Group Number # _____

SMALL BUSINESS ELIGIBILITY REQUIREMENTS

- A minimum of two (2) employees that work full-time (30 hours or more weekly) with an anticipated work future of at least five (5) months
- 75% of full-time eligible employees must participate in the plan
- Business must reside in Wayne or Oakland County
- Employer has not contributed to or sponsored a health insurance plan for the past three (3) months

CHECKLIST OF REQUIRED FORMS

- ☐ Copy of Quarterly Wage and Detail Form (UIA 1028) or other supporting documents verifying business and eligible employees
- ☐ Federal Tax ID Number
- ☐ Employee Applications
- ☐ Pay Stubs
- ☐ Copy of the employees State of Michigan driver's license or state identification
- ☐ Signed Group Operating Agreement
- ☐ 1st Month Premium (due by the 15th of the month for following month coverage)
- ☐ Waiver of coverage form

THIS FORM MUST BE COMPLETED TO BE ACCEPTED

I have read, understand and agree to adhere to the above eligibility requirements under penalty of fraud. I understand that any misrepresentation of the facts will result in termination of the HealthChoice benefits.

Business Name: _____

Business Email:_____

Owner Name (Print) _____ Signature: _____

Address: _____ City: _____ County: _____ Zip:_____

Phone: ( ) _____ Fax: ( ) _____ Tax ID: _____

Marketing Representative: _____ Date:_____

Riders: (circle all that apply) 3-Vision (Heritage) 7-Dental (Golden Dental)

Group Operating Agreement Between

Group Name_____Group # _____

HealthChoice of Michigan (The "Program") and Managed Care Provider/CPE

The intent of this Agreement is to establish between the parties hereto the terms under which the Program will offer health care coverage to Eligible Employees of the Group (Subscribers) and the Eligible Dependents (collectively referred to as 'Members') by reference to the Program's Subscriber Certificate of Eligibility, any amendments thereto, and any applicable riders (hereinafter collectively referred to as the 'Subscriber Certificate'), and the underwriting and administrative requirements under which the Group is to operate.

The Group, the Program and the selected Managed Care Provider/CPE hereby agree:

1. This Agreement is effective only when a fully-executed copy of this Agreement that is approved by the Program's Executive Director is returned to the Group. This Agreement is subject to and the Group agrees to comply with the terms of the Subscriber Certificate, the provisions of which are incorporated herein. The Group acknowledges that the Program has provided a copy of the Subscriber Certificate to the Group and all Subscribers.
2. Subject to the terms of the Subscriber Certificate, the Program will provide Covered Services to all Members as provided for in the Subscriber Certificate, including Covered Services to any individual who is required to be provided with and elects continuation coverage pursuant to the Comprehensive Omnibus Budget Reconciliation Act (COBRA).
3. The Group is at all times acting as agent for individuals who are enrolled as Members. Notification received from, or given to, such agent by the Program will fulfill all notice requirements of the Subscriber Certificate. The group, at its own expense, agrees to provide any notification received from the Program to all its Subscribers.
4. The Group agrees to prepay, on or before the Premium Payment deadline, the monthly advance premiums calculated on the basis of and pursuant to the terms of the current Premium Rate Schedule for all Members, including members entitled to continued services pursuant to Part XIII of the Subscriber Certificate.
5. The Group agrees to the operating procedures as described in this Agreement, the HealthChoice Program Handbook and Subscriber Certificate, as furnished and amended by the Program from time to time, and the Subscriber Application/Change Form. Upon initiating coverage for its employees, the Group represents and warrants that it complies with the criteria set forth in the Subscriber Certificate to be qualified as a Group. The Group agrees to furnish upon request, but not less than annually, to the Program such information as may be required for its underwriting review and to permit a membership and payroll audit by the Program or its representatives.
6. This Agreement may be canceled or amended by the Program or the Group upon 30 days written notice, except as otherwise provided pursuant to the terms of the Subscriber Certificate. Termination will be effective the first day of the month immediately following the month for which premiums for the Member have been paid, unless the Subscriber Certificate provides for a different termination date.
7. The group agrees to comply with all requirements under COBRA/ERISA as documented in the HealthCHoice Program Handbook and Subscriber Certificate.
8. The Group understands and acknowledges that HealthChoice is a Michigan Municipal Health Facilities Corporation, the Covered Services provided are provided pursuant to the HealthChoice Program, and that HealthChoice and the Managed Care Provider/CPE are not licensed or regulated by the Michigan Office of Financial and Insurance Regulation.
9. The Managed Care Provider/CPE selected by the Group accepts the selection and agrees to deliver health care services to Members in a manner and to the extent identified in its contract with HealthChoice of Michigan in return for the monthly premiums paid by the Group and Subscribers references in its HealthChoice contract. The Managed Care Provider/CPE is not liable for the provision or payment of Mental Health, Dental or Vision Services.

