

Greater Franklin Development Council
Franklin Health Insurance Incentive Program

Business Application (1-50 employees)

This new program helps uninsured small businesses and the self-employed in Greater Franklin County purchase health insurance for employees and themselves. The incentive program is offered to businesses through the Greater Franklin Development Council. It is funded through an endowment Franklin Community Health Network established in 2005 to increase access to health care services in greater Franklin County. Under the Franklin Health Insurance Incentive Program, employers and the self-employed get discounts on their share of the health insurance premiums – 30% in year one and 15% in year two.

ELIGIBILITY REQUIREMENTS:

1. Business must be located in greater Franklin County*;
2. Business must have between 1 and 50 employees;
3. Employees must have legal residence in greater Franklin County;
4. Business must purchase health insurance for employees;
5. Business must not have offered health insurance to employees in the last 12 months or if businesses offered health insurance, coverage included a deductible of \$5000 or more per individual;
6. New health insurance products must not have a deductible greater than \$2,500 per individual or \$5,000 per household;
7. Ongoing documentation of health insurance statements and other documentation are required to demonstrate that grant funds received by the Employer are used to reimburse a Qualified Employee for health insurance premium expenses and any grant funds not used for such purposes shall be immediately repaid to Greater Franklin Development Council.

APPLICATION PROCEDURE:

You will need to apply for and commit to purchase health insurance coverage in order to complete this application. Once you have applied for health insurance coverage, submit:

1. Completed and signed grant application, pages 2-3;
2. Copies of employees' enrollment forms (available from insurance broker);
3. Completed employee roster showing employee name, city/town, zip code, total premium cost and employer and employee contribution. If you have not yet received all of this information, you may submit it once you receive it from your insurance provider.

Your application for grant funding will be reviewed to ensure eligibility. If approved, you will receive:

1. A grant number;
2. Monthly "Request for Payment" form;
3. An employee roster.

You will need to send a signed Monthly Request for Payment form every month for which you are requesting funding of premium reimbursement. Each month, you will also need to submit a copy of your health insurance statement showing the previous month's premium cost paid in full and update the employee roster with the most current information.

6. PAYMENT SCHEDULE

Incentive payments are made monthly to area businesses. Payments will be mailed after the Monthly Request for Payment Form, health insurance statement showing premium paid in full, and an updated Employee Roster are received and reviewed. Checks are normally sent within three weeks of when documentation forms are submitted. For each Monthly Request for Payment, you must submit:

1. Signed Monthly Request for Payment Form showing total employee premium costs, employer & employee contributions, and employee city/town;
2. Copy of health insurance statement showing last month premium paid in full.

Employees added to coverage after grant award:

1. If you have added employees to health insurance coverage since your grant acceptance, you must attach employee health insurance enrollment forms.
2. Additional employees will be approved on a first-come, first-serve basis subject to available endowment funding.

7. CERTIFICATION

As the sole representative of the business, I certify that the applying business

1. has been located in greater Franklin County* for at least the three months prior to application;
2. has not offered health insurance to employees in the last 12 months, or if offered health insurance, it included a deductible of \$5000 or more per employee;
3. has verified that the employee addresses submitted with this application are valid and current;
4. will submit required documentation; and
5. will repay any incentive payments to Greater Franklin Development Council not used by the Qualified Employer for reimbursement of permitted DirigoChoice premium expenses pursuant to the Franklin Health Insurance Incentive Program.

I understand that the incentive applies only to employees who live in greater Franklin County* and that the incentive may only be used to cover the business contribution toward employee premium costs. I agree to submit requested documentation to ensure proper distribution of funds. I am aware that the Incentive Payment will be an amount equal to 30% of the employer contribution in my first year of DirigoChoice coverage, and 15% in the second year of health insurance coverage and that there is a limited amount of endowment funding available. I further understand and agree that the funds for this Incentive Payment are received by Greater Franklin Development Council under a Grant Agreement, and that if the Grant Agreement is terminated, Greater Franklin Development Council will not continue to make further installment payments. I also understand that if new employees are added to health insurance coverage after a grant award is approved, these employees will be served on a first-come, first-serve basis subject to available grant funding.

