maryland health connection for small business

(Carrier Use Only)
Group Number(s):

Maryland Health Connection for Small Business - 2025 Employer Direct Enrollment Form
(Not an Employer Eligibility Application)

Section 1: Company Information

Legal Company Name:	Doing Business As (if Applicable):		
Physical Street Address (PO Box not acceptable):	City:	State:	Zip:
Mailing Address (if different from physical):	City:	State:	Zip:
Business Phone Number:	Fax Number:		
Primary Group Contact: (Name & Title)		Email:	Phone:
Secondary Contact (if available):		Email:	Phone:
Chief Executive Officer:	Organization type: ☐C-Corp ☐S-Corp ☐Non-Profit ☐LLC ☐LLP ☐Partnership ☐Sole Proprietor ☐Other: _____		
SIC Code:	NAICS Code:	Federal Tax ID:	Date Established:

Section 2: Group Information

Please answer the questions below to help us understand more about your group.	Yes	No
Does this business have multiple locations? If so, please attach a sheet with all locations with Street Address, City, State, ZIP, and number of employees at each broken down by Full-time, Part-time, Retired, COBRA or State Continuees, 1099, Union, Seasonal, and other.	☐	☐
Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company? If yes, please provide the name of the associated company:	☐	☐
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	☐	☐
Are there any associated companies to be included with this group that are commonly owned?	☐	☐
Is your company a branch of another company, or does your company have branch offices?	☐	☐
Do you use the services of a payroll company? If "Yes", provide the name of the payroll company:	☐	☐
Does your group have Worker's Comp: If yes, what is the Carrier Name:	☐	☐
Are all employees covered by Worker's Compensation? If no, explain below:	☐	☐

Section 3: Prior Insurance Information

Please list any coverage with any carrier in the past 12 months

	Name of Carrier (Corporate Name)	Policy # (if available)	Coverage Begin & End Date (MM/DD/YY)
Medical Carrier:			
Medical Carrier:			

Section 4: Employer Contribution

Select Employer Contribution	Medical Plan Percentage Contribution	Medical Plan Fixed Dollar Contribution
For Employee:	%	$
For Dependents:	%	$

Section 5: Period Employee Waiting

Effective November 1st, 2024, the maximum waiting period an employer can impose on an employees is 60 days (COMAR 14.35.18.04). The new hire waiting period for coverage cannot exceed 60 calendar days from the first day of employment, with coverage beginning on the first day of the month following the end of the waiting period.

Select a waiting period for present and future employees	Yes	No
Waive the waiting period for present employees enrolling with the group?	☐	☐
Waive the waiting period for rehires?	☐	☐

Waiting Period for future Employees, the first day of policy Month following:	☐ 0 days	☐ 30 days	☐ 60 days

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Section 6: Plan Selection

Requested Effective Date:

Please select the desired model of plan selection: ☐ Employer Choice (Multiple Plans) ☐ Employer Choice (Single Plan) ☐ Employee Choice (Select Two (2) Ters)

For Employer Choice: Please select one participating insurance carrier for your company. All metal levels will be available for the chosen carrier.

☐ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ☐ Aetna ☐ CareFirst/GHMSI ☐ UHC/OPTUM/MAMSI

For Employee Choice: Please select metal tiers across participating insurance carriers for your company. No more than two consecutive metal levels are allowed.

