SMALL GROUP BUSINESS APPLICATION

(For small employers – 1 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)

❑ Add or Change Medical Product (include enrollment forms or a list of subscribers to be transferred)

❑ Add or Change Supplemental Product ❑ Vision ❑ Dental

❑ Market/Pool Movement-Current Group No(s). ____________

❑ Add Mini-COBRA Group (2 - 19 employees)

❑ Add Federal COBRA Group (20 or more employees)

❑ Other Changes (Check all that apply): ❑ Group Name/Address ❑ Ownership ❑ Member Eligibility ❑ eEnrollment ❑ eBilling
Complete all sections that apply and include explanations in Comments.

REQUESTED PRODUCT INFORMATION

Effective Date: ____________ Pool/Affiliation Name ____________

Medical Product(s): Quote ID ____________ Product Description ____________

Quote ID ____________ Product Description ____________

Vision: Quote ID ____________ Product Description ____________

Dental: Plan ID ____________ Product Description ____________

MyBenefits Product Names: ____________

Does group wish to sign-up for electronic enrollment and billing transactions? ❑ Yes ❑ No

Spending Account(s) to be administered by Highmark: ❑ HRA ❑ HSA ❑ FSA *(Please attach Small Group HRA or HSA form, if applicable.)*

EMPLOYER/GROUP INFORMATION

Company/Group Name				**Federal Tax I.D./E.I.N.**
Physical Address (No P.O. Box)	**City**	**State**	**County**	**Zip Code**
Mailing Address ❑ **Same as physical address above**	**City**	**State**	**County**	**Zip Code**
Contract Signor Name			**Title**	
Contract Signor Address (Must be in service area)	**City**	**State**	**County**	**Zip Code**
Phone Number ( )	**Fax Number** ( )		**E-Mail Address**	
Nature of Business			**SIC Code**	**Years in Business**

NOTE: If Correspondence/Billing contacts are different, **please attach a separate sheet of paper with names, titles, addresses and phone numbers.**

1. Is the above company affiliated with other entities that are to be treated as a **"single employer"** under the Internal Revenue Code section 414 aggregation rules (e.g., controlled group corporations, entities under common control, etc.)? ❑ Yes ❑ No

   If **Yes**, please list ALL affiliated company names and their locations (city and state) that are part of the "single employer", including those NOT included in this application for coverage.

   ____

   ____

   IMPORTANT: If applying for coverage for multiple (aggregated) entities, please attach a letter from your legal counselor or tax accountant citing names of all related entities and the applicable IRC section 414 rule **as evidence that they are to be treated as a "single employer"**. Also, please complete an ADDENDUM (page 4) for additional "in area" companies included in this application for group coverage. Companies that are not aggregated must apply for separate group health plans, by completing individual Small Group Business Applications.

2. Do you currently have a group medical plan? ❑ Yes (Current Carrier Name ____________) ❑ No
3. Plan Sponsorship: ❑ Private Entity (ERISA) ❑ Government Entity ❑ Church Entity ❑ Public Schools
4. Ownership Type: ❑ Partnership* ❑ Sole Proprietorship* ❑ Corporation ____________ *State of Inc.* ❑ Other ____________

   *List the Name of each Partner or Owner below:

   A. ____________ C. ____________

   B. ____________ D. ____________

GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. In addition to employees, do you wish to cover (Check all that apply): ❑ Children ❑ Spouses* ❑ Domestic Partners
   ❑ Act 4 Dependents - to age 30
   *Same sex spouses are eligible to enroll provided the marriage took place in a state that sanctions such marriages by law.
2. Number of hours employees must work per week to be considered eligible for coverage: ____________________
3. New employees are eligible to enroll on: ❑ Hire Date ❑ First Day Following _______ Days (**Cannot** exceed 90 calendar days) - **OR** -
   First Day of Next Month Following (Check one): ❑ Hire Date ❑ 30 Days ❑ 60 Days
   (If hourly and/or probationary period requirements vary by employee class, please explain in Comments section).
4. Do you have Union employees that have coverage through a separate Union organization? ❑ Yes ❑ No
   (If Yes, please attach a copy of union bargaining agreement or health carrier invoice that identifies all covered union employees.)
5. Please enter applicable employee counts below:

	Active Employees			COBRA			Other (e.g., disabled)		
	Medical	Vision	Dental	Medical	Vision	Dental	Medical	Vision	Dental
Number Eligible									
Number Enrolling									
Number Waiving									

EMPLOYER MEDICAL CONTRIBUTION(S)

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

Enter amounts for all members to be covered.

