

Small Group Business Application

(For small employers – 2 to 50 employees – headquartered in the 29 counties of Western PA)

Complete this application in its entirety in blue or black ink.

Do not use pencil or highlighter.

Group Submission Status

- New Business** (check all that apply)
 Add Act 4 Group (Dependent(s) to age 30)
 Add Mini-COBRA Group (2-19 employees)
 Add Federal COBRA Group (20 or more employees)

- Existing Business Change** (check all that apply)
- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Add New Medical Group Option:
<input type="checkbox"/> Total Transfer Prior Group Number: _____
<input type="checkbox"/> Partial Transfer (For partial transfers, please include a list of employees to move to new product being added.)
<input type="checkbox"/> Add Supplemental Product(s) e.g. Vision, Dental
<input type="checkbox"/> Pool to Pool Movement - Current Group No(s). _____ | <input type="checkbox"/> Add Mini-COBRA Group (2 - 19 employees)
<input type="checkbox"/> Add Federal COBRA Group (20 or more employees)
<input type="checkbox"/> Add Act 4 Group (Dependent(s) to age 30)
<input type="checkbox"/> Updates (Group Name/Address, Ownership, Renewal Eligibility Changes, Change to ePlatform, etc.) Complete all sections that apply and include explanations in Comments. |
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Requested Product Information

Proposed Effective Date: _____
 Association/Pool: _____

Medical Product(s):	Quote ID _____	Product Description _____
	Quote ID _____	Product Description _____
Supplemental Product(s):	Quote ID _____	Product Description _____
	Quote ID _____	Product Description _____

ePlatform? Yes No Lifestyle Returns? Yes No Not Applicable

HRA? Yes No (if "Yes" and administered by Highmark, then Small Group HRA form must be attached)

Group Information

Group applying for coverage is: A Single Employer Part of a Common Ownership or IRS Controlled Group having multiple businesses. If the latter, is a Consolidated Tax Return filed for all businesses? Yes No (If No, please explain in "Comment" section.)

Note: Please complete separate applications for each commonly owned/controlled business applying for coverage and identify which company will be contracting on behalf of all the businesses, if approved: _____

Company/Group Name	Federal Tax I.D./E.I.N.
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Address (Physical Location – No P.O. Boxes)	City	State	County	Zip Code
Mailing Address (If different from Main Office Address)	City	State	County	Zip Code

Contract Signor Name (If Group Administrator/Billing Contacts are different, please attach a separate sheet of paper with name, title, address and phone number):

Name	Title
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Address (If different than Physical Location above)	City	State	County	Zip Code
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Phone Number ()	Fax Number ()	E-Mail Address
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Nature of Business	SIC Code	Years in Business
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Subsidiaries and Affiliates (Name and E.I.N.) – If additional space is needed, please attach information on a separate sheet of paper)

Bargaining Unit/Union Affiliate Name (If not applicable, write N/A. If it is applicable, please attach a copy of union health carrier subscriber listing)

1. Current Medical Coverage: Uninsured? Yes No (if "No," then name of other carrier): _____
 2. Plan Sponsorship: Private Entity (Erisa) Government Entity Church Entity
 3. Ownership Type: Partnership* Proprietorship* Common Ownership* Corporation _____ Other _____
 State of Inc. _____
- *Name of each Partner, Owner or Commonly Owned Business Entity:

Group Eligibility/Enrollment Policy Information

1. Do you wish to cover: Domestic Partners Act 4 Dependent(s) - to age 30
2. Number of hours employees must work per week to be considered eligible for coverage: _____
3. New employees are eligible to enroll first of the month following:
 - Hire Date 30 days 60 days 90 days 120 days 150 days 180 days
 - Other: _____
4. Will any other group coverage be offered? (e.g., union employees covered under bargaining unit) Yes No
 If "Yes," provide carrier/product names and number enrolled: _____

5.

	Active Employees			COBRA			Other † (e.g., disabled)		
	Medical	Vision	Dental	Medical	Vision	Dental	Medical	Vision	Dental
Number Eligible									
Number Enrolling									
Number Opt-Outs									
Number Waivers									

* Early Retirees and Retirees Age 65 and Older enrolled in Medicare are not eligible under this program. † Please identify individuals and eligibility status in Comments section.

Employer Medical Contribution

	Employee*	Employee & Spouse*	Employee & Child*	Employee & Children*	Family*
Percentage OR Dollar Amount					

*All tiers must be completed for your contribution type.