☐ Platinum ☐ Gold ☐ Silver ☐ Bronze

MEDICAL PLAN CHOICES

Aetna Health, Inc.	☐ Aetna Gold HMO 1000 100% E	☐ Aetna Silver HMO 3500 100% HSA T	☐ Aetna Bronze HNOption 8000 70/50 INT	**Aetna Life Insurance Company**	☐ Aetna Gold OAEPO 1500 80%	☐ Aetna Silver OAEPO 2500 100%	☐ Aetna Bronze PPO 7600 70/50 INT
CareFirst BlueChoice, Inc.	☐ BlueChoice Advantage Gold 1000 Ded	☐ BlueChoice Advantage HSA/ HRA Gold 1700 Ded	☐ BlueChoice HMO Gold 1500 Ded	☐ BlueChoice HMO HSA/HRA Silver 1950 Ded	☐ BlueChoice HMO HSA/HRA Silver 2900 Ded	☐ BlueChoice HMO Silver 6500 Ded	
	☐ BlueChoice HMO Bronze 6000 Ded	☐ BlueChoice Advantage HSA/ HRA Bronze 6100 Ded	☐ BlueChoice HMO Referral HSA/HRA Bronze 6200 Ded				
Group Hospitalization and Medical Services, Inc.	☐ BluePreferred PPO Gold 1250 Ded	☐ BluePreferred PPO HSA/HRA Silver 2900 Ded	☐ BluePreferred PPO HSA/HRA Bronze 6200 Ded	**CareFirst of Maryland, Inc.**	☐ BluePreferred PPO Gold 1250 Ded	☐ BluePreferred PPO HSA/HRA Silver 2900 Ded	☐ BluePreferred PPO HSA/HRA Bronze 6200 Ded
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	☐ KP MD Platinum 0 Ded/Vision	☐ KP MD Platinum 500 Ded/Vision	☐ KP MD Gold 0 Ded/Vision	☐ KP MD Gold 1000 Ded/100 Rx Ded/Vision	☐ KP MD Gold Virtual Complete 2000 Ded	☐ KP MD Gold 1650 Ded/HSA/Vision	☐ KP MD Silver 2000 Ded/HSA/ Vision
	☐ KP MD Silver 1800 Ded/ 350 Rx Ded/Vision	☐ KP MD Silver 2500 Ded/Vision	☐ KP MD Silver Virtual Forward 3000 Ded	☐ KP MD Bronze 7000 Ded/HSA/ Vision	☐ KP MD Bronze 6150 Ded/HSA/ Vision	☐ KP MD Bronze 6500 Ded/Vision	
UnitedHealthcare of the Mid-Atlantic, Inc.	☐ UHC Core Essential Gold 750-2	☐ UHC Core Essential HSA Gold 1850-2	☐ UHC Core Essential HSA Silver 2700-2	☐ UHC Core Essential HSA Bronze 7100-2			
UnitedHealthcare Insurance Company	☐ UHC Choice Plus Platinum 0-7	☐ UHC Choice Plus HSA Gold 1800-2	☐ UHC Choice Plus Gold 750-2	☐ UHC Choice Plus HSA Silver 2700-2	☐ UHC Choice Plus Silver 3800-2	☐ UHC Choice Plus Silver 5250-3	☐ UHC Choice Plus HSA Bronze 7100-2
Optimum Choice, Inc.	☐ UHC OCI Platinum 0-2	☐ UHC OCI Platinum 750-2	☐ UHC OCI Gold 750-2	☐ UHC OCI HSA Gold 2600-2	☐ UHC OCI HSA Silver 2700-2	☐ UHC OCI HSA Bronze 7100-2	
MAMSI Life and Health Company	☐ UHC Choice Plus Platinum 0-2	☐ UHC Choice Platinum 0-4	☐ UHC Choice Gold 1600-4	☐ UHC Choice HSA Gold 1850-2	☐ UHC Choice HSA Silver 2700-2	☐ UHC Choice Silver 3800-2	☐ UHC Choice HSA Bronze 7100-2

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Section 7: Employee Count

The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H(2) must be utilized to determine group size for health coverage.

A. FTEs from full-time employees. The number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a year (even if they are not eligible or enrolling for health coverage).	
B. FTEs from part-time employees (excluding seasonal workers). Number of part-time employees who worked on average less than 30 hours a week. (Add up the total number of hours worked in a week by part-time employees and divide by 30. For example, 10 employees working 20 hours a week: 10 x 20 = 200 / 30 = 6.66 = 6 (rounding down to the nearest whole number).	
C. Total number of FTEs = A + B.	

