



2014 Employer Subsidy Renewal Application

You and your employees may continue to 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.

A complete application includes this Employer Subsidy Renewal Application, an Employee Subsidy Renewal 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 Address: _____

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 is actively engaged in business in the state of Maryland and (initial which applies):
- _____ has filed 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 nineteen eligible employees at the time of renewal. 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.
- _____ 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.
- _____ I have established 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 Renewal Application

You must complete this form if you are requesting a subsidy for coverage of your dependents OR if you were not covered by this employer’s plan last year.

Employee’s Name: _____

You and your employer may continue to be eligible for the Health Insurance Partnership, which provides a health insurance premium subsidy to certain small businesses. 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 individual coverage and 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.

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 designated financial institution administering your HSA to release information about those deposits. Your signature at the end of this application authorizes the designated financial institution to release this information to the Commission.

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



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 Renewal Application and either:
 - the Quarterly Wage Report information entered in Part II of the Employer Subsidy Renewal Application is consistent with the information in the employer's most recent Quarterly Wage Report, which I have personally reviewed, or
 - the Employer Subsidy Renewal 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 Renewal 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