



NEW GROUP SET UP

SECTION I GENERAL INFORMATION

Group Name: _____
Contact Name: _____
Billing Address: _____
City: _____ **State:** _____ **ZIP:** _____
Phone Number: _____
Fax Number: _____
Contact Email: _____

MUST Representative: _____
Agent Name: _____
Agent Employer: _____
Agent Phone Number: _____
Agent Address: _____
City: _____ **State:** _____ **ZIP:** _____
Agent Email: _____

SECTION II GROUP DATA

Tax ID#: _____
Legal Name: _____
Effective Date: _____
Months in Benefit Year: _____
Eligibility Hours: _____
Medical Deductible and Out of Pocket Maximum Credit:
 Yes No N/A
of COBRA: _____ **Retirees:** _____ **Medicare Retirees:** _____
Married Couples: _____ **Trustees:** _____ **Other:** _____

Basic Life:
(Plan Provided for Active Employees covered under Medical): **\$10,000**

Employer Paid Life: Yes \$ _____ No

Voluntary Life (Employee Paid): Yes No

Basic Long Term Disability:
(Plan Provided for Active Employees covered under Medical):

Buy Up Long Term Disability Yes No
(Employer Paid)

LTD Non-medical Participant Coverage Yes No
(Employer Paid)

SECTION III EMPLOYER CONTRIBUTIONS

THIS SECTION IS REQUIRED IF:

1. **Large Groups**—You have selected MUST for your ACA reporting, and have MUST coverage for the entire ACA report period.

OR

2. **All Groups**—Group wants employees to see employer contribution when enrolling online.

Enter ALL of your Group's Structure Classifications (e.g., certified, certified part-time, classified, classified part-time, administrators, etc.) For additional classifications, please attach an additional sheet.

Structure Classification: _____

How much does your district contribute to this Structure Classification?

Medical	Amount: _____
Dental	Amount: _____
Vision	Amount: _____

Structure Classification: _____

How much does your district contribute to this Structure Classification?

Medical	Amount: _____
Dental	Amount: _____
Vision	Amount: _____

Structure Classification: _____

How much does your district contribute to this Structure Classification?

Medical	Amount: _____
Dental	Amount: _____
Vision	Amount: _____

Structure Classification: _____

How much does your district contribute to this Structure Classification?

Medical	Amount: _____
Dental	Amount: _____
Vision	Amount: _____