

WISCONSIN BADGERCARE PLUS EMPLOYER VERIFICATION OF HEALTH INSURANCE

If you have questions about completing this form, please call 1-866-710-2026. Thank you for your cooperation.

Please return this completed form to: Department of Health Services, EVHI Unit, PO Box 6530, Suite 100, Madison, WI 53716, or fax to (608) 222-4523.

SECTION 1 – BASIC INFORMATION

Please provide the basic information about you, the employer. Your FEIN is a mandatory field and accuracy is extremely important. A separate form must be completed for each FEIN you have. You may make a copy of this form or you can get a copy at dhfs.wisconsin.gov/forms/DHCF/HCF10181.pdf.

Employer Name			Telephone
Employer Address			Fax Number
City	State	Zip Code	FEIN

SECTION 2 – DOING BUSINESS AS (if different than Section 1)

If your business is operating under more than one name, provide business names and addresses for the FEIN listed in Section 1.

Employer Name			
Employer Address	City	State	Zip Code

Employer Name			
Employer Address	City	State	Zip Code

Employer Name			
Employer Address	City	State	Zip Code

SECTION 3 – CONTACT INFORMATION

Please tell us who we should contact, if we have questions about the information you provided on this form.

Name		Job Title	Telephone	
Address			Fax Number	
City	State	Zip Code	Email Address	
Which method do you prefer? <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Telephone <input type="checkbox"/> Fax				
Preferred Time of Contact:				
<input type="checkbox"/> Early Morning	<input type="checkbox"/> Morning	<input type="checkbox"/> Late Morning	<input type="checkbox"/> Early Afternoon	<input type="checkbox"/> Afternoon
<input type="checkbox"/> Late Afternoon	<input type="checkbox"/> Early Evening	<input type="checkbox"/> Evening	<input type="checkbox"/> Late Evening	<input type="checkbox"/> Any time

SECTION 4 – ADDITIONAL EMPLOYER INFORMATION

Provide additional information including your Wisconsin Employer Identification Number and business email (if available).

Wisconsin State Employer Number	Business Email	Number of Employees
		<input type="checkbox"/> 250 and over <input type="checkbox"/> Under 250

SECTION 4a – EMPLOYER COMMENTS

Indicate any comments or additional information you wish to provide in the space below. For example, if you offer health insurance coverage outside of your open enrollment period, tell us which qualifying events may give an employee a special enrollment period. If you are self-insured or offer separate dental and/or vision plans, provide that information.

SECTION 5A – HEALTH INSURANCE SUMMARY

Check “yes” or “no” as it applies to your business. If you do not offer major medical health insurance coverage to any of your employees, please indicate “no” and return the form. By major medical, we mean a plan that covers doctor visits, not catastrophic coverage or Health Savings Accounts. For any question to which you answer “yes”, indicate the dates the coverage is available or the dates of the open enrollment period to sign up for the coverage.

Do you provide access to major medical health insurance to any of your employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coverage Dates	Begin Date	End Date
Did you have an open enrollment period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enrollment Period	Begin Date	End Date
Do your employees have access to the State employees' health insurance plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION 5B – PREMIUM DETAILS

In this section, tell us to which groups you offer coverage (“employee only”, “employee and spouse”, and/or “employee and family”). For each group you cover, provide the total premium amount and the amount you contribute for the plan. Remember to use the plan for which you pay the highest percentage toward the premium cost. Check the box that describes how often the premiums are paid (weekly, bi-weekly, monthly, or yearly). If you offer family coverage, check the box for each family member covered under this plan.

Check all the categories of coverage you provide	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Family
If provided, what is the total premium for each?	Employee Only \$	Employee and Spouse \$	Family \$
What is the premium amount paid by employer?	Employee Only \$	Employee and Spouse \$	Family \$
How often are premiums paid?	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
Does a domestic partner have the same eligibility as a spouse for employee plus spouse coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Under family coverage, which family members are covered?	<input type="checkbox"/> Children <input type="checkbox"/> Siblings	<input type="checkbox"/> Step-children <input type="checkbox"/> Nieces/Nephews	<input type="checkbox"/> Grandchildren <input type="checkbox"/> Aunts/Uncles <input type="checkbox"/> Spouse <input type="checkbox"/> Parents <input type="checkbox"/> Domestic Partners

SECTION 5C – ELIGIBLE EMPLOYEES

Please tell us which of your employees are eligible to sign up for the plans identified in Section 5. Examples:

- Permanent employees working at least 20 hours/week and employed for 3 months.
- All managers regardless of scheduled hours or start date.
- Temporary employees working 30 hours each week and employed for 6 months.

Each of these examples would be a separate group. If you have more than four groups with different criteria for eligibility for health insurance access, please copy this section or go to dhfs.wisconsin.gov/forms/DHCF/HCF10181.pdf to get a copy of this form as needed and attach it to your completed form.

	Employee Type	Number of Hours Must Work Per Week	Job Title	Length of Service Required for Enrollment	Once eligible, how long to enroll?	Once Enrolled, when will coverage start?
Group 1	<input type="checkbox"/> Any <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Any _____ hours _____ hours	<input type="checkbox"/> Any <input type="checkbox"/> Manager <input type="checkbox"/> Staff	_____ Days _____ Months _____ Hours	_____ Days _____ Months	<input type="checkbox"/> In Enrollment Month <input type="checkbox"/> Month Following Enrollment <input type="checkbox"/> 2 Months From Enrollment <input type="checkbox"/> 3 Months From Enrollment _____ Months From Enrollment
Group 2	<input type="checkbox"/> Any <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Any _____ hours _____ hours	<input type="checkbox"/> Any <input type="checkbox"/> Manager <input type="checkbox"/> Staff	_____ Days _____ Months _____ Hours	_____ Days _____ Months	<input type="checkbox"/> In Enrollment Month <input type="checkbox"/> Month Following Enrollment <input type="checkbox"/> 2 Months From Enrollment <input type="checkbox"/> 3 Months From Enrollment _____ Months From Enrollment
Group 3	<input type="checkbox"/> Any <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Any _____ hours _____ hours	<input type="checkbox"/> Any <input type="checkbox"/> Manager <input type="checkbox"/> Staff	_____ Days _____ Months _____ Hours	_____ Days _____ Months	<input type="checkbox"/> In Enrollment Month <input type="checkbox"/> Month Following Enrollment <input type="checkbox"/> 2 Months From Enrollment <input type="checkbox"/> 3 Months From Enrollment _____ Months From Enrollment
Group 4	<input type="checkbox"/> Any <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Any _____ hours _____ hours	<input type="checkbox"/> Any <input type="checkbox"/> Manager <input type="checkbox"/> Staff	_____ Days _____ Months _____ Hours	_____ Days _____ Months	<input type="checkbox"/> In Enrollment Month <input type="checkbox"/> Month Following Enrollment <input type="checkbox"/> 2 Months From Enrollment <input type="checkbox"/> 3 Months From Enrollment _____ Months From Enrollment