GROUP SIZE 2 to 50
NEW BUSINESS SUBMISSION CHECKLIST

PLEASE CONFIRM ALL ITEMS ARE ATTACHED BY CHECKING THE BOX. IF ITEMS ARE NOT COMPLETE AND/OR DOCUMENTS ARE NOT ENCLOSED, THE REVIEW OF THE SUBMISSION WILL BE DELAYED. ALL NEW BUSINESS SUBMISSIONS MUST BE SUBMITTED NO LATER THAN THE REQUIRED DUE DATE. ATTACH THIS CHECKLIST WITH YOUR NEW GROUP SUBMISSION.

NEW BUSINESS SUBMISSION EMAIL: MEWANEWBUSINESS@concordmgt.com

- ☐ Broker of Record Letter (if applicable)
- ☐ Proof of Membership Documentation (Select One)
  - ☐ EANJ Membership # _____
  - ☐ Hospital IPA - Membership letter
  - ☐ Medical Society of NJ (MSNJ) – Invoice/Membership letter
  - ☐ Chambers of Commerce – Membership letter
  - ☐ BioNJ – Membership letter

- ☐ Completed and Signed New Group Health Plan Contract ☐ *Sections 1-7*
- ☐ Completed and Signed Employer Certification Form
  - ☐ Page 1 – Employee Calculations, Total Benefit Eligible Employees Section should equal to letter (A)
  - ☐ Page 2 - Signatures, Census Grid
  - ☐ If providing your own Census, columns must match Census Grid on Page 2, DO NOT ADD COLUMNS

- ☐ Attach Payroll Verification – Required Tax Documents
  - ☐ Last two quarters of WR-30 (1 Full Time eligible employee must be listed on the most recent quarterly wage and tax statement (QWTS/WR-30 and employee must have worked 13 weeks in each of the last two quarters

-For Owners not on WR-30-

  - ☐ K1 with personal 1040 and a minimum of 1 Full Time eligible employee must be listed on the most recent quarterly wage and tax statement (QWTS/WR-30) and employee must have worked 13 weeks in each of the last two quarters. (If there is an amount on line 1 of personal 1040, a W-2(s) must be provided to account for total amount)

- ☐ Completed and Signed Employer Plan Selection Form
- ☐ Completed and Signed Employee Benefit Enrollment Forms
  - ☐ Total forms Equals Page 1 of Employer Certification – Total# Eligible Employees applying/enrolling
  - ☐ COBRA Questionnaire for members who are currently enrolled with COBRA or DU31 benefits (applicable for groups who elect OCA as the administrator)
- ☐ Completed and Signed Employee Waiver Forms
  - ☐ Total forms Equals Page 1 of Employer Certification – Total# Eligible waving with and without other coverage
- ☐ Signed Rates & Plans
- ☐ Name of Current Carrier and Plan Design _____
- ☐ Were you previously enrolled with the plan? No ____ Yes____ When_____
- ☐ Attach Binder Check (provide a copy with paperwork) and mail 1st months healthcare fees payable to:

APEMT/Members Health Plan NJ
P.O. Box 412491
Boston, MA 02241-2491