



Employer Subsidy Application

You and your employees may be eligible for the Health Insurance Partnership, which provides a premium subsidy from the State of Maryland to help small businesses insure their employees. The subsidy will be provided to your business in the form of a reduction in your health insurance premium. If your employees pay part of the premium, you will pass part of the subsidy through to them in the form of lower payroll deductions for the health insurance.

A complete application includes this Employer Subsidy Application, an Employee Subsidy Application from each full-time employee who may be covered by the policy, and a Producer Affirmation completed by your insurance agent or broker.

The Health Insurance Partnership is administered by the Maryland Health Care Commission.

Part I: Information about the Business

Federal Employer Identification Number _____
 Maryland Central Registration Number _____

Name of business: _____
 Address: _____

City: _____ State: _____ ZIP: _____

Contact name: _____
 Telephone: _____ Fax: _____
 Email: _____

Part IA: Employer Contribution to Premiums and to Health Savings Accounts

This information is necessary to calculate the employer and employee subsidy amounts. Please complete when you have selected the plans you will offer and the amounts you will contribute toward coverage.

Type of coverage	Health plan Product ID:			Health Plan Product ID:		
	Annual Premium (before subsidy)	Employer Contribution to premium (before subsidy)	Employer contribution to HSA (before subsidy)	Annual Premium (before subsidy)	Employer Contribution to premium (before subsidy)	Employer contribution to HSA (before subsidy)
Employee						
Employee/Child(ren)						
Employee/Spouse						
Family						



Part II: Employee Information

Please list all eligible employees, whether or not they will be insured. An eligible employee is someone who has a normal work week of 30 or more hours at the business, and is not a temporary, seasonal or substitute employee. An owner, partner, or spouse of an owner or partner must be included if they work more than 30 hours a week at the business. Independent contractors who are eligible for the employer's health benefit plan must be counted if they work more than 30 hours a week.

For employees with significant income from tips, report income as you would on the quarterly wage report. (A representative quarterly wage from the DLLR report can be used, if it reflects the likely work week over the coming year).

Information from employer: (Employer affirmation applies only to this information)										Information from employee applications:			Choice of health plan:		
Employee Name (First MI. Last)	SSN	DOB	Status	Wages per wage period	Wage period	Hours per week	Calculated annual wage (\$) <small>(see instructions for owner/spouse)</small>	Wages from most recent Quarterly Wage Report	Eligible for subsidy for dependent coverage	Previous insurance (past 3 mos.)			Type of coverage	Plan chosen by employee (product ID)	Total # of covered lives
										Employee	Spouse	Children			
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															

Instructions for owner/partner/spouse:

For purposes of this application, an Owner is anyone with at least a 20% ownership interest in the business. A spouse of an owner is treated the same as an owner. In calculating the average wage of the business, for each owner or spouse who is listed on the application as a full-time employee, list either the person's adjusted gross income (AGI) or \$60,000, whichever is lower.

If the person is single, use the AGI from the most recent individual federal income tax return.

If the person is married and files a separate return, use the AGI from the most recent individual federal income tax return.

If the person is married and files a joint return, use 50% of the AGI on the couple's most recent joint federal income tax return.

Status:

F=Full-time employee

O=Owner/partner

S=Spouse of owner/partner

Wage Period:

A=Annual

Q=Quarterly

M=Monthly

B=Bi-Weekly

W=Weekly

H=Hourly

Average annual wage of business = average of the annual wages in this column

Eligible:

Enter "Yes" if employee signed family income attestation

Previous Insurance:

0=Not insured in past 3 months

1=Yes, from this employer

2=Yes, at another job

3=Yes, spouse's employer

4=Yes, Medicaid or HealthChoice

5=Yes, Medicare

6=Yes, MHIP

7=Yes, Non MHIP Individual policy

Type of Coverage:

E=Employee

EC=Employee + Child(ren)

ES=Employee + Spouse

F=Family

W=Waived or in Waiting Period

Name of Business _____

Part III: Affirmations

By placing my initials next to each provision, I affirm that:

