



# SMALL GROUP BUSINESS APPLICATION

(For small employers – 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

Current Client or Group No(s) \_\_\_\_\_

Product Changes: Add Change\* Renew "As Is" Cancel

Medical

Vision

Dental

\*Include enrollment forms to report changes, if not signed up for eEnrollment.

Add 2<sup>nd</sup> Medical Option

Market/Movement (Renewing as a small group)

Add Mini-COBRA Group (2 - 19 employees)

Add Federal COBRA Group (20 or more employees)

Add Act 4 Group (Dependents to age 30)

Other (e.g., Group Name/Address, Ownership, Eligibility Changes, etc. —

Complete all applicable sections and explain in Comments section.)

## REQUESTED PRODUCT INFORMATION

Effective Date: \_\_\_\_\_ (If electing My Benefits, enter IDs/Names below and additional product selections in MyBenefits question that follows.)

Medical Product(s): Quote ID \_\_\_\_\_ Product Name \_\_\_\_\_

Quote ID \_\_\_\_\_ Product Name \_\_\_\_\_

Vision: Quote ID \_\_\_\_\_ Product Name \_\_\_\_\_

Dental: Plan ID \_\_\_\_\_ Product Name \_\_\_\_\_  Tier 2 or  Tier 4

My Benefits 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  Using an Outside Vendor

(If administered by Highmark, please attach Small Group HRA or HSA form.)

## 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 of corporations, entities under common control, etc.)?  Yes  No

If Yes, please list all company names and their locations (city and state), including those NOT applying for coverage.

\_\_\_\_\_

**ATTESTATION:** If application includes multiple entities, please attach an attestation letter from your tax accountant (or legal counselor) citing all affiliated entity names and the applicable IRC Section 414 (aggregation) rule that they fall under as evidence that they are to be treated as a "single employer". In addition, complete the ADDENDUM (page 3) to identify all companies included in this application. Non-aggregated companies must apply for separate coverage via separate group 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 \_\_\_\_\_  Other \_\_\_\_\_

State of Inc.

List names of ALL business owners/partners (or write 'NA' if business is solely owned by shareholders).

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
2. Number of hours employees must work per week to be 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
<b>Number Eligible</b>									
<b>Number Enrolling</b>									
<b>Number Waiving</b>									

## EMPLOYER MEDICAL CONTRIBUTION(S)

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

\* 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, those not receiving W-2s and union 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 (not considered to be common law employees) as well as 1099 independent contractors and retirees.

**IMPORTANT:** Please aggregate all employees collectively **for all related entities** 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**).

1. In the **PRECEDING** calendar year, did you have at least:
  - a. **20 or more** employees for each working day of 20 or more calendar weeks?  Yes  No  Company did not exist then  
 If yes, on what date did you first meet the threshold? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date must be between 5/20 and 12/31 of the calendar year
  - b. **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:
  - a. **20 or more** employees for each working day of 20 or more calendar weeks?  Yes  No  Unknown, enough time has not expired  
 If yes, on what date did you first meet the threshold? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date must be between 5/20 and 12/31 of the calendar year
  - b. **100 or more** employees during 50% of your regular business days?  Yes  No  Unknown, enough time has not expired
3. Please provide your **average** number of employees on all your business days during the **PRECEDING** calendar year: \_\_\_\_\_

## COBRA/MINI-COBRA INFORMATION

1. How many full-time equivalent employees 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-time equivalent employees on at least 50% of your typical business day?  
 Yes  No  Company did not exist



**PRODUCER OF RECORD**

<b>Agency Name</b>	<b>Agency Number</b>	<b>Agency Phone Number</b> (       )
<b>Producer Name</b>	<b>Producer Number</b>	<b>Producer Phone Number</b> (       )

**Producer Signature**

<b>General Agency Name</b>	<b>General Agency Number</b>	<b>General Agency Phone Number</b> (       )
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**Highmark Sales Representative**

**COMMENTS**

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**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](http://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.**

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to [DiscoverHighmark.com/QualityAssurance](http://DiscoverHighmark.com/QualityAssurance); or for a paper copy, call 1-855-873-4106.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your Member ID card to request these free services (TTY/TDD users may call 711).

Highmark Blue Cross Blue Shield, Highmark Health Insurance Company (HHIC), Highmark Coverage Advantage (HCA) and Highmark Choice Company (HCC) are independent licensees of the Blue Cross and Blue Shield Association. Insurance may be provided by Highmark Blue Cross Blue Shield, HHIC, HCA or HCC. Health care plans are subject to terms of the benefit agreement.