SMALL GROUP BUSINESS APPLICATION

(For small employers headquartered in the 29 counties of Western PA)

I. GROUP SUBMISSION UPDATES

- ❑ New Business Update
- ❑ Existing Business Update
- ❑ Add Act 4 Group (Dependents to age 30)
- ❑ Other
  (e.g., Ownership, Off-Cycle Benefit , Subsidiary and/or Buyout/Mergers, Federal Tax ID/EIN, COBRA Changes, etc. — Complete all applicable sections and explain in Comments section.)

II. REQUESTED PRODUCT INFORMATION

Effective Date: _____

Medical Product(s): Quote ID _____ Product Name _____

Quote ID _____ Product Name _____

Quote ID _____ Product Name _____

Vision: Quote ID _____ Product Name _____

Dental: Plan ID _____ Product Name _____ ❑ Tier 2 Rates or ❑ Tier 4 Rates

❑ $1000 max or ❑ $1500 max

III. 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
Phone Number ( )	Fax Number ( )	E-Mail Address		
Nature of Business			SIC Code	Years in Business

1. Do you currently have a group/individual medical plan? ❑ Yes (Current Carrier Name _____) ❑ No
2. Plan Sponsorship:
   ❑ Private Entity (ERISA) ❑ Government Entity ❑ Church Entity ❑ Public Schools
3. Ownership Type *(List business owners/partners on line below)*:
   ❑ Partnership ❑ Proprietorship ❑ C- Corporation: State of Inc. _____ ❑ S - Corporation: State of Inc. _____ ❑ Other: (e.g., NonProfit) _____

   List the names of ALL business owners/partners:

   _____ _____

   _____ _____

4. 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 or Sales Representative.

   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.

OPT-IN SELECTION: ❑ I agree ❑ I do not agree

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Coverage Advantage or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association. 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.

IV. GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. This policy will cover eligible employees and their eligible dependents unless otherwise stated in the comments section on Page 3.
2. Do you wish to make coverage available to domestic partners? ❑ Yes ❑ No If applicable, additional documentation may be required.
3. Do you wish to make coverage available for Act 4 dependents? ❑ Yes ❑ No If applicable, additional documentation may be required.
4. Number of hours employees must work per week to be eligible for coverage: _____
5. Probationary period for new employees. Please choose an option:
   ❑ Hire Date
   ❑ First Day Following: ❑ Hire Date ❑ 30 Days ❑ 60 Days ❑ _____ (enter days)
   ❑ First Day of Next Month Following: ❑ Hire Date ❑ 30 Days ❑ 60 Days ❑ _____ (enter days)
   Note: Probationary periods cannot exceed 90 calendar days
6. Do you wish to waive the probationary period for all eligible employees on the group's initial effective date only? ❑ Yes ❑ No
7. Employer agrees to contribute at least 10% of the cost of employee coverage.

V. FEDERAL AND STATE REQUIREMENTS

Affordable Care Act Group/Market Size Determination

1. Is the above company affiliated with other entities that have a separate Federal Tax I.D./ E.I.N. and are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules (If you are unsure how to answer this question, please seek assistance from your tax accountant or legal counsel).

   ❑ Yes - If affiliated entities are to be included in this application and are enrolling in coverage, 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

   For the Affordable Care Act (ACA) group/market size determination 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.

   IMPORTANT: If you answered Yes to question 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.

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

Medicare Secondary Payer Employee Count

For Medicare and Secondary Payer (MSP) purposes, count all employees. This includes full-time, part-time, seasonal/intermittent, in/out-of-area employees, all leased employees and employees that are not working but receiving disability payments (which for non-government employers are subject to FICA). **Note:** If you answered Yes to question one in the Affordable Care Act Group/ Market Size Determination section, please follow the instructions in the IMPORTANT note contained within that same section when answering questions one and two in this Medicare Secondary Payer Employee Count portion of the form.

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
   b. **100 or more** employees during 50% or more 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
   b. **100 or more** employees during 50% or more 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 days?
   ❑ Yes ❑ No ❑ Company did not exist

VI. ONLINE ENROLLMENT/BILLING TRANSACTIONS

1. Do you wish to sign up for online enrollment and/or billing transactions? ❑ Yes ❑ No

Contact Name _____ Contact Email _____

VII. PRODUCER OF RECORD

Agency Name	**Broker access:** Should this client be added to your on-line existing multi-client access? ❑ Yes ❑ No Logon ID: _____ Should enrollment access be: ❑ View ❑ Edit Billing Access: ❑ Yes ❑ No
General Agency Name	
Producer Name	
Producer Signature	Highmark Sales Representative

VIII. 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 https://shop.highmark.com/sales/#!/sbcs.

IX. 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.

Enrollment Applications and Waiver Forms: Eligible employees enrolling or waiving coverage as indicated on the Unemployment Compensation report and/or payroll history and the enrollment-waiver spreadsheet have completed and signed an application or waiver form (either hard copy or electronic) reflective of their respective enrollment decisions. The enrollment applications and waiver forms include enrollment decisions for not only the eligible employees, but also their spouse(s)/domestic partner(s), eligible dependent child(ren), adopted child(ren), step-child(ren), or other (i.e., ward of the state, etc.) dependent(s). The completed enrollment applications and waiver forms are being kept on file and could be made available to Highmark, upon request.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

_____ _____

Authorized Representative Signature
(please hand sign if this is a paper request)

Date

_____

Authorized Representative Title

X. COMMENTS

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).

ATTENTION: Si c’est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d’identité. (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.