THIS AGREEMENT IS NOT EFFECTIVE UNLESS AND UNTIL SIGNED BY THE EXECUTIVE DIRECTOR OF THE PROGRAM

HEALTHCHOICE OF MICHIGAN

By:_____
HealthChoice Executive Director
Date:_____

MANAGED CARE PROVIDER/CPE

By:_____
Date:_____

COMPANY REPRESENTATIVE

By:_____
Title:_____
Address:_____
City:_____ Zip_____
Phone: ( ) _____
Federal ID#_____
Date:_____

Dental / Vision Rider
Group Operating Agreement between HealthChoice of Michigan (the "Program") and CPE/TPA and

Group Name_____ Group # _____

The intent of this Agreement is to establish, between the parties hereto, the terms under which the Program will offer vision and/or dental care coverage to Eligible Employees of the Group (Subscribers) and their Eligible Dependents (collectively referred to as 'Members) by reference to the Program's Subscriber Certificate of Eligibility, any amendments thereto, and the selected Dental and/or Vision Riders (hereinafter collectively referred to as the 'Subscriber Certificate'), and the underwriting and administrative requirements under which the group is to operate.

The Group, the Program and the CPE/TPA hereby agree:

1. The following Riders are selected by the Group for all employees of the Group who enroll as Subscribers and their Eligible Dependents who are enrolled by the Subscriber:

   Vision Exam & Glasses (R/3) ☐ Dental (R/7) ☐

2. This Agreement is effective only when a fully-executed copy of this Agreement that is approved by the Program's Executive Director is returned to the Group. This Agreement is subject to and the Group agrees to comply with the terms of the Subscriber Certificate and the selected Rider(s), the provisions of which are incorporated herein. The Group acknowledges that the Program has provided a copy of the Subscriber Certificate to the Group and all Subscribers.
3. Subject to the terms of the Subscriber Certificate and the selection made in paragraph 1 above, the Program will provide Dental and/or Vision Services to all Subscribers and their Eligible Dependents as provided for in the Subscriber Certificate and the selected Rider(s).
4. The Group is at all times acting as agent for individuals who are enrolled as Members. Notification received from, or given to, such agent by the Program will fulfill all notice requirements of the Subscriber Certificate related to Dental and/or Vision Care Coverage. The Group, at its own expense, agrees to provide any notification received from the Program to all of its Subscribers.
5. The Group agrees to prepay, on or before the Premium Payment Deadline, the monthly advance premiums for the selected Rider(s) calculated on the basis of and pursuant to the terms of the current Premium Rate Schedule for all Members, including Members entitled to continued services pursuant to Part XIII of the Subscriber Certificate.
6. Dental and/or Vision Services described in the selected Rider(s) will be offered by the Group to all individuals eligible under the terms of the Subscriber Certificate and the selected Rider(s). The Group agrees to notify the Program each month of the names of the Subscribers and their Eligible Dependents for whom a Premium Payment for Dental and/or Vision Services has been made to the Program.
7. The Group agrees to the operating procedures as described in this Agreement, the HealthChoice Program Handbook and Subscriber Certificate furnished and amended by the Program from time to time, and the Subscriber Application/Change Form. The Group agrees to furnish upon request, but not less than annually, to the Program such information as may be required for its underwriting review and to permit a membership and payroll audit by the Program or its representatives.
8. This Agreement may be canceled or amended by the Program or the Group upon 30 days written notice, except as otherwise provided pursuant to the terms of the Subscriber Certificate and Dental and/or Vision Rider. Termination will be effective the first day of the month immediately following the month for which premiums for the Member have been paid, unless the Subscriber Certificate provides for a different termination date.
9. The Group understands and acknowledges that HealthChoice is a Michigan Municipal Health Facilities Corporation, the Dental and/or Vision Services provided are provided pursuant to the HealthChoice Program, and that HealthChoice and the CPE/TPA are not licensed or regulated by the Michigan Office of Financial and Insurance Regulation.
10. The CPE/TPA selected by the Group accepts the selection and agrees to deliver Dental or Vision Services to Members in a manner and to the extend identified in its contract with HealthChoice of Michigan in return for the monthly premiums paid by the Group and Subscribers referenced in its HealthChoice contract. The TPA/CPE is not liable for the provision or payment of health care services or Supplemental Services not required by its contract with HealthChoice.

