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 online enrollment.

❑ Add 2nd 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 ❑ $1000 max or ❑ $1500 max

Does the group wish to choose Dental Pediatric Smart Savings Rider? ❑ Yes ❑ No

My Benefits Product Names: _____

Does the group wish to sign-up for **online** enrollment and/or billing transactions? ❑ Yes ❑ No

Spending Account(s) to be administered by Highmark Blue Cross Blue Shield: ❑ 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 (If Correspondence/Billing contacts are different, indicate in the comments section on page 4) | **Title**

Contract Signor Address (Must be in service area) (❑ Same as Physical Address above) | **City** | **State** | **County** | **Zip Code**

Phone Number ( ) | **Fax Number** ( ) | **E-Mail Address**

Nature of Business | **SIC Code** | **Years in Business**

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., (b) controlled group of corporations, (c) partnership or proprietorship, etc., under common control or, (m) employees of an affiliated service group, or (o) other regulations)?

   ❑ Yes - Attach a Certification of Eligibility to Combine and Employer Group Size Form completed by an authorized representative of the company. The form must include all affiliated entity names and Employer Identification Numbers (EIN).

   ❑ No

Note: 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 ❑ Proprietorship ❑ C- Corporation: _____ *State of Inc.* ❑ S - Corporation: _____ *State of Inc.* ❑ Other: _____

List names of ALL business owners/partners.

A. _____ C. _____

B. _____ D. _____

GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. In addition to employees, do you wish to cover dependents at any time during the contract period?
   If yes, please 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 wish to waive the probationary period for all eligible employees on the group's initial effective date only? ❑ Yes ❑ No
5. 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.)
6. 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)

Write the percentage or dollar amount the employer will contribute for all tiers (even if amount is zero).

Employee*	**Employee & Spouse**	**Employee & Child**	**Employee & Children**	**Family**

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

ACA AND MSP GROUP/MARKET SIZE EMPLOYEE COUNTS

IMPORTANT: If you answered Yes to question 1 of the EMPLOYER / GROUP INFORMATION section on page 1, please count all employees collectively for all related entities that are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules. These aggregation rules apply to all questions in this section.

For the Affordable Care Act (ACA) group/market size determination (question 1), count all employees for each month in the preceding calendar year. This includes full-time, part-time, seasonal/intermittent, and in/out-of-area employees – who were issued a W-2; regardless of whether they were eligible to enroll, and/or participated in the group health plan. Exclude owners and working family members (who do not qualify as common law employees), 1099 independent contractors and retirees.

1. Please provide your **average** number of employees on all your business days during the **PRECEDING** calendar year: _____

For Medicare Secondary Payer (MSP) purposes **(questions 2 and 3)**, in addition to the above also **INCLUDE** all leased employees and employees that are not working but receiving disability payments (which for non-government employers are subject to FICA).

2. 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

3. 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

COBRA/MINI-COBRA INFORMATION

	Preceding Calendar Year:	**Current Calendar Year:**
1. How many full-time equivalent employees did/do you employ?		

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

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 ❑ Proprietorship ❑ C- Corporation: _____ *State of Inc.* ❑ S - Corporation: _____ *State of Inc.* ❑ Other: _____

List names of ALL business owners/partners.

A. _____ C. _____

B. _____ D. _____

GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. In addition to employees, do you wish to cover dependents at any time during the contract period?
   If yes, please 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 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 wish to waive the probationary period for all eligible employees on the group's initial effective date only? ❑ Yes ❑ No
5. 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)

Write the percentage or dollar amount the employer will contribute for all tiers (even if amount is zero).

Employee*	Employee & Spouse	Employee & Child	Employee & Children	Family

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

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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		

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

ONLINE CONTRACT AVAILABILITY

By checking the "I agree" Opt-in selection and signing below, the Company/Group agrees to log onto the secure employer portal at HighmarkBCBS.com to access the Company's/Group's annual health plan contract as well as any amendatory riders to the contract that may be required. The Company/Group understands that by making this selection, it will not receive paper copies of its health plan contract or any amendatory riders thereto. These documents will only be provided in electronic format. The Company/Group's Highmark Broker/representative will send a request to Highmark to create a secure employer portal login ID and password which will be sent directly to the Company/Group. The Company/Group will receive an email from CCBS_OnlineContracts@HIGHMARK.COM each time new information about its health plan contract is posted. This will be the only notification that the Company/Group will receive regarding contract updates.

The Company/Group acknowledges that it is responsible to immediately report any changes to its contact email address to its Highmark Broker/representative, or by sending the change to: CCBS_OnlineContracts@HIGHMARK.COM.

Note: The Company/Group has the right to receive paper copies of documents, including health plan contracts and amendatory riders to its contract at any time, without charge. To update how the Company/Group receives its health plan contract information from Highmark at any time, please contact the appropriate Highmark Broker or representative, or send your request to: CCBS_OnlineContracts@HIGHMARK.COM.

OPT-IN SELECTION

❑ I agree ❑ I do not agree

Authorized Representative Name and Title	Authorized Representative Email Address
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 Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.