Employee Counts for MSP and other State/Federal Mandates

In determining who is an eligible employee for this purpose, the Federal Government counts all employees who work under a common ownership or corporation and who are subject to FICA taxes. (If you are exempt from FICA taxes, count employees who would be subject to FICA taxes if the exemption did not apply.) This includes individuals employed both locally as well as out of area who are full-time, part-time, intermittent or on a seasonal basis.

- 1a. In the PRECEDING calendar year, did you have at least 20 or more employees for each working day of 20 or more calendar weeks?
 - Yes No Company did not exist
- 1b. If you answered "Yes" to question 1a, on what date did you **first** meet the threshold of 20 or more employees for 20 calendar weeks?
 Date must be between 5/20 and 12/31 of the calendar year: _____ / _____ / _____
- 2a. As of today's date in the CURRENT calendar year, did you have at least 20 or more employees for each working day for 20 or more calendar weeks? Yes No Unknown, enough time has not expired
- 2b. If you answered "Yes" to question 2a, on what date did you **first** meet the threshold of 20 or more employees for 20 calendar weeks?
 Date must be between 5/20 and 12/31 of the calendar year: _____ / _____ / _____
3. In the PRECEDING calendar year, did you have at least 100 or more employees during 50% of your regular business days?
 - Yes No Company did not exist
4. As of today's date in the CURRENT calendar year, did you have at least 100 or more employees during 50% of your regular business days? Yes No Unknown, enough time has not expired
5. Are any employees eligible for Medicare? Yes No If you answered "Yes," please list on a separate sheet of paper the employee names and reason for Medicare coverage.
6. Is the company obtaining this coverage through an Association? . . . Yes No If "Yes," has the Association informed the Centers for Medicare and Medicaid Services (CMS) that Medicare is primary for those individuals currently employed and entitled to Medicare based on age? Yes No
7. Please provide your average number of employees on all your business days during the preceding calendar year: _____
8. Please provide the total number of your employees that are currently eligible to participate in your group sponsored health care coverage(s): _____

Note: In determining the number of employees requested in questions 7 and 8, if you are responding on behalf of an organization that is a member of a controlled group or affiliated service group, or on behalf of employees of trades or businesses that are under common control, refer to Internal Revenue Code Sections 414 and 4980D.

COBRA/Mini-COBRA Information

1. How many full-time equivalents did/do you employ?

Preceding Calendar Year:	Current Calendar Year:
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2. Within the preceding calendar year, did you have 20 or more full and/or part-time employees on at least 50% of your typical business day? Yes No

3. List your COBRA eligible members below with the applicable Qualifying Event and Date of Event. Attach separate paper if necessary.

COBRA Eligible Member Name	Qualifying Event	Date of Event

Producer of Record

Agency Name	Agency Number	Agency Phone Number ()
Producer Name	Producer Number	Producer Phone Number ()
Producer Signature		
General Agency Name	General Agency Number	GA Phone Number ()

Comments

Company/Group Authorized Signature

I, the undersigned, hereby represent that I have the authority to bind the Company/Group and to make this application for group insurance coverage. I further represent that the agency (or agencies) listed above is our exclusive Producer of Record (POR) for all Highmark Health Insurance Company (HHIC) products and they will receive any and all commissions included in the rates.

I also understand that the POR may be eligible to receive additional compensation for achieving specified sales goals. The POR named above will remain the POR until I notify HHIC of a

change, or until my HHIC insurance coverage terminates.

In addition, I understand that all HHIC underwriting and participation guidelines must be satisfied in order for the Company/Group to be eligible for the coverage requested and that rates are not binding until approved by HHIC. I further understand that any need for additional information may impact the effective date of coverage, the rates quoted, or the ability to offer the group insurance coverage requested.

It is also acknowledged that the Company/Group has the right to

review and examine the insurance contract(s) issued by HHIC which provide the group coverage requested and that payment of the premium amount due following the contract(s) issuance shall be deemed acceptance of all terms and conditions of the insurance contract(s) unless the Company/Group notifies HHIC of any changes, mistakes, or discrepancies within the thirty (30) day period that follows.

Furthermore, the Company/Group acknowledges that all underwriting and participation guidelines must continue to be met throughout the term of the insurance contract(s) involved and that HHIC reserves

the right to request information necessary to reconfirm compliance with these guidelines at anytime.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Authorized Representative Name

Authorized Representative Title

Authorized Representative Signature

Date

Underwriting Control Use Only

Approved (A) Denied (D) Withdrawn (W)	Underwriting Control Analyst	Date	Reviewer	Eligible	Enrolled

Comments:

Client Number: _____ **Group Numbers:** _____

Please return form to:
Highmark • P.O. Box 890172 • Camp Hill, PA 17089-0172 or Fax to: 888-567-5685