_____ I have the authority to act on behalf of this business entity.

_____ This business entity has been actively engaged in business in the state of Maryland for at least 12 months and (initial which of the following applies):

_____ has filed at least three quarterly wage reports with the Department of Labor, Licensing, and Regulation (DLLR). I give consent to DLLR to release this business entity’s wage and employer reports to the Maryland Health Care Commission for the purpose of determining eligibility for this subsidy; or

_____ is not required to file Quarterly Wage Reports with DLLR.

_____ Employees of any affiliated business have been included in this application, for purposes of determining eligibility for the subsidy. Affiliated businesses are businesses eligible to file a single tax return.

_____ This business employs at least two but not more than nine eligible employees both at the time of initial application and on at least fifty percent (50%) of its working days during the preceding calendar quarter. An eligible employee is an individual who has a normal work week of at least 30 hours and who is not a seasonal, temporary, or substitute employee. An owner, partner, or spouse of an owner or partner who works more than 30 hours a week at the business must be included as an eligible employee. Independent contractors who are eligible for the employer’s health benefit plan must be counted as employees if they work 30 or more hours a week at the business.

_____ The majority of eligible employees in this business work in Maryland.

_____ This business has not offered a health benefit plan to its employees in the most recent 12 months.

_____ The average annual wage of eligible employees calculated in Part II is less than \$50,000.

_____ I will pass through to each employee the employee’s share of the premium subsidy from the State of Maryland in the form of payroll deductions for the health insurance plan.

_____ If this business is claiming a subsidy for contributions to employees’ Health Savings Accounts, I will make those contributions on a monthly basis.

_____ Within 60 days, I will establish a Section 125 premium only plan (POP) or a more comprehensive Section 125 cafeteria plan.

_____ I understand that the Maryland Health Care Commission may employ an auditor to examine business records to assure the accuracy of statements made in this application and I will cooperate fully with any such audit.

Waiver of Remedies and Affidavit

On behalf of the business entity named in this application and upon whose authority I am acting, I hereby waive any and all claims or causes of action against the State of Maryland, its subdivisions, or its agents which said business entity, including its parents, subsidiaries, predecessors, affiliates, successors, and assigns, may have by reason related in any way to the Health Insurance Partnership. I understand that the Health Insurance Partnership provides a premium subsidy to assist in the purchase of health insurance, but has no role in providing the health insurance itself. Any questions about the insurance and all appeals of carrier decisions are handled exclusively by the carrier and, if necessary, by the Maryland Insurance Administration.

On behalf of the business entity named in this application, I acknowledge that I have read the foregoing provisions and affirmations in this application and understand and agree to them in their entirety. I solemnly affirm under the penalties of perjury that the contents of the foregoing application and the attached documentation are true to the best of my knowledge, information, and belief.

Signature

Date

Print Name

Title



Employee Subsidy Application

Employee's Name: _____

Name of Business: _____

You and your employer may be eligible for the Health Insurance Partnership, which provides a health insurance premium subsidy to certain small businesses who have not offered insurance in the past year. Your employer receives a subsidy in the form of lower premiums for health insurance. If you pay part of the cost of the insurance, your employer will pass part of the subsidy through to you in the form of lower payroll deductions for the insurance.

Subsidies are available for employee only coverage and for different types of family coverage. You will receive information from your employer about your health plan options and what each health plan will cost after the subsidy is applied.

The Health Insurance Partnership is administered by the Maryland Health Care Commission. To receive a subsidy, you must complete this application.

Eligibility and Income

Eligibility for a premium subsidy for your own coverage is based on the average wage of all full-time employees in the business, and does not depend on your personal wages or income.

Eligibility for a premium subsidy for coverage of your spouse or children requires that your family adjusted gross income (family AGI) be less than \$75,000.

- If you are a single parent, your family AGI is the Adjusted Gross Income on your last year's federal tax return.
- If you are married and filed a joint tax return last year, your family AGI is the Adjusted Gross Income on last year's joint federal tax return.
- If you are married and you and your spouse filed separate returns, your family AGI is equal to the Adjusted Gross Income on your last year's federal tax return plus the Adjusted Gross Income on your spouse's last year's federal tax return.

