Employer Medical Plan Selection Form

Save this form to your computer before filling out

Version 4.4.14

EMPLOYER INFORMATION

COMPANY NAME:	**DOING BUSINESS AS:**
COMPANY ADDRESS:	
CONTACT NAME:	**CONTACT PHONE:**
CONTACT E-MAIL ADDRESS:	
BROKER NAME (if applicable):	**BROKER PHONE:**
BROKER E-MAIL ADDRESS:	**BROKER NATIONAL PRODUCER NUMBER (NPN):**

EMPLOYER PLAN

PLAN EFFECTIVE DATE (MM/DD/Year):	**Waiting Period:** ☐No Waiting ☐30 Days ☐60 Days	**NEW HIRE EFFECTIVE DATE** (COVERAGE START DATE): ☐First of the month after waiting period ends ☐On new hire date
EMPLOYER CONTRIBUTION - EMPLOYEES (%):		**EMPLOYER CONTRIBUTION - DEPENDENTS (%):**

HOW MANY HOURS PER WEEK DO YOU REQUIRE EMPLOYEES TO WORK IN ORDER TO BE DETERMINED FULL-TIME AND ELIGIBLE FOR HEALTH PLAN COVERAGE?

Eligibility to participate in MNsure requires you offer all employees working a minimum of 30 hours per week the opportunity to purchase one of your employer sponsored plans. **PLEASE CONFIRM THAT YOU OFFER COVERAGE TO ALL EMPLOYEES WORKING 30 OR MORE HOURS EACH WEEK** ☐ Yes ☐ No

REFERENCE PLAN - Must be provided when more than one plan is being offered

PLAN NAME (If you are offering more than one plan, please choose a Reference Plan)**:**

PLANS BY LOCATION (OPTIONAL)*

LOCATION NAME:	**ZIP CODE:**	**PLAN NAME(S):**
LOCATION NAME:	**ZIP CODE:**	**PLAN NAME(S):**

PLANS BY CLASS (OPTIONAL)*

CLASS NAME: ☐Part-Time ☐Full-Time ☐Disabled ☐COBRA ☐Retired ☐Administration ☐Bargaining ☐Executive ☐Exempt ☐Highly Compensated ☐Hourly ☐Key-Employee ☐Management ☐Non-Administration ☐Non-Bargaining ☐Non-Executive ☐Non-Exempt ☐Non-Management ☐Non-Union ☐Owner ☐President ☐Salaried ☐Union ☐Vice Pres.	**PLAN NAME(S):**
CLASS NAME: ☐Part-Time ☐Full-Time ☐Disabled ☐COBRA ☐Retired ☐Administration ☐Bargaining ☐Executive ☐Exempt ☐Highly Compensated ☐Hourly ☐Key-Employee ☐Management ☐Non-Administration ☐Non-Bargaining ☐Non-Executive ☐Non-Exempt ☐Non-Management ☐Non-Union ☐Owner ☐President ☐Salaried ☐Union ☐Vice Pres.	**PLAN NAME(S):**

*If no Locations or Classes are selected, all of your plan selections are available to your employees.

Select your medical plan option. Please ☒ check all plans being offered. See [service areas for each provider](#).
(Make sure the plan you select is offered in the county in which your business is located.)

