



Trilogy Health Insurance, Inc.  
 18000 West Sarah Lane, Suite 310  
 Brookfield, WI 53045  
 (262) 432-9140 (866) 429-3241

**EMPLOYER GROUP APPLICATION**

Please print in black or blue ink.

Requested Effective Date \_\_\_\_\_

**SECTION A - GENERAL EMPLOYER INFORMATION**

1. Exact Legal Name of Employer (Policyholder) \_\_\_\_\_  
 Name "Doing Business As" \_\_\_\_\_  
 Nature of Business \_\_\_\_\_ Years in Business \_\_\_\_\_  
 Tax ID \_\_\_\_\_ Industry Code \_\_\_\_\_
  
2. Business Street Address (Policyholder) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
 Billing/Mailing Address (if different) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
  
3. Employer Administrative Contact Name \_\_\_\_\_ Title \_\_\_\_\_  
 Phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 E-mail address \_\_\_\_\_
  
4. Employer Management Contact Name \_\_\_\_\_ Title \_\_\_\_\_  
 Phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 E-mail address \_\_\_\_\_
  
5. Employer Billing Contact Name \_\_\_\_\_ Title \_\_\_\_\_  
 Phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 E-mail address \_\_\_\_\_
  
6. Is this group associated or affiliated with any other group already insured by Trilogy?  
 YES  NO Name(s) \_\_\_\_\_
  
7. Is this group multi-located?  YES  NO If "yes", are any of the group's other working locations eligible to file a combined tax return?  YES  NO
  
8. If you answered "yes" to the above (multi-location question #6), please list other locations below or add attached list if necessary.  
  
 Company Name \_\_\_\_\_ Total # Eligible Employees\* \_\_\_\_\_  
 Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 E-mail Address \_\_\_\_\_

*\*Eligible employees = Active Employees (See Section B, Question #2)*

**PLEASE SELECT BILLING OPTION (Please Note: Billing statements will be available electronically; paper copies will be mailed if indicated below:)**

- One bill for all locations sent to main billing address above
- Each location receives separate bill
- Separate bills for each location sent to main billing address above
- Paper copies requested

9. Have you employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year?  YES  NO If "Yes," skip question #10. If "No," the average number of employees during the preceding calendar year was \_\_\_\_\_.
10. Were you in existence in the preceding calendar year?  YES  NO If "No", do you employ at least 2 employees at the beginning of the policy year, and do you reasonably expect to employ an average of at least 2 but not more than 50 employees on business days during the current calendar year?  YES  NO If "No," the average number of employees you expect to employ during the current calendar year is \_\_\_\_\_.
11. Would you like Trilogy to assist you in the administration of Continuation of Coverage?  YES  NO

Note: Trilogy's assistance in the administration of Continuation of Coverage does not absolve the group of its responsibility for administration. Please refer to Continuation of Coverage information, which is provided in the employer kit. A copy of this information can be provided upon request to a Trilogy Health Insurance representative. Trilogy will automatically provide assistance for groups eligible for State Continuation

12. New case benefit plan certificates should be sent to:  Agent  Employer

## SECTION B –ELIGIBILITY GUIDELINES

1. Is this coverage part of a union negotiated agreement?  
 YES  NO Date of Expiration \_\_\_\_\_
2. "Active Employee" means the employee is performing all of his/her customary duties:
- On a regular, full-time basis, and
  - For the required number of hours per week shown on the Employer Group Application, and
  - For 48 weeks per year, and
  - Is maintaining a bona fide employee/employer relationship with the sponsor of this group policy on a regular basis.
  - Employees who work on a temporary or substitute basis are not eligible for coverage.
- a) Indicate hourly requirement: \_\_\_\_\_
- Active Employees are eligible for coverage provided they work a of minimum of 30 hours per week on average. The hourly requirement for coverage may not exceed 30 hours. You may reduce the hourly requirement to no less than 20 hours per week with underwriting approval.
- b) Number of **active** employees **eligible** for coverage based upon the hourly requirement specified above: \_\_\_\_\_
- c) Number of active employees currently **enrolled** in an employer sponsored medical plan: \_\_\_\_\_
- d) Number of total employees on payroll: \_\_\_\_\_
- Eligible employees who have been laid off from employment and rehired within ninety (90) days can have coverage reinstated without any additional waiting period.*
3. Do you have Workers' Compensation coverage?  YES  NO
- a) If yes, who is your Workers' Compensation Carrier? \_\_\_\_\_
- b) Do you wish to have 24-hour coverage for owners, officers, or partners not covered by Workers' Compensation?  YES  NO If yes, please provide name(s) \_\_\_\_\_

