Greater Tompkins County Municipal Health Insurance Consortium

408 East Upland Road, Suite 2 • Ithaca, New York 14850 • (607) 274-5590
healthconsortium.net • consortium@tompkins-co.org

"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

New Group Application for Membership

(Upload Application to the Consortium at https://lfweb.tompkins-co.org/Forms/TCHCCForms)

****A Certified Resolution and/or copy of minutes showing approved resolution must also be attached to this application** (See example attached to this application)**

Municipality or District (Town/Village/City/County/School) of: _____

If not a municipality, name of Entity: _____

Contact Information:

Individual Submitting Form:
Name: _____ Title: _____
Email: _____ Phone: _____

Mailing Address: _____
Tax ID # _____ ***PLEASE also include a copy of your W-9***
Billing Address: _____

Main Contact for Health Care Related Information (Benefit Clerk)
Name: _____ Title: _____
Email: _____ Phone: _____

Current Coverage Information *(provide for each plan currently offered):*

Current Insurance Carrier and Plan(s) Name: _____
Please provide a copy of municipality's last premium invoice.

Total # of employees: _____ Total # of employees who are eligible under your health care policy: _____
Total # of contract lives (including subscribers, spouse, domestic partner, dependents): _____

List current premium rates for your health insurance coverage and # of subscribers enrolled in each plan:
Plan Name: _____
Individual Rate: $_____ # of subscribers _____
Subscriber and Spouse Rate: $_____ # of subscribers _____
Subscriber and Children Rate: $_____ # of subscribers _____
Family Rate: $_____ # of subscribers _____

Additional Plan Name: _____
Individual Rate: $_____ # of subscribers _____
Subscriber and Spouse Rate: $_____ # of subscribers _____
Subscriber and Children Rate: $_____ # of subscribers _____
Family Rate: $_____ # of subscribers _____

Is Retiree Coverage Offered: Y/N
If Yes, what type of Retiree Coverage & Carrier: _____
If Yes, do you offer Medicare Advantage or Medicare Supplement Plan (circle each that applies)

Other Benefit Related Information:

(Although we do not provide these services, it is helpful to know what other services you offer.)

Do you contract for an HRA/HSA/FSA?

If Yes, list the coverage and company you contract with: _____

If Yes, how much is funded for the HRA or HSA? _____

Do you provide additional Dental or Vision Insurance?

If Yes, Name of the Insurance Company: _____

Union Groups:

Does your municipality have any Union groups (CSEA, etc.)? Please list Name of each group.

_____

Are there union contracts that set guidelines for your health insurance? **If yes, please provide a copy of the current union contract language.**

Financial Information:

Is the plan an experience-rated or community-rated plan? _____

Please attach the following according to your type of coverage:

- **Community-Rated:** Most recent monthly premium billing statement for <u>each</u> plan from ALL health insurance carriers providing health benefits to all active employees and retirees.
- **Experience-Rated:** Most recent monthly premium billing statement for <u>each</u> plan from ALL health insurance carriers providing health benefits to all active employees and retirees AND a minimum of three (3) years of monthly paid claims (medical and pharmacy separately) data and monthly covered lives counts (Redact any subscriber-specific information before submitting).

New Coverage:

GTCMHIC Plan Coverage Selection:

____ Platinum ____ Gold ____ Silver _____ Bronze _____ Medicare Supplement

(Groups with less than 50 employees must select only one plan, unless reviewed by Executive Director and approved for exception.)

Method of Enrollment: Groups with less than 50 employees will be submitted to GTCMHIC for enrollment through the portal unless previously discussed. Groups with 50+ will enroll online through the Excellus online enrollment process.

By signing this application, I authorize on behalf of the municipality listed above, submission for membership in the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC). I have attached a resolution from our Board with approval to file this application. In addition, once membership is accepted, this municipality recognizes they must submit approval by resolution, sign the GTCMHIC Municipal Cooperative Agreement, and comply with all Participant responsibilities.