MEDICAL PLAN OPTIONS	
BCBS-Allina Health Network	**PreferredOne -Choice Network**
☐ Silver: BluePrint 2000/0/20 (AABH)	☐ Bronze: B1 Choice 3000.60 D
☐ Gold: BluePrint 1500/0/20 (AABK)	☐ Bronze: B2 Choice 3250.60 D
☐ Platinum: BluePrint 1000/0/0 (AABM)	☐ Silver: S1 Choice 2000.75.50 D
BCBS-Aware Network	☐ Silver: S2 Choice 1250.75 D
☐ Bronze: BlueAccess HSA 5350/0/0 (AAB1)	☐ Silver: S3 Choice 1500.80 D
☐ Bronze: BlueAccess HSA 3250/0/20 (AAB2)	☐ Silver: S4 Choice 2000.75 D
☐ Bronze: BlueAccess HSA 4500/0/0 (AAB3)	☐ Silver: S5 Choice 2000.80 D
☐ Silver: BlueAccess 2000/45/25 (AAB4)	☐ Silver: S6 Choice 2000.80 D
☐ Silver: BlueAccess HRA 2000/0/20 (AAB5)	☐ Gold: G1 Choice 500.70.40 D
☐ Silver: BlueAccess HSA 1650/0/20 (AAB6)	☐ Gold: G2 Choice 750.80.30 D
☐ Silver: BlueAccess HSA 2000/0/20 (AAB7)	☐ Gold: G3 Choice 1000.80.30 D
☐ Silver: BlueAccess HSA 2650/0/0 (AAB8)	☐ Gold: G4 Choice 1500.75.25 D
☐ Gold: BlueAccess 1000/25/20 (AAB9)	☐ Gold: G5 Choice 1500.80 D
☐ Gold: BlueAccess 1000/40/20 (AABA)	☐ Gold: G6 Choice 1750.100 D
☐ Gold: BlueAccess HSA 1250/0/10 (AABB)	☐ Gold: G8 Choice 2000.100 D
☐ Gold: BlueAccess HSA 1500/0/0 (AABC)	☐ Platinum: PL1 Choice750.100 D
☐ Gold: BlueAccess HRA 1000/0/20 (AABD)	**PreferredOne -Select Network**
☐ Gold: Blue Access HSA 1850/0/0 (AABE)	☐ Bronze: B1 Select 3000.60 D
☐Platinum: BlueAccess 0/25/10 (AABF)	☐ Bronze: B2 Select 3250.60 D
☐Platinum: BlueAccess 500/0/20 (AABG)	☐ Silver: S1 Select 2000.75.50 D
BCBS-Consumer Value Network	☐ Silver: S2 Select 1250.75 D
☐ Bronze: BlueBasic HSA 5350/0/0 (AABP)	☐ Silver: S3 Select 1500.80 D
☐ Silver: BlueBasic 2000/45/20 (AABQ)	☐ Silver: S4 Select 2000.75 D
☐ Silver: BlueBasic 2000/55/30 (AABR)	☐ Silver: S5 Select 2000.80 D
BCBS-Sanford Health Network	☐ Silver: S6 Select 2000.80 D
☐ Silver: BlueConnect Sanford Health 2000/0/20 (AABJ)	☐ Gold: G1 Select 500.70.40 D
☐ Gold: BlueConnect Sanford Health 1500/0/20 (AABL)	☐ Gold: G2 Select 750.80.30 D
☐ Platinum: BlueConnect Sanford Health 1000/0/0 (AABN)	☐ Gold: G3 Select 1000.80.30 D
Medica -Elect Network	☐ Gold: G4 Select 1500.75.25 D
☐ Bronze: Medica Elect MN 4950-50% HSA Bronze	☐ Gold: G5 Select 1500.80 D
☐ Silver: Medica Elect MN 1750-25% HSA Silver	☐ Gold: G6 Select 1750.100 D
☐ Gold: Medica Elect MN 1300-20% HSA Gold	☐ Gold: G8 Select 2000.100 D
Medica -Essential Network	☐ Platinum: PL1 Select 750.100 D
☐ Bronze: Medica Essential MN 4950-50% HSA Bronze	
☐ Silver: Medica Essential MN 1750-25% HSA Silver	
☐ Gold: Medica Essential MN 1300-20% HSA Gold	

I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I intentionally provide false information. I acknowledge these are the medical plans I am selecting.

SIGNATURE	
PRINT EMPLOYER NAME:	
EMPLOYER SIGNATURE:	**DATE SIGNED: (MM/DD/YEAR):**

OR

Mail completed original form to:

MNsure SHOP
P.O. Box 64246
St. Paul, MN 55164-0246

1. Scan this form and your application.
2. Convert it to PDF format.
3. Reply *only* to the secure e-mail you received from MNsure SHOP to send your attachments.