The Hartford's Group Retiree Health Plan Group Application Form

Through The Hartford Employer Group Insurance Trust (HEGIT) Program

The undersigned employer requests retiree medical coverage under The Hartford's GRIP, SMIP or Medicare Supplement Plans (refer to Plan Designs and Rates for specifics).

Employer Name: City of Manitowoc (herein referred to as the Participating Firm)

Address: 900 Quay Street Manitowoc, WI 54220

Employer Identification Number (EDI): _____

Requested Coverage Effective Date: July 1, 2014

Employer's Contribution: 0% towards the cost of the premium for Retirees
0% towards the cost of the premium for Dependents

Do you consider this plan to be an ERISA Plan: ☐ yes ☒ no
If yes, will you be requesting a Schedule A Form 5500? ☐ yes ☐ no
If yes, when (date) will you be requesting it _____

Eligible Insured (please choose all that apply):

Class	Description of Class
I ☒	Retirees only, of the Participating Firm who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over.)
II ☒	Retirees and their Eligible Dependents who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over). Eligible Dependents are as follows: ☒ Spouse ☐ Domestic Partner
III ☒	All Retirees of the Participating Firm under age 65 are not eligible for coverage under this policy, but they may enroll their Eligible Dependents who are entitled to Medicare benefits by Reasons of Age.
IV ☐	All widow or widowers who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over) whose deceased spouse was an active employee of the Participating Firm.

Coverage is **not** available to persons under age 65 who are Medicare disabled.

The Hartford's Group Retiree Health Plan Group Application Form (cont'd)

Through The Hartford Employer Group Insurance Trust (HEGIT) Program

Plan Design(s) & Rate(s)

Plan Design and rates available in most states; refer to proposal document for details and exceptions:

☒ Silver Plan: $ Age Banded Rates as reflected in the proposal

Premium and /or benefit adjustments for the **Silver** Plan will occur on January 1st of each year.

The PARTCIPATING FIRM agrees to the following:

- Agrees that they will be joining a Trust;
- The Minimum Participation required to put the policy in force is 2 lives;
- The Maximum number of lives is 250;
- The Hartford plan(s) may be the only Group plan(s) sponsored by the Participating Firm;
- There no other competing group insurance plans and that The Hartford medical and prescription drug plan options will be the only options available to the firm's eligible retirees and their eligible dependents;
- The Hartford must review and approve all announcement letters and/or solicitation materials prior to their release (other than those set up for the HEGIT Program); and
- Claim experience is pooled together with all of the other Participating Firms under the Trust.

The Hartford's Group Retiree Health Plan Group Application Form (cont'd)
Through The Hartford Employer Group Insurance Trust (HEGIT) Program

Responsibilities

Please complete any additional information that is being requested in the spaces that are provided. Any incomplete information could result in the delay of the policy effective date and/or the materials that are needed.

Billing

Type: **Direct Bill**

Mode: **Monthly**

Billing Performed by: **The Hartford's Approved Billing Administrator**

Bill sent to: **N/A**

Primary Contact for Billing:
Name: **N/A**

Address: **N/A**

Phone Number: ( ) - E-Mail Address: @

Claims

Claims Paid by: **The Hartford's Approved Claims Administrator**

Eligibility

Duties Performed by: **The Hartford's Approved Enrollment Administrator**

Verify Eligibility: _____

Provide Eligibility to The Hartford: _____

Maintain Eligibility: _____

Primary Contact for Eligibility

Name: _____

Address: _____

Phone Number: ( ) - E-Mail Address: @

The Hartford's Group Retiree Health Plan Group Application Form (cont'd)
Through The Hartford Employer Group Insurance Trust (HEGIT) Program

Enrollment

Duties Performed by: **The Hartford's Enrollment Administrator**

Number of Plans Offered: ☒ One (1) Plan to Retiree ☒ & Dependent Spouse

Type of Enrollment: ☒ Auto-enroll Retirees
☐ True voluntary for Retirees

Agent of Record:
Agent Name and Address: (Please print or Type)

M3 Insurance Solutions, Inc.

Nancy Cirra, Account Executive

N19 W24200 Riverwood Drive #140 Waukesha, WI 53188

Sub-Agent of Record:
Sub-Agent Name and Address: (Please print or Type)

____

____

Participating Firm Name and Signature

Name: (Please print or type) _______City of Manitowoc__________________________

Signed____

Title____________________ Date__________________________

Licensed Producer*

Name (Print): ____________________________

Signature: ____________________________

Date: ____________________________

* *For Illinois sitused Policies – Producer must sign the Group Application*

Please see the enclosure for important information on disclosure

Group Benefits Disclosure Notice

The Hartford compensates both internal and external producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions regarding your insurance producer's compensation directly to your insurance producer. For specific questions on The Hartford's internal producers, please contact our Customer Service 800 number (800-523-2233).

SilverScript Prescription Drug Plan (PDP) Application Form

For coverage issued through The Hartford

Participating Firm Name: City of Manitowoc **Policy Effective Date:** July 1, 2014

Enrollment	
Number of Eligible members for PDP	20
Employer Contribution Amount for PDP	$_____ or 0 % towards cost of ☐ Retiree only or ☒ Retiree & Dependent
Medical & PDP offered as combined coverage?	☒ Yes ☐ No
Additional Employer eligibility requirements for PDP?	☐ Yes ☒ No If yes, explain:
Is there an Annual Enrollment Period for coverage selection?	☐ Yes ☒ No If yes, what period:

Sold PDP Plan Design & Rate **(Plan Designs and rates available in all states.)**

Monthly Rate per person: $ 161.00 (TPA admin fee is included)

Standard Medicare Part D Prescription Drug Plans

☐ Sapphire **X** Sapphire Enriched ☐ Topaz Enriched

Special Instructions/ Notes:

Formulary

Sold Formulary	Platinum

Creditable Coverage

Was previous prescription drug plan considered Creditable Coverage? ☒ Yes ☐ No

If yes, please include letter of Creditable Coverage, If previous plan was not creditable members may be assessed a late enrollment penalty mandated by the Centers for Medicare & Medicaid Services (CMS).

Late Enrollment Penalty

Employer/Policyholder hereby represents and warrants the following to SilverScript Insurance Company ("SSIC")

All individuals Employer will group enroll in the SilverScript plan for the 2014 plan year do not and will not meet the requirements for imposition of the late enrollment penalty (LEP) under 42 CFR §423.36(a). A LEP should not be assessed against these enrollees based on the fact that each such enrollee had creditable coverage (as defined in 42 CFR §423.36(a)) through a plan sponsored by the Employer continuously since the Part D Initial Enrollment Period (IEP) for that individual, or for those individuals who did not have such continuous coverage, that any gaps in such coverage since the enrollee's IEP were for less than 63 continuous days each, up to the proposed effective date of enrollment in SSIC.

Will Employer/Policyholder attest to creditable coverage? ☒ Yes ☐ No

If not, who will be responsible for paying the penalty? ☐ Employer ☐ Retiree

Employer Name and Signature

Name: (Please print or type)______City of Manitowoc____________________

Signed____