THIS AGREEMENT IS NOT EFFECTIVE UNLESS AND UNTIL SIGNED BY THE EXECUTIVE DIRECTOR OF THE PROGRAM

HEALTHCHOICE OF MICHIGAN

By:_____ Date:_____

Title: Executive Director

TPA/CPE

By (R/3):_____ Date:_____

By (R/7):_____ Date:_____

GROUP

By:_____ __ Date:_____

Title: _____

Address: _____

Phone:_____ Federal ID#_____

Employee Enrollment Guide

Enrollment

1. All enrollment information must be submitted on or before the 15th of the month in order to be processed for the following month.
2. A HealthChoice Subscriber Application Form must be completed within 90 days of the employees hire date. Employees with a hire date longer than 90 days must enroll when the company starts coverage, have a qualifying event, or wait until the next open enrollment period.
3. Two (2) consecutive printed payroll stubs issued within the last two (2) pay periods or a payroll ledger must accompany the application.
4. A copy of the employees State of Michigan driver's license or State identification.
5. The correct payment must accompany all enrollment information in order to be processed. See attached rate sheet to calculate payment.

Add and/or Change

1. All requests for changes to employee information (address, name, etc.) must be on a HealthChoice Subscriber Application Form.
2. A new tax ID number must accompany any requests to change the name of the company.

Disenrollment/Termination

1. All termination information must be submitted on a HealthChoice Subscriber Application Form on or before the 15th of the month in order to be processed for the following month.
2. Complete the Subscriber Application Form with the member and/or dependent information and indicate the requested action in the specified area.
3. Cross off the name of the member on the current invoice and subtract their payment from the total amount.

Subscriber Application Form

HealthChoice of Michigan GROUP #_____

500 Griswold, 15th Floor

PRINT CLEARLY Detroit, MI 48226

Last Name:	First Name:	Middle Initial	Phone Number ( )	**Circle One** New Change Term
Social Security #	Date of Birth	Sex	Date of Hire	
Home Address:	City	County	State	Zip Code
Do you have other medical insurance coverage? Yes or No	If Yes, Insurance Name:	Policy #		
Email address:				

List the names of each eligible dependents to be covered (see reverse side for dependent criteria)

1 Last Name:		First Name:		Middle Initial	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? Y or N	If yes, insurance Name:
2 Last Name:		First Name:		Middle Initial	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? Y or N	If yes, insurance Name:
3 Last Name:		First Name:		Middle Initial	Birth Date
Social Security #	Sex	Relationship	Age	Does dependent have other medical insurance coverage? Y or N	If yes, insurance Name:

Dependent change only: Date of event: _____ Circle One: Marriage Newborn Principle Support Adoption/Legal Guardianship

Deletion (Date of event) _____

Circle one: Divorce Death Other _____

By signing below, I acknowledge that I have been provided with at copy of this form, read understand and agree to the conditions listed and attached my most recent pay stub.