4. Retirees – Medical Coverage **(All Retiree coverage is subject to Trilogy’s approval)**

If you have 21 or more enrolled employees and would like to offer retiree coverage, please outline below your requirements for retiree eligibility:

Attained Age \_\_\_\_\_ Years of Service \_\_\_\_\_

Please also indicate desired length of coverage:  Until Medicare Eligible  Indefinite  
 Other; please explain: \_\_\_\_\_

5. If there currently are any employees on State Continuation or COBRA please complete the information below.

**State Continuation / COBRA**

Name	COBRA/State Continuation Expiration Date	Date Employment Terminated	Date and Description of other Qualifying Event

6. Indicate your group’s Medicare payer status below:

- Medicare is primary payer (19 or Less Employees)
- Medicare is secondary payer (20 or More Employees)

Medicare is the **secondary** payer if your group meets the “20 or More Employees” threshold.

The "20 or More Employees" threshold is met when an employer has 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year. The 20 calendar weeks do not have to be consecutive. The requirements of the Medicare secondary law are based on the number of employees, not the number of people covered under the plan.

The employer will assure correct application of the "20 or more employees" rule by taking the following steps:

At the beginning of the calendar year, the employer should examine their records to determine whether they had 20 or more employees for each working day in each of 20 or more calendar weeks during the preceding calendar year. If so, the threshold has been met and Medicare is the secondary payer for working aged people covered by the group health plan for the entire calendar year that has just begun.

Once the employer has met the requirements in a particular year, they must provide primary coverage for the remainder of that calendar year and throughout the following calendar year.

If the employer has not satisfied the threshold during the previous calendar year, it is still possible that they will meet it at some point during the new calendar year.

Once the employer reaches the threshold, Medicare becomes the secondary payer from that point on through the remainder of that calendar year and through the next calendar year.

Medicare does not become secondary retroactively for the part of the year before the threshold is reached.

7. Please identify your choices by checking the appropriate box below.
- Employee Probationary Period:  0 Calendar Days  30 Calendar Days  60 Calendar Days  
 90 Calendar Days  120 Calendar Days  150 Calendar Days  
 180 Calendar Days
- Effective Date Provision for New Employees:  Immediately following probationary period  
 First of month following probationary period

Do any classes of employees have a different waiting period?  YES  NO If yes, please explain:

Management: \_\_\_\_\_ Non-Management: \_\_\_\_\_

Union: \_\_\_\_\_ Non-Union: \_\_\_\_\_

Salary: \_\_\_\_\_ Hourly: \_\_\_\_\_

8. Is this a replacement of your current group medical coverage?  YES  NO  
 If YES, you must furnish the following information:  
 a. Name of current group carrier \_\_\_\_\_  
 b. Termination date of current/prior coverage \_\_\_\_\_  
 c. Please attach your most recent billing statement.
9. Will your employees have access to another medical plan by virtue of their employment with you?  
 YES  NO If Yes, name of carrier(s) \_\_\_\_\_

## SECTION C - UNDERWRITING, PARTICIPATION AND CONTRIBUTION REQUIREMENTS

### Underwriting

The following applies to all products underwritten by Trilogy Health Insurance, Inc. (Trilogy). You, the participating Employer, Policyholder or Contract Holder intend to establish, sponsor, and endorse an Employee Benefit Plan which will be governed by the Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA Plan Administrator.

*Small Employer* means an employer that employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employees on the first day of the plan year, unless otherwise provided under state law. Entities that are affiliated with other companies or that are eligible to file a combined tax return for the purposes of taxation, are considered an Employer. YOU agree to make available your records that we determine are relevant to this Application and group coverage for inspection by the Trustee, Administrator, Trilogy, or our representative during your normal business hours.