If you are eligible and wish to apply for a premium subsidy for coverage of your spouse or children, you must complete the following affidavit. Signing the affidavit does not commit you to include spouse or child coverage, but should you choose to do so, it will allow the State to provide a larger premium subsidy.

Affidavit: I solemnly affirm under penalties of perjury that I have reviewed my family's federal tax returns for last year and my family AGI is less than \$75,000.
 I understand that the Maryland Health Care Commission may later request a copy of my federal tax return as verification of my family AGI and I agree to fully cooperate with that request.

Signature: _____

Address: _____

City: _____ State: ___ ZIP: _____

Health Savings Accounts

If your employer elects to make a contribution to a qualified Health Savings Account (HSA) that was established in conjunction with a high-deductible health plan, the employer’s contribution is eligible for a subsidy. In order for the Commission to confirm that your employer made those contributions, you must authorize the financial institution administering your HSA to release information about those deposits. Your signature at the end of this application authorizes the financial institution to release this information to the Commission.

Health insurance coverage in the last 3 months

In an effort to effectively evaluate the Health Insurance Partnership, the Commission would like to know if you or any family member has had health insurance coverage in the last 3 months. Please check the appropriate boxes for you and your dependents, if any. **Reporting this coverage does not in any way affect your eligibility for health insurance or the premium subsidy.**

	Myself	My spouse	My children
Not insured during the past 3 months			
Insurance through another employer			
Insurance through spouse’s employer			
Medicaid, HealthChoice, Medical Assistance, Maryland Children’s Health Insurance Program, or Primary Adult Care			
Medicare			
MHIP policy (Maryland Health Insurance Plan)			
Individual policy (purchased directly from a broker or an insurance company)			

Section 125 Premium Conversion Plan

If you pay any part of the health insurance premium, your employer is required to offer a Section 125 Premium Conversion Plan that allows you to pay your health insurance premium with salary that is excluded from both income and FICA taxes. Your employer must establish the Section 125 plan within 60 days of joining the Partnership.

Waiver of Remedies and Affidavit

I waive any and all claims or causes of action against the State of Maryland, its subdivisions, or its agents which I or any of my dependents may have by reason related in any way to the Health Insurance Partnership. I understand that the Health Insurance Partnership provides a subsidy to assist in the purchase of health insurance, but has no role in providing the health insurance itself. Any questions about the insurance and all appeals of carrier decisions are handled exclusively by the carrier and, if necessary, by the Maryland Insurance Administration.

I acknowledge that I have read the provisions in this application and understand and agree to them in their entirety.

Employee Signature

Date

Name of Business: _____



Producer Affirmation

I affirm that:

- To the best of my knowledge, this employer is eligible for the Health Insurance Partnership.
- I have reviewed the Employer Subsidy Application and either:
 - the Quarterly Wage Report information entered in Part II of the Employer Subsidy Application is consistent with the information in the employer's most recent Quarterly Wage Report, which I have personally reviewed, or
 - the Employer Subsidy Application includes the affirmation that the business is not required to file Quarterly Wage Reports with DLLR.
- Each health benefit plan selected by the employer includes a wellness benefit.
- I have included with this affirmation:
 - a complete, signed Employer Subsidy Application, and
 - an Employee Subsidy Application for each employee for whom a subsidy may be requested.

I hereby waive any and all claims or causes of action against the State of Maryland, its subdivisions, or its agents which I may have by reason related in any way to the Health Insurance Partnership. I understand that the Health Insurance Partnership provides a premium subsidy to assist in the purchase of health insurance, but has no role in providing the health insurance itself. Any questions about the insurance and all appeals of carrier decisions are handled exclusively by the carrier and, if necessary, by the Maryland Insurance Administration.

I solemnly affirm under the penalties of perjury that the contents of the foregoing applications are true to the best of my knowledge, information, and belief.

Signature

Date

Print Name

Title

Maryland Insurance Producer License Number