Applicant's Signature_____ **Date**_____

Company Name:		
Address:	City	Zip Code
Phone: ( ) -		
Federal Tax Id:		

The undersigned represents and warrants that he/she has been authorized to execute this subscriber application and make the foregoing certifications on behalf of the employer, has been provided a copy and has read, understands and agrees to the conditions on the reverse side of this form.

Employer's Signature_____ **Date**_____

Subscriber Id# _____

Phone: 1-800-935-5669

Fax: 313-967-6386

Effective Date: _____

SUBSCRIBER CERTIFICATION OF ELIGILIBITY

By submission of this Subscriber Application, I am applying for Basic Services specified in my Subscriber Certificate of Eligibility with HealthChoice of Michigan and any amendments thereto (hereinafter collectively referred to as 'Subscriber Certificate') and for the selected Supplemental Services (also known as 'riders'), as defined in my Subscriber Certificate of Eligibility with HealthChoice of Michigan.

I understand that all Supplemental Services elected have been elected for me and all eligible dependents as defined in the Subscriber Certificate, and that I am responsible for paying my portion, an amount agreed upon with my employer, of the premium for the Supplemental Services in addition to the premium for Basic Services.

By submission of the Subscriber Application, I herby certify that, to the best of my knowledge, I qualify as a Subscriber under the terms of the Subscriber Certificate by meeting all the following criteria:

A. I am an employee of a qualified employer or a member of a qualified association and have an anticipated work future of more than five (5) months.
B. I am currently without health care benefits and am not eligible, without regard to the availability of coverage, for Medicare, Medicaid or other employer sponsored health coverage.
C. I am currently working at least 20 hours per week. I agree to notify HealthChoice if my hours are reduced to less than 20 hours per week for any reason at any time after enrollment.
D. My employer has not offered or contributed to health care benefits of employees in the same or similar job classification in which I am employed in the 65 day period immediately preceding the effective date of the Group Operating Agreement between my employer and HealthChoice of Michigan.
E. I am a resident of the State of Michigan as defined in the Subscriber Certificate, and I have accurately listed the County of my residence.
F. I have completed and signed this Subscriber Application for enrollment.

By submission of this Subscriber application for an eligible dependent as defined in the Subscriber Certificate, I hereby certify that, to the best of my knowledge, each eligible dependent listed on this application qualifies as an eligible dependent under the terms of the Subscriber Certificate by meeting all of the following criteria:

A. Be my spouse (Family income is not exceeded), OR
B. Be a child of the Subscriber, which is defined as a son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the Subscriber until the child reaches the age of 26. An eligible foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adopted child includes both a legally adopted child of the Subscriber and a child who is lawfully placed with the Subscriber for legal adoption by the Subscriber.
C. Not serving in the United States Armed Forces.
D. Be without health care benefits and not be eligible for any other health care program at time of enrollment.

By submission of this subscriber Application to my employer, I hereby authorize my employer to deduct from my wages, as a payroll deduction, an amount not to exceed that portion of the monthly advance premium and any Supplemental Services selected for myself and eligible dependents that my employer may charge to me under the terms of the subscriber Certificate of Eligibility.

I further certify that I have received and read the Subscriber Certificate, and I acknowledge that I have been advised that the Subscriber Certificate of Eligibility is available online at www.waynecounty.com/hhs/HealthChoice.htm I understand that the subscriber certificate, any riders thereto and this Subscriber Application Form contain the specific provisions and limitations of my coverage and are my contract with HealthChoice of Michigan.