Participation Determination: The total number of eligible employees based on state law must work a minimum of 30 hours a week. Note: An employer may not set eligibility rules that would require an employee to work more than 30 hours a week to obtain small group coverage. As long as the employee meets the 30-hour-a-week standard, they are considered full-time for purposes of coverage.

Is your company under 50 full-time equivalent employees (FTEs)?	
Number of employees eligible for coverage (employees working 30 hours per week):	

Number of employees enrolling:		**Number of employees waiving coverage:**	
Number of full-time employees excluding union employees:		**Number of employees working outside Maryland List all states:**	
Number of part-time employees:		**Number of employees not actively at work:**	
Number of 1099 employees:		**Number of COBRA continuees:**	
Number of union employees:		**Number of employees in waiting period and not eligible:**	

General Information	**Yes**	**No**
Cover Part-time (Part-time is defined as more than 17.5 hours and less than 30 hours) Employees?	☐	☐
Cover Domestic Partners of Employees?	☐	☐
Cover Employees with Other Coverage?	☐	☐
Do you have any present or former employees/dependents on COBRA or State Continuation? If yes, please attach a list of people with names, qualifying information, date of eligibility, and date of coverage termination	☐	☐

Section 8: Medicare Primary or Secondary Payor

Did you employ 20 or more employees for at least 20 weeks during the current or prior calendar year?

Include: Full-time, part-time, seasonal, temporary, union, owners, partners, officers.
Exclude: Self-employed persons, independent 1099 contractors, directors.

Special Provisions Related to Medical Eligibility:

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for:
(1) No longer than 3 consecutive months if the employee is: temporarily laid-off; or in part-time status. (2) No longer than 6 consecutive months if the employee is totally disabled.
If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision described in the Certificate of Coverage for the carrier(s).

NEW! Effective November 11, 2024, the Minimum Participation Requirement for all MHC for Small Business groups is 60%.

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FRAUD STATEMENT

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an insurance application is guilty of a crime and may be subject to fines and confinement in prison.

CARRIER STATEMENT

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

PARTICIPATING CARRIER CORPORATE NAMES AND ADDRESSES

Aetna Health, Inc. 1425 Union Meeting Road Blue Bell, PA 19422	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 (844) 241-0209	Group Hospitalization and Medical Services, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	CareFirst BlueChoice, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	CareFirst of Maryland, Inc. dba CareFirst BlueCross BlueShield 1501 S. Clinton Street, 10th Floor. Baltimore, MD 21224

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 East Jefferson Street Rockville, MD 20852 (800) 777-7904	Optimum Choice, Inc. MAMSI Life and Health Insurance Company 4 Taft Court Rockville, MD 20850 (301)294-1578	UnitedHealthcare Insurance Company UnitedHealthcare of the Mid-Atlantic, Inc. 4 TAFT COURT ROCKVILLE, MD 20850 (952)992-5878

EMPLOYER ATTESTATION AND SIGNATURE

Note: Your broker is/may be paid commissions and other financial incentives by any of the participating insurance carriers.

Name of Group:			
Group Officer Signature:		Group Officer Title:	
Group Officer Printed Name:		Date:	
Group Officer Email:		Group Officer Phone Number:	

BROKER ATTESTATION AND SIGNATURE

- ☐ I certify that I am not aware of any information not disclosed in this application by the client that may have a bearing on this risk, for all products being applied for.
- ☐ I represent that I am licensed and authorized to sell small business program-eligible products in the State of Maryland.
- ☐ I certify that I have advised the client not to terminate any existing coverage until receiving written notice from the carriers that the coverage being applied for by this application is accepted.

Broker Name:		Broker NPN:	
Agency Name:		Broker License Number:	
Agency/Broker Email:		Broker TAX ID Number:	
Agency/Broker Phone Number:		Agency/Broker Full Address:	
Broker Signature:		Date:	
General Agent:			

CARRIER ATTESTATION AND SIGNATURE

Carrier Name:		Carrier ID:	
Carrier Representative Signature:		Date:	
Carrier Email:		Carrier Phone Number:	