Ohio Department of Insurance

Mike DeWine, *Governor*
Jon Husted, *Lt Governor*
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# Renewal 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
614-644-2658 | 614-644-3741 FAX | insurance.ohio.gov

**A completed renewal application must be submitted by each Small Employer Health Care Alliance (Alliance) no later than June 1st of each year.**

Alliance Name: _____ Contact Name: _____

Application Date: _____ Contact E-Mail: _____

Renewal Year: _____ Contact Phone #: _____

| **Section A: The following information and documentation must be submitted annually.** | | ☒ |
|---|---|---|
| 1.(a) | List of Directors and Officers of the Alliance. | ☐ |
| 1.(b) | Questionnaire for Directors and Officers completed by each Director and Officer of the Alliance. (See Attachment 1.)<br>*Note: A request for exemption from this requirement may be submitted for consideration from any Alliance 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) with a Board of Directors consisting of more than 10 members.* | ☐ |
| 2. | A Certification of Nonprofit Status and Corporate Control. (See Attachment 2.) | ☐ |
| 3. | An Insurer Health Plan Forms Certification completed by each insurer. (See Attachment 3.) | ☐ |
| 4. | The number of Participants (employees, retirees, and eligible dependents), broken down by each insurer, who were covered by health benefit plans provided to small employer groups of from 1 to 500, under the alliance program, as of May 1st of the renewal submission year. | ☐ |
| 5. | In accordance with Ohio Revised Code section 1731.09(B)(7), disclosure from each insurer as to whether the small employer members of the Alliance, as defined in Ohio Revised Code section 3924.01, will be underwritten or rated as part of a separate class of business. If so, the required actuarial certification must be provided by the insurer and included with this renewal application. (See Attachment 4.) | ☐ |

| **Section B: Please indicate whether there was any change to the following information or documentation. If so, documentation of the change is required to be submitted with this renewal application.** | | No Change ☒ | Change ☒ |
|---|---|---|---|
| 1. | The full legal name of the Alliance (include any alias or DBA); contact name; street and mailing address; phone and fax numbers; or email address. | ☐ | ☐ |
| 2. | Alliance operations, corporate structure, or governance that relates to or impacts how the organization complies with Ohio Revised Code section 1731.01(A)(1) and (2). | ☐ | ☐ |
| 3. | Alliance or sponsoring organization Articles of Incorporation, By-laws, or other corporate organizational documents (including amendments or Board resolutions). | ☐ | ☐ |
| 4. | Agreement(s) between the Alliance and each insurer providing health coverage to members through the Alliance program. | ☐ | ☐ |
| 5. | Agreement(s) between the Alliance and any other Alliance(s). | ☐ | ☐ |
| 6. | The processes and requirements applicable to enrollment and renewal of small employer groups and participants for membership in the Alliance, including requirements relating to eligibility, participation, and fees. | ☐ | ☐ |
| 7. | Forms used by the Alliance 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. | ☐ | ☐ |

**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 Alliance renewal 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 annually to the Ohio Department of Insurance (ODI) with the Certificate of Authority Renewal 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 annually to the Ohio Department of Insurance (ODI) with the Certificate of Authority Renewal 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) 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 named above is a nonprofit corporation or association, or is controlled by one or more nonprofit corporations or associations.

**And**

In accordance with ORC section 1731.01(A)(1)(d), the Alliance 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 identified above is comprised of members who are either insurance agents or providers, and is 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 this 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 this 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 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: _____

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 offers or provides health benefit plan coverage to members of the Small Employer Health Care Alliance (Alliance) and submitted annually to the Ohio Department of Insurance (ODI) with the Certificate of Authority Renewal 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: _____

**ATTACHMENT 4**

**Small Employer Health Care Alliance**

**Sample Language**

**Alliance Separate Class of Business**

**Actuarial Certification**

**Required Pursuant to ORC section 1731.09(B)(6)**

I, [name and title of actuary], am an employee of [named organization] and a member of the American Academy of Actuaries. I certify that for the following classes of business [list the classes of business the certification applies to] that the underwriting and rating methods of the [insurer name] do all of the following:

(a) Comply with accepted actuarial practices;

(b) Are uniformly applied to health benefit plans covering small employers within the class of business;

(c) Comply with the applicable provisions of sections 1731.09, and 3924.01 to 3924.14 of the Ohio Revised Code.

Signature of certifying actuary

Date Signed