Signature of business representative

Date

**Greater Franklin Development Council
Franklin Health Insurance Incentive Program**

APPLICATION CHECKLIST:

- 1. Applied for health insurance coverage if uninsured? _____ Yes _____ No
- 2. Completed and signed application (p. 2-3)? _____ Yes _____ No
- 3. Copies of employee enrollment forms attached? _____ Yes _____ No

You can obtain this documentation from your broker.

- 4. Completed Employee Roster with current information attached? _____ Yes _____ No
- 5. Copies kept for records? _____ Yes _____ No

Please mail completed applications to: **Greater Franklin Development Council
Franklin Health Insurance Incentive Program
c/o Ed David, Esq.
P.O. Box 31
Farmington, ME 04938**

Completed applications must be received by **December 31, 2008**. If you have questions or need help completing the application, please call Ed David at 207-778-2958.

How to Apply for Health Insurance

I. How do I apply for health insurance?

Insurance is offered through local brokers.

1. Call local broker for health insurance.

Kyes Insurance: 778-9862 (toll free at 800-244-5937)
Shiretown Insurance Agency: 778-5282
Western Maine Brokerage Services, LLC: 364-3355
Cross Employee Benefits: 623.1238 (toll free at 800 244.7717)

II. Looking for more information?

Print an application for Franklin Health Insurance Incentive Program at www.greaterfranklin.com;

See you local insurance agent; visit the Maine Health Forum at www.MaineHealthForum.org; or

Contact Joyce, David, & Hanstein (Program Administrator) by phone at (207) 778-2958.

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Monthly Request for Payment

Incentive payments are made monthly to qualified businesses. Payments will be mailed after this form is received and reviewed. Checks are normally sent within 3 weeks of when documentation forms are received. If you have questions or need help completing this form, please call Ed David at 207-778-2958.

Please **fax** completed form with health insurance statement and updated employee roster to **778-3828**, or mail to:

**Greater Franklin Development Council
Franklin Health Insurance Incentive Program
c/o Ed David, Esq.
P.O. Box 31
Farmington, ME 04938**

DATE _____

1. GRANT AWARD NUMBER _____

2. BEGINNING DATE OF DIRIGOCHOICE COVERAGE _____

3. NAME OF BUSINESS _____

4. DOCUMENTATION

Attach to this form:

1. Health insurance statements for employees showing employer contribution paid in full. You must submit documentation for each month for which you are requesting grant funding.
2. Completed employee roster with the most current information.

Employees added to coverage since grant award:

3. If you have added employees to health insurance coverage since your grant approval, then you must attach employee health insurance enrollment forms.
4. Additional employees may be approved on a first-come, first-serve basis subject to available grant funding.

5. CERTIFICATION

As the sole representative of the business, I certify that this form is an accurate reflection and reconciled to my bill for health insurance coverage. I also certify that the business maintains health insurance for employees located in greater Franklin County. *

Signature of business representative

Date

* Greater Franklin County includes all of Franklin County and surrounding towns, including Livermore, Livermore Falls, Fayette, Vienna, Mercer, New Portland, North New Portland, Mount Vernon, and Starks.

**Greater Franklin Development Council
Franklin Health Insurance Incentive Program**

Employee Roster

Grant Award Number _____ Name of Business _____

Employee Name	City	Zip	Total Premium Cost	Employee Contribution	Employer Contribution	Grant Funding (Leave Blank)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
					TOTAL	

**Greater Franklin Development Council
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Employee Roster

Grant Award Number _____ Name of Business _____

Employee Name	City	Zip	Total Premium Cost	Employee Contribution	Employer Contribution	Grant Funding (Leave Blank)
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
					TOTAL	

**Greater Franklin Development Council
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Employee Roster

Grant Award Number _____ Name of Business _____

Employee Name	City	Zip	Total Premium Cost	Employee Contribution	Employer Contribution	Grant Funding (Leave Blank)
41						
42						
43						
44						
45						
46						
47						
48						
49						
50						
					TOTAL	