also purchase group pediatric dental coverage offered by an Exchange-certified standalone dental plan. PHP can assist you in obtaining group pediatric dental coverage offered by an Exchange-certified standalone dental plan.

Because you are only eligible to purchase this group health benefit plan if you also purchase group pediatric dental coverage from an Exchange-certified standalone dental plan, PHP is required to obtain reasonable assurances from you that you have such coverage before PHP is permitted to sell you this group health benefit plan. Therefore, please attest to the following:

- I understand that I am only eligible to purchase this PHP group health benefit plan if I also purchase group pediatric dental coverage offered by an Exchange-certified standalone dental plan.
- I certify that I have purchased group pediatric dental coverage offered by an Exchange-certified standalone dental plan.
- I will inform PHP immediately if this group pediatric dental coverage is discontinued for any reason.
- I understand that if I am not truthful in this attestation, the PHP group health benefit plan may be rescinded by PHP due to fraud or intentional misrepresentation of material fact, and that the group may be required to reimburse PHP for any medical expenses that PHP paid on its behalf.

Signature: _____ Date: _____

Printed Name: _____

Group Name: _____

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A Sparrow Subsidiary

1400 E. Michigan Avenue
P.O. Box 30377
Lansing, Michigan 48909-7877

T 517.364.8400
F 517.364.8460
phpmichigan.com

Physicians Health Plan

# HRA/HSA/FSA ATTESTATION

## Plan ID(s): _____

## PLAN EFFECTIVE DATE: _____

## PURPOSE:

The Physicians Health Plan coverage selected by the group is not attached to a Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). By signing below, you indicate that you understand and are not currently using or intend to use an HRA, HSA or FSA to fund your employees cost sharing responsibilities.

## PLAN SPONSOR INFORMATION & ATTESTATION:

_____
Group Name

_____
Employer(s) Federal Identification Number

I, the undersigned, duly-authorized representative for

_____ ("Name of Group"), understand that I have selected a plan without an HRA or FSA attached that is not HSA compatible. I hereby attest that I will not fund an HRA, HSA or FSA and employees will be fully financially responsible for all member cost-sharing. I also acknowledge that by signing this attestation, I understand that knowingly giving incorrect information is considered a breach of contract with Physicians Health Plan and in such case, is cause for termination of our Group Policy.

_____
Group Representative Printed Name and Title

_____
Signature Date

_____
Producer Printed Name

_____
Producer Signature Date

Physicians Health Plan

**Company Name:**

**Requested Effective Date:**

# New Business Group Size Determination Form

Effective January 1, 2018, group size will be determined by your total number of full-time and full-time equivalent employees. To determine your group size:

- ***Count the average number of full-time employees (defined as employees who are employed on average at least 30 hours of service per week) during the preceding calendar year, and then add to that total the number of full-time equivalents.***
- ***The number of full-time equivalent employees for each calendar month in the preceding calendar year is determined by calculating the aggregate number of hours of service for that calendar month for employees who were not full-time employees (but no more than 120 hours of service for any employee) and dividing that number by 120.***
- ***Knowing how many full-time and full-time equivalents you have is important. You should seek legal advice if you need assistance with this calculation.***

| | |
|---|---|
| Number of full-time employees | |
| Number of full-time equivalent employees | |
| **Total** number of full-time **and** full-time equivalent employees | |

Authorized Group Representative Signature _____

Printed Name _____

Title _____

Date _____

MyPHP is an online portal giving employers access to make changes to employee demographics, order ID cards and make eligibility updates. There can be up to 6 contacts for each group. Please list each contact's name and email address below to be added to your account.

| First Name | Last Name | Email |
|---|---|---|
| First Name | Last Name | Email |
| First Name | Last Name | Email |
| First Name | Last Name | Email |
| First Name | Last Name | Email |

Also, do you grant access to your Producer to have access to your group's information and to be able to make changes on the web portal on your group's behalf? YES_____ NO_____

Producer's Name_____

Producer's Email_____

Group Administrator's Signature_____

In the future, if any of the above individuals should no longer have access to PHP's web portal and your group's account information, please call the PHP Sales Department at 517.364.8484.