



Checklist and Acknowledgment Employers and Prospective Members of CHC

Employee Health Questionnaire:

- Distribute the Health Questionnaire to all actively working employees/associates (working 20 hours per week or more).
Notice: Based on the response from the May 14th webcast, the eligibility for coverage has been changed to twenty (20) hours per week or one thousand (1,000) hours per year, at the discretion of the Employer (i.e. the entity that joins CHC as a Member).
- Assign a Number to each employee/associate. This helps ensure the confidential nature of the Health Questionnaires. Each employee/associate will insert his/her number in the blank entitled 'Employee #' near the top of the Health Questionnaire.
- Employee/Associate completes Health Questionnaire, including Employee and Dependent Information and Health Information.
- For employees/associates not eligible for proposed health insurance coverage, or, for employees/associates that decline coverage, please instruct them to mark the box entitled 'Waive Coverage' (Questionnaires with the 'Waived Coverage' box checked must be returned to CHC).
- Employees/Associates return Health Questionnaires, including Questionnaires checked with Waived Coverage, to person designated to collect them.

Notice of Privacy Practices and Business Associate Contract:

- Employer/Prospective Member of CHC Reviews Notice of Privacy Practices and Business Associate Contract. Employer signs Business Associate Contract.

Checklist and Acknowledgment:

- Employer/Prospective Member of CHC completes the Checklist and Acknowledgment and returns all documents (Checklist/Acknowledgment, Health Questionnaires, and Business Associate Contract) **by June 19, 2009.**

Mail to:

**Cooperative Health Choices of Western Wisconsin
808 Carmichael Road #298
Hudson, WI 54016**

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Acknowledgment

Organization Name: _____

Main Contact Name: _____ Title: _____

Mailing Address: _____

Street Address (if different): _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ E-mail: _____

Website: _____

Legal Entity: self-employed partnership
for-profit entity: sole proprietor limited liability company limited partnership
 "s" corporation "c" corporation other _____
 non-profit rural utility cooperative trade or labor organization
municipality/public: town village city county school district

Total Number of Employees: _____ Number of Employees Waiving Coverage: _____

Number of Full-time (30 hours per week or more): _____ Number of Part-time (less than 30 hours per week): _____

Location #1 Mailing Address* _____

Street Address (if different): _____

City: _____ State: _____ ZIP Code: _____

Number of Employees at Address #1: _____

Number of Employees at Address #1 Enrolled in Company Insurance Plan: _____

Location #2 Mailing Address* _____

Street Address (if different): _____

City: _____ State: _____ ZIP Code: _____

Number of Employees at Address #2: _____

Number of Employees at Address #2 Enrolled in Company Insurance Plan: _____

If applicable, attached information for each additional location, including: addresses; number of employees; and number of employees enrolled in company insurance plan at each address.

*Within the 17-county geographic area of CHC Cooperative – Ashland, Barron, Bayfield, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Pepin, Pierce, Polk, Price, Rusk, St. Croix, Sawyer, and Washburn counties.

The undersigned, by affixing a signature and date, requests inclusion in a group health insurance rate quote, as arranged through Cooperative Health Choices of Western Wisconsin (CHC). The information contained in the Checklist/Acknowledgment and Health Questionnaire(s) is complete and accurate, to the best of my knowledge.

Signature _____ Date _____