Census Form

Information on participating in the MDA Health Plan

1. A minimum of two people in your practice must be eligible to particpate in the MDA Health Plan. One of the two may be the dentist.
2. You must offer your eligible employees the ability to enroll in the health plan.
3. Offering the plan to your employees does not mean you must contribute toward the cost. You may contribute any amount or percentage of the cost you wish, or you may require employees to pay 100% of the cost. This must be uniform for all employess.
4. To be eligible to participate in the health plan, employees must work a minimum of 24 hours per week. You determine how many hours, between 24 and 40 hours per week, your employees must work to be eligible for the health plan. This must be uniform for all employees.
5. You can allow employees to add their spouse and/or children to the plan. Employees can be required to pay the cost for spouse and/or children on the plan, or you can contribute if you wish.
6. 75 percent of eligible employees must participate. Employees may waive coverage under your plan if they have coverage through a spouse, parent, or have a subsidized individual health plan. These employees will be counted toward the 75 percent participation threshold.
7. Eligible employees waiving because they have coverage through their spouse or parent will be counted as a “participant” for purposes of determining participation percentage. **Please circle "S" in the Acceptable Waiver column if insurance is through the spouse or "P" if insurance is through the parent.**
8. Eligible employees waiving for individual subsidized coverage will be counted as a “participant” for purposes of determining participation percentage. **Please circle "Sub" in the Acceptable Waiver column.**
9. Eligible participants waiving coverage and not able to prove insurance elsewhere will have a negative impact on your participation percentage. **This is an Unacceptable Waiver. Please check the Unacceptable Waiver column.**
10. MDA Health Plan will collect waivers from all eligible employees for record keeping purposes, to calculate participation and to track qualifying events.

Instructions for completing this form

1. Group Name is the name of your dental practice.
2. Include yourself on the census form as an employee of the practice.
3. Provide all requested information on each employee who is electing to enroll in coverage.
4. If enrolling spouses/children, complete requested information for those individuals.
5. Those employees waiving coverage do not need to provide spouse and family informaiton.
6. On the reverse side of the Census Form, in the area indicated, please list your part-time employees and the weekly hours worked for those who are ineligible for the MDA Health Plan.
7. Employee information submitted on the Census Form should match your most recent Quarterly Wage Detail Report.

* If you have 50 or more full-time equivalent employees, you must offer "affordable" coverage to all employees who work 30 hours or more per week. This means employees' premiums for self-only coverage cannot exceed 9.5% of their household income. This may influence your decision on how much to contribute on behalf of your employees.

Group Name: _____

Office Address: _____
Street address

_____
Address 2 County

_____
City ZIP

Submitted by: _____

Phone #: _____

FAX #: _____

Email: _____

_____
Currently insured? If yes, what company?

_____
Requested Effective Date

Member ID	First Name	Last Name	Gender	DOB	Hours Worked	Acceptable Waiver S=Spouse P=Parent Sub=Subsidy	Unacceptable Waiver (Check if waiving for reasons other than at left)	MDA Office Use Only Previously Underwritten = A
Employee 1			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
Employee 2			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
Employee 3			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
Employee 4			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		

Copy blank form for additional applicants

Submit via fax to:
MDA Health Plan
517-484-5460
Fax reverse side if necessary!
MDA Insurance
3657 Okemos Road, Suite 100
Okemos, MI 48864

Group Name: _____

Member ID	First Name	Last Name	Gender	DOB	Hours Worked	Acceptable Waiver S=Spouse P=Parent Sub=Subsidy	Unacceptable Waiver (Check if waiving for reasons other than at left)	MDA Office Use Only Previously Underwritten = A
Employee5			M F					
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
Employee 6			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
Employee 7			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
Employee 8			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
Employee 9			M F			S P Sub		
spouse			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		
child			M F			S P Sub		

Ineligible Part-Time Employees			Hours Worked
Employee 1			
Employee 2			
Employee 3			
Employee 4			
Employee 5			
Employee 6			
Employee 7			
Employee 8			
Employee 9			

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