With respect to paying claims for benefits or determining eligibility for coverage under this Policy or Group Plan, Trilogy, as administrator for claims determinations and as ERISA claims review fiduciary as described in 29 C.F.R. 2560.503-1(g)(2), shall have full and exclusive discretionary authority to: 1) interpret policy provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage and benefits.

For you to remain eligible for the Policy or Group Plan, the eligibility, Underwriting, Participation and Contribution Requirements must be maintained, for all coverages. Failure to maintain the plan eligibility, Underwriting, Participation and Contribution Requirements will result in the termination of your coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan.

**Participation and Contribution Requirements**

You must have the greater of 2 employee lives or as indicated in the chart below. Failure to maintain the below requirements will result in termination of your coverage. If the only employees of a two (2) life group are husband and wife; the group will only be eligible if:

- 1) A bona fide business entity exists;
- 2) Each work the required number of hours per week at the business;
- 3) Each must enroll and maintain eligibility as an employee. Dependents may be covered under either employee.

A. For groups with up to 2-50 eligible employees the following participation must be met:

Eligible employees (All Locations)	Participation Requirement (Less Waivers for Creditable Coverage)
Up to 4	2 participants
5 or 6	3 participants
7	4 participants
8 or 9	5 participants
10	6 participants
11 to 50	70 %

B. For groups with 51+ or more employees eligible for medical coverage, the minimum participation must be as follows:

Plan Offering	# of Enrollees Required
<b>Exclusive Offering</b> If 100% Paid by Employer  If Employer/Employee share cost	<ul style="list-style-type: none"> <li>• 100% (no spousal waivers permitted)</li> <li>• 70% less spousal waivers, but not less than 50% of all full-time employees.</li> </ul>

The number of eligible employees, for the purpose of participation compliance, will only include the number of employees who apply for medical coverage through one of your sponsored medical plans. Eligible employees who have other creditable coverage (i.e., through a spouse’s employer sponsored plan) will not be included. Employees on continuation coverage (state or federal) will not be included.

You are required to contribute at least 50% of the total employee portion of the premium for each group benefit selected. There is no dependent contribution requirement. Please indicate you contribution percentages below:

Tier	Contribution %
Employee	
Employee & Child(ren)	
Employee & Spouse	
Family	

**Participation and Contribution Requirements**

You, the employer, understand and agree that the fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on the Application. You agree to collect any employee contribution toward premium. Insurance coverage is not in effect unless and until you receive written notification from us. You understand and agree that neither you, nor the agent, has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of Trilogy’s other rights or requirements.

You hereby certify that you have read this document and that the information provided is accurate and complete. You also certify that information provided here can be substantiated by business records maintained by you. You agree to provide the documentation requested by Trilogy which establishes that all eligibility and participation requirements of the policy are met. You understand that only individuals who meet the eligibility requirements of the Policy are entitled to maintain coverage. You understand that providing incomplete, inaccurate, or untimely information may void, reduce, or terminate an individual's coverage or the group's coverage. You acknowledge that you have received a general description of the benefits noted in Section C and by signature here fore agree to be bound by the terms of the Master Group Policy. This document will form part of any contract issued.

**UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR NOTICE OF APPROVAL BY TRILOGY.**

DATED: \_\_\_\_\_  
*(Month, Day, Year)*

BY: \_\_\_\_\_  
*(Employer Signature)*

\_\_\_\_\_  
*(Title)*

**SECTION D - AGENT/AGENCY INFORMATION**

**AGENT/AGENCY OF RECORD**

*(Agent/Agency for Commissions/Correspondence)*

Agent Name \_\_\_\_\_

Agency Name \_\_\_\_\_

You, the agent(s), certify that you have met with the Employer submitting this application and that you have fully explained its contents. You have discussed coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions. If employer is a small group, I certify that I have made the rate disclosure required by Wis. Statute 635.11.

DATED: \_\_\_\_\_  
*(Month, Day, Year)*

WRITING AGENT: \_\_\_\_\_  
*(Please Print)*

\_\_\_\_\_  
*(Signature)*

**SECTION E- HOME OFFICE USE ONLY**

Group Number(s):	Comments:
Broker Advocate:	
Effective Date:	
Approved by (Underwriter):	
Approved Date:	