_____ _____

Signature **Date**

_____ _____

GTCMHIC Application: Documentation Deadlines*

Date Due:	Documentation Needed:
Preferred by July 1st, but no later than August 1st	Submit a New Group Membership Application along with a resolution approving submittal of the application to join the Greater Tompkins County Municipal Health Insurance Consortium with the required financial and operational documents as follows: a. for Municipal Corporations with taxing authority (county, city, town, or village), two years of State Comptroller AUD reports; or b. for Municipal Corporations without taxing authority: i. five years of audited financial statements. ii. internal governance documents and/or rules such as bylaws, resolutions, and/or statutes creating the Municipal Corporation; and iii. financial documents confirming funding sources, funding mechanisms, account balances, assets, investments, contractual obligations, and any debts, contingent liabilities, and/or lawsuits. iv. Copy of your municipality's W-9 - Municipal Corporations that are currently experienced-rated or operate a self-insured employer-sponsored health insurance plan must submit a minimum of 3 years monthly paid claims (medical and pharmacy separately) data and monthly covered lives counts.
Between October 1-December 1st	**Upon notification** that the GTCMHIC Board of Directors has approved the Municipal Corporation's application to become a Participant in the GTCMHIC: - ADOPT municipal resolution approving membership and signature to the Municipal Cooperative Agreement of the GTCMHIC. - SUBMIT Resolution/MCA Signature Page to the Consortium. - SUBMIT Broker/ Carrier Termination Letter to current insurance provider.
By November 1st	Confirm with your current Medical Claims Administrator the names of all employees, retirees, and dependents to be covered in the Consortium's health insurance plans. Complete the GTCMHIC's dependent verification process and forward the updated roster to the GTCMHIC. **a sample roster provided below*
By November 1st	For Municipal Corporations **without taxing authority**, provide the Consortium with a secure financial instrument equal to the value of 25% of the estimated annual premium as determined by the Consortium as protection against expulsion or cancellation due to a default in premium payment. Said financial instrument may include the following: a. A Secured Bank Account; b. Letter of Credit; or c. Surety Bond *Please Note: municipal corporations with taxing authority (county, city, town, villages) will be exempt from this provision.
By December 15th	Provide formal written notification from the governing body of the appointment of the Director and Alternate to the Consortium Board of Directors.
By December 15th	Provide formal written notification from the governing body of the appointment of the Municipal representative to the Joint Committee on Plan Structure and Design.

SAMPLE ROSTER:

First Name	Last Name	Date of Birth	Single or Family Coverage (if Family add Dependent info.)	Plan Enrollment (ie. Platinum, Gold, etc.)	Class ID (A= Active, R= Retired, C= COBRA)	Date of Hire or Date of Retirement
Dependent First Name	Dependent Last Name	Dependent Date of Birth	Subscriber's Name	Plan Enrollment (ie. Platinum, Gold, etc.)	Class ID (A= Active, R= Retired, C= COBRA)	Date of Hire or Date of Retirement

SAMPLE RESOLUTION:

RESOLUTION TO SUBMIT AN APPLICATION TO JOIN THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

WHEREAS, the _____ has performed due diligence for the responsibility it accepts with membership in the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC), now therefore be it

RESOLVED, that the _____ Board hereby directs its officers and appointees to take the following Consortium membership applicant steps:

1. Submit as soon as practicable, but no later than August 1st, a board resolution authorizing application for membership along with the GTCMHIC "New Group Member Application" completed which states the GTCMHIC Health Benefit Insurance Plan or Plans the Municipal Corporation's employees and retirees will be participating in upon the effective date of participation in the GTCMHIC.

2. As soon as practicable, but no later than August 1st, submit the Municipal Corporations' two most recent years of State Comptroller AUD reports.

3. As soon as practicable, but no later than August 1st, submit the Municipal Corporation's most recent monthly premium billing statements from all health insurance carriers providing benefits to all active employees and retirees.

   Said premium billing statements should include the name of the Municipal Corporation and the month for which the billing is related. In addition, said premium bills must include the number of contracts (employee, employee + spouse, employee + child (children), and family) and the monthly premium rate for each plan of benefit.

Further RESOLVED, if the Consortium Board accepts this _____ application, the _____will comply with the following action steps:

4. By October 1st, notify the GTCMHIC of the name and contact information for the person within your organization for benefit administration; and who will attend a new member orientation.

5. Sign the Municipal Cooperative Agreement of the GTCMHIC upon notification that the GTCMHIC Board of Directors has approved the Municipal Corporation's application to become a Participant in the GTCMHIC by October 15th.

6. Confirm by October 15th, the names of all employees, retirees, and dependents to be covered in which Consortium's Health Insurance Plans. (Note: a list of those enrolled will be sent to the Municipal Corporation by the Medical Claims Administrator by no later than November 15th for verification purposes).