*** The employer is required to contribute at least 10% of the total monthly premium.**

MSP AND ACA GROUP/MARKET SIZE EMPLOYEE COUNTS

Please count all employees (full-time, part-time, seasonal/intermittent, and in and out of area employees - typically all W-2 employees) in your responses below. For Medicare Secondary Payer (MSP) purposes **(questions 1 and 2)**, also **INCLUDE** all leased employees and employees that are not working but receiving disability payments (which for non-government employers are subject to FICA). For the Affordable Care Act (ACA) group/market size determination **(question 3)**, **EXCLUDE** owners and working family members.

NOTE: If you have affiliated companies that are to be treated as a **"single employer"**, please refer to **"IMPORTANT"** note below for additional instructions.

1. In the PRECEDING calendar year, did you have at least:
   ❑ 20 or more employees for each working day of 20+ calendar weeks? . . . . . . ❑ Yes ❑ No ❑ Company did not exist
   - If yes, on what date did you first meet the threshold? ______/______/______
     Date must be between 5/20 and 12/31 of the calendar year

   ❑ 100 or more employees during 50% of your regular business days? . . . . ❑ Yes ❑ No ❑ Company did not exist
2. 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+ calendar weeks? . . . . . . ❑ Yes ❑ No ❑ Not enough time has elapsed
   - If yes, on what date did you first meet the threshold? ______/______/______
     Date must be between 5/20 and 12/31 of the calendar year

   ❑ 100 or more employees during 50% of your regular business days? . . . . ❑ Yes ❑ No ❑ Not enough time has elapsed
3. Please provide your **average** number of employees on all your business days during the PRECEDING calendar year: ________________

   IMPORTANT: Please aggregate all employees collectively **for all related entities** that are part of (a) controlled group of corporations in your group with employees of groups that are part of (a) controlled group of corporations, (b) partnership, proprietorship, etc. under common control or (c) affiliated service group. Refer to Internal Revenue Code Sections 52(a) & (b) and 414(m) for MSP purposes **(questions 1 & 2)** and Internal Revenue Code Section 414 for ACA group/market size determination **(question 3)**.

COBRA/MINI-COBRA INFORMATION

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

Preceding Calendar Year:	Current Calendar Year:

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 ❑ Company did not exist

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**	**General Agency Phone Number** ( )
Highmark Sales Representative		

NOTE: Please ensure that employer completed the "Small Group Business Application" in its entirety.

COMMENTS

SUMMARY OF BENEFITS AND COVERAGE

To help you make an informed choice, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about any health coverage option in a standard format. You can view an SBC for each available product at www.highmark.com/SBC.

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 Blue Cross Blue Shield (Highmark) products and they will receive any and all commissions included in the rates.

I further acknowledge and agree that Highmark may disclose enrollment, disenrollment, summary health and/or premium billing information requested by the POR for purposes of inputting, updating and/or reviewing the same for the above - identified business.

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 Highmark of a change, or until my Highmark insurance coverage terminates.

In addition, I understand that all Highmark 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 Highmark. 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 Highmark 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 Highmark of any changes, mistakes, or discrepancies within the thirty (30) day period that follows.

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

Please send the Small Group Business Application (and other relevant materials) to your Highmark Small Group Sales Contact.

This form is for use with health care benefits issued or administered by Highmark Blue Cross Blue Shield and/or its affiliated companies, Highmark Health Insurance Company, Highmark Select Resources and Highmark Coverage Advantage (collectively "Highmark"), as independent licensees of the Blue Cross Blue Shield Association.

ADDENDUM - Only Complete for Multiple (Aggregated) Businesses that are to be Treated as a "Single Employer".
(If more than three businesses are included in application, please copy addendum page.)
Company/Group Name:______________________________ (as shown on page 1).

ADDITIONAL COMPANY INFORMATION

Company/Group Name			SIC	Federal Tax I.D./E.I.N.
Physical Address (No P.O. Box)	**City**	**State**	**County**	**Zip Code**

1. Plan Sponsorship: ❑ Private Entity (ERISA) ❑ Government Entity ❑ Church Entity ❑ Public Schools
2. Ownership Type: ❑ Partnership* ❑ Sole Proprietorship* ❑ Corporation ❑ Other ____________

*List the Name of each Partner or Owner below:

A. ______________________ C. ______________________
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4. Do you have Union employees that have coverage through a separate Union organization? ❑ Yes ❑ No
   (If Yes, please attach a copy of union bargaining agreement or health carrier invoice that identifies all covered union employees.)

EMPLOYER MEDICAL CONTRIBUTION(S)

	Employee*	Employee & Spouse	Employee & Child	Employee & Children	Family	
Percentage OR Dollar Amount						**Enter amounts for all members to be covered.**

*** The employer is required to contribute at least 10% of the total monthly premium.**

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