I appoint my employer as my agent to handle all matters of HealthChoice of Michigan coverage. I am responsible for giving notices of changes in my status and that of my family members, which affect coverage, to my employer. I authorize HealthChoice of Michigan to obtain hospital and medical records relating to me and my family from providers of service.

HealthChoice or its Managed Care Providers may require any person to verify their ineligibility for Medicaid or Medicare by completion and submission of an application for Medicaid or Medicare benefits as a part of the Subscriber Application for the person or at any time during the period a person is a Member. **Refusal by a Member of request by the Program or its Managed Care Providers to complete and submit an application for Medicaid or Medicare benefits may result in termination of this Subscriber Certificate for the Member.**

I represent and warrant that the information provided by me on this Subscriber Application is true, correct and complete. I understand that if I falsify or withhold information requested by HealthChoice on the Subscriber Application, or as required under the Subscriber Certificate, including a refusal of a request by HealthChoice or its Managed Care Providers, I will be terminated from the Program immediately and coverage for myself and my eligible dependents will end as of the effective date of termination

EMPLOYER CERTIFICATION

By execution of and submission of this Subscriber Application, the undersigned certifies, on behalf of the employer, that to the best of the employer's knowledge, the applicant qualifies as a Subscriber under the terms of the Subscriber Certificate, that all eligible dependents for whom coverage is sought by the Subscriber qualify as eligible dependents under the terms of the Subscriber Certificate and that the employer qualifies as a Group whose employees may enroll as Subscribers under the terms of the Subscriber Certificate by meeting the following criteria unless waived in writing by HealthChoice.

A. Have their principle place of business for global operations located in Wayne or Oakland County.
B. At the time the Group enters into the Group Operating Agreement, the Group has two (2) or more employees that work full-time (30 hours or more weekly) who are otherwise eligible to enroll as Subscribers.
C. Including this Subscriber Application, the employer has submitted two (2) or more complete Subscriber Application for employees who otherwise qualify as Subscribers and will have two (2) or more employees enrolled in the program.
D. That 75% of full-time eligible employees are participating in the Plan.
E. At the time the Group enters into the Group Operating Agreement, not less than 50% of all employees have an hourly wage of fourteen dollars and fifty cents ($14.50) or less.
F. The employer has entered into a Group Operating Agreement with HealthChoice of Michigan.
G. Has provided verification of the legal existence of their business and list of employees.

If this form is being submitted for purposes of a Subscriber Change Form relating to COBRA coverage, employer certifies that it is responsible for determining the employee's eligibility for COBRA coverage and sending out all required COBRA notifications. Employer agrees to indemnify and hold harmless HealthChoice of Michigan related to COBRA eligibility, notification and coverage.

EMPLOYEE WAIVER OF COVERAGE

Employer:_____

Group ID#:_____

I have been given the opportunity to apply for the HealthChoice of Michigan health care program offered to me by my employer. I have decided not to apply for health care coverage in this program for the following reason:

- ☐ I have coverage through a spouse or parent
- ☐ I have coverage through a previous employer as a retiree
- ☐ I have coverage through the Exchange
- ☐ I have Medicaid
- ☐ I am not choosing coverage – Reason:

Employee Name:_____

Employee Signature:_____ Date:_____

HEALTHCHOICE of Michigan

2017 Rate Sheet

Enrollment Category	Employer & Employee Monthly Total	Vision Rider 3	Dental Rider 7
E - Employee Only	$239.77	$2.60	$12.90
S - Employee & Spouse	$555.93	$5.67	$25.89
C - Employee & one (1) minor family dependent	$378.74	$3.95	$21.93
B - Employee & two (2) minor family dependents	$504.21	$4.97	$28.40
F - Employee, Spouse & one (1) minor child or any three (3) family members	$757.28	$7.62	$34.88
L - Employee & any four (4) family members	$981.00	$7.62	$41.35