Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt Governor
Judith L. French, Director

Application for a Small Employer Health Care Alliance Certificate of Authority

Product Regulation Division (LH), 50 W Town Street, 3rd Floor - Suite 300, Columbus OH 43215
1-614-644-2658 | 1-614-644-3741 FAX | insurance.ohio.gov

Alliance Name: _____

Application Date: _____ Contact Name: _____

Contact Phone #: _____ Contact E-Mail: _____

Section A: The following information and documentation must be submitted with the application form:		☒
1.	Provide the full legal name of the Alliance (include any alias or DBA), along with the street and/or mailing address, phone and fax numbers, and website address (if applicable).	☐
2.	Describe and document how the Alliance corporate structure, governance, and operations comply with Ohio Revised Code (ORC) section 1731.01(A)(1) and (2). Include:	☐
2(a).	A list of the Directors and Officers of the Alliance.	☐
2(b).	A complete Questionnaire for Directors and Officers, for each Director and Officer of the Alliance (see Attachment 1). *Note: A request for exemption from this requirement may be submitted for consideration from an Alliance applicant that 1) is sponsored by an organization with membership representing a broad spectrum of the business community (e.g., Chambers of Commerce, Better Business Bureau, etc.), and 2) has a Board of Directors consisting of more than 10 members.*	☐
2(c).	A Certificate of Nonprofit Status and Corporate Control (see Attachment 2)	☐
2(d).	A copy of the Alliance or sponsoring organization corporate organizational documents (e.g., Articles of Incorporation or By-laws) and evidence of non-profit incorporation or registration filings with the Ohio Secretary of State (if applicable).	☐
3.	Provide a copy of an Agreement that is in compliance with all applicable requirements of ORC 1731.04, between the Alliance and each insurer.	☐
4.	Provide a copy of any agreement(s) between the Alliance and any other Alliance(s).	☐
5.	State the estimated number of participants (employees, retirees, and eligible dependents), that are initially anticipated to be eligible to obtain coverage under the alliance program health benefit plan(s).	☐
6.	Provide documentation of the processes and requirements applicable to enrollment and renewal of small employers for membership **in the Alliance**, including:	☐
6(a).	Description/documentation of requirements relating to eligibility, participation, and fees.	☐
6(b).	A copy of all forms used by the Alliance or sponsoring organization to solicit, enroll, or administer small employer groups and participants, including, but not limited to, solicitation or advertising materials (including Internet or Website material), applications, and enrollment forms.	☐
7.	Provide information regarding each type of health benefit plan option that is to be offered to participants under the alliance program, including:	☐
7(a).	A brief description of health benefit plan options to be offered.	☐
7(b).	A copy of each policy form document (policies, certificates, applications, etc.), that will be used by the insurer(s), **and** a listing of those form documents that provides the form number, ODI filing number, and ODI approval date for each form.	☐
7(c).	An Insurer Health Plan Forms Certification completed by each insurer (see Attachment 3).	☐
8.	Provide disclosure from each insurer, in accordance with ORC section 1731.09(B)(7), as to whether the small employer members of the Alliance will be underwritten or rated as part of a separate class of business.	☐

Please be advised that all materials submitted are considered public records in accordance with O.R.C. section 149.43. For additional information on the Ohio Small Employer Health Care Alliance Certificate of Authority application process, please contact the Office of Product Regulation and Actuarial Services – Life & Health Division at (614) 644-2644.

ATTACHMENT 1

Small Employer Health Care Alliance
Questionnaire for Directors and Officers

This form must be completed and signed by each Director and Officer of the Small Employer Health Care Alliance and submitted to the Ohio Department of Insurance (ODI) with the Certificate of Authority Application.

