A Program of Wayne County Government

HEALTHCHOICE of Michigan

SMALL BUSINESS HEALTH COVERAGE

WAYNETREPRENEURS

Group Number # _____

SMALL BUSINESS ELIGIBILITY REQUIREMENTS FORM

DOCUMENTS NEEDED FOR NEW BUSINESS SUBMISSSION

- **Small Business Eligibility Requirements Form**
- **WAYNETREPENEURS Program Agreement (if applying)**
- **Group Operating Agreement**
- **Dental/Vision Rider Agreement (if selecting either rider)**
- **Subscriber Application for each employee**
- **If adding spouse or dependent/s provide marriage or birth certificate/s**
- **Primary Care Physician Selection Form for each**
- **enrollee/spouse/dependent Employee Waiver of coverage form (if any employee is waiving coverage) Photocopy of any Michigan ID**
- **LARA Report or proof of business opening**
- **Most recent employee payroll stubs (2) or most recent MI-Employers Quarterly Wage/Tax Report as an alternative to payroll stubs**

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 from the Waynetrepreneurs/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 (DENCAP Dental) ☐

Would you like online access to your account? ☐ Yes ☐ No

How did you hear about us? _____

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Employer Enrollment Guide

Employee Enrollment (Required Information)

1. All enrollment information must be submitted on or before the 15th of the month 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 more than 90 days must enroll when the company starts coverage, have a qualifying event within 60 days, or wait until the next HealthChoice open enrollment period. (Starting every October with eligible employees effective the upcoming January)
3. Be without any other type of health care; Medicaid, State Spenddown, BCBS, HAP etc. upon acceptance into the HealthChoice of Michigan Plan.
4. Two (2) consecutive printed payroll stubs issued within the last two (2) pay periods or an employer's most recent quarterly wage/tax report will be accepted. Voided checks are not acceptable.
5. A copy of the employees State of Michigan driver's license or State identification.

Spouse/Dependent Enrollment (Required Information)

1. A HealthChoice Subscriber Application Form must be completed with spouse/dependent information.
2. If enrolling a spouse, a marriage certificate must accompany the application. (WITHIN 60 DAYS OF marriage)
3. If enrolling a dependent a birth certificate, adoption certificate, or court ordered document of legal custody must accompany the application. (WITHIN 60 DAYS OF BIRTH)

Add and/or Change

1. All requests for changes to employee information (address, name, etc.) must be on a HealthChoice Subscriber Application Form and submitted by the 15th of the month to be processed for the following month.

Disenrollment/Termination

1. All termination information must be submitted on a HealthChoice Subscriber Application Form on or before the 15th of the month to be processed for the following month.
2. Cross off the name of the member on the current invoice and subtract their payment from the invoice.

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WAYNETREPRENEURS

Waynetrepreneurs Program Agreement (if applying)

Business Name: _____

The intent of this Agreement is to establish between the parties the criteria, terms, and enrollment under which the Waynetrepeneurs Program will operate.

Eligibility Criteria

- Any new small business incorporated or opened for business January 1, 2024, or after, located in Wayne County that qualifies for HealthChoice's small business coverage is eligible for the Waynetrepreneurs program.
- The Business owner or employee/s including spouse and legal dependents of a new small business located in Wayne County, are eligible for coverage under the Program.
- The business must have at least 2 full-time employees during the Covered Period.
- Employee/s must be employed by the business during the Covered Period unless otherwise required by law.
- The business must not have more than 50 Full Time employees at the time of application.
- The business and/or employees are ineligible if they have previously been enrolled with HealthChoice.
- Plan Participant must not be enrolled in other health coverage.
- The business must commit to stay with HealthChoice for an additional 9 consecutive months following Program participation for a total of 12 months.
- The business must remain open and operational for the duration of the Covered Period.
- This Program may be adjusted to comply with any applicable law, rule, or regulation.

Enrollment

- Enrollment will occur on the 1st of the next month after the application has been submitted & approved as outlined in Plan Guidelines.
- The 3 months of free premiums that businesses receive is based on the coverage that they elect during enrollment. Coverage cannot be changed during the first 3 months. There are no restrictions on the HealthChoice Plan/riders that the business may choose at enrollment.
- HealthChoice will credit the amount of the covered premiums against the cost of the program. There will be no disbursement of Program Funds to the business.
- Businesses will not be allowed to add individuals to the program once enrolled unless a Qualifying Event occurs.
    - A Qualifying Event is a life event that triggers a special enrollment period for an individual or family to enroll in health insurance outside the regular annual open enrollment period. Examples of life events that would qualify are birth or adoption of a child; marriage; loss of other health coverage due to legal separation, divorce, cessation of dependent care status, death of employee, or termination of employment.
- "First Come First Served" – based on availability of funds.

COMPANY REPRESENTATIVE

By (Print): _____ Signature: _____

Title: _____ Date: _____

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 always 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 based on 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 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 always 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 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 based on 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#_____