Alliance Information:

Name: _____

Address: _____

Please check all that apply to the person completing this questionnaire:

☐ Alliance Director ☐ Alliance Officer / Specify Office(s) Held: _____

Director/Officer Information:

Full Name: _____

Address: _____

Phone No.: _____ Email Address: _____

Please provide complete answers to each of the following questions. If additional space is needed, please attach a separate sheet(s) and reference the applicable question number(s).	
1. Do you have a professional, financial, or familial affiliation with any of the following?	
a) An insurance company, health insuring corporation, or any other person, firm, or corporation that sells insurance,	☐ Yes ☐ No
b) A health care provider,	☐ Yes ☐ No
c) An organization or person representing any of the entities listed in items (a) and (b), including officers, trustees, or directors, or	☐ Yes ☐ No
d) Anyone employed by the Ohio Department of Insurance.	☐ Yes ☐ No
2. If you answered yes to any of items a) through d) of Question 1, please provide the name, address, and a description of the type and scope of your affiliation with each organization or person.	

I hereby certify that the information provided on this questionnaire is true and correct to the best of my knowledge and belief.

Signature: _____ Date: _____

ATTACHMENT 2

Small Employer Health Care Alliance
Certification of Nonprofit Status and Corporate Control

This form must be completed and signed by a Director or authorized Officer of the Small Employer Health Care Alliance and submitted to the Ohio Department of Insurance (ODI) with the Certificate of Authority Application.

Section 1

Small Employer Health Care Alliance Name: _____

Sponsoring Organization: _____

I, _____ , a Director or duly authorized Officer of the Small Employer Health Care Alliance (Alliance applicant) or sponsoring organization named above, do hereby certify that:

In accordance with Ohio Revised Code (ORC) section 1731.01(A)(1)(a) or 1731.01(A)(2), the Alliance applicant named above is a nonprofit corporation or association, or is controlled by one or more nonprofit corporations or associations.

And (Check one below)

☐ In accordance with ORC section 1731.01(A)(1)(d), the Alliance applicant identified above is not directly or indirectly controlled by any insurance company, person, firm or corporation that sells insurance, any provider, or by persons who are officers, trustees, or directors of such enterprises.

Or

☐ In accordance with ORC section 1731.01(A)(1)(e), the Alliance applicant identified above will be comprised of members who are either insurance agents or providers, and controlled by the organization's members or by the organization itself, and elects to offer health insurance exclusively to any or all of the following: (i) Employees and retirees of the organization; (ii) Insurance agents and providers that are members of the organization; (iii) Employees and retirees of the agents or providers specified in division (A)(1)(e)(ii) of the section; (iv) Families and dependents of the employees, providers, agents, and retirees specified in divisions (A)(1)(e)(i), (A)(1)(e)(ii), and (A)(1)(e)(iii) of the section.

Signature: _____ Date: _____

Title: _____

Phone No.: _____ Email Address: _____

Section 2

List and briefly describe all contractual arrangements, not contained in Alliance-Insurer agreement(s) or agreement(s) with another Alliance already provided to the Ohio Department of Insurance, that would relate to or impact operations of the Alliance Program, including, but not limited to, administrative or marketing services agreements, wellness programs, or brokerage agreements.

Section 2 Completed for (Alliance or sponsoring organization name): _____

By:

Signature: _____ Date: _____

Name: _____ Title: _____

Phone No.: _____ Email Address: _____

ATTACHMENT 3

Small Employer Health Care Alliance
Health Plan Insurer Forms Certification

This form must be completed and signed by **each Insurer** that has agreed to provide health benefit plan coverage to members of the Small Employer Health Care Alliance (Alliance) and must be submitted to the Ohio Department of Insurance (ODI) with the Certificate of Authority Application.

Small Employer Health Care Alliance (Alliance) Information:

Alliance Name: _____

Address: _____

Insurer Information:

Insurer Name: _____

Address: _____

I, _____ (Name),

_____ (Title),

a duly authorized representative of _____ (Insurer Name),

certify that all health benefit plan forms and rates, that are required to be filed with the Ohio Department of Insurance (ODI), are now or will be on file at ODI prior to the time such plans or rates are offered to any eligible participant under the Alliance program of _____ (Alliance Name).

Signature: _____ Date: _____

Phone No.: _____ Email Address: _____