HIGHMARK® HEALTH INSURANCE COMPANY

An Independent Licensee of the Blue Cross and Blue Shield Association

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

❑ Existing Business Change *(check all that apply)*

- ❑ Add New Medical Group Option:
  - ❑ Total Transfer *Prior Group Number:* _____
  - ❑ Partial Transfer *(For partial transfers, please include a list of employees to move to new product being added.)*
- ❑ Add Supplemental Product(s) e.g. Vision, Dental

Existing Business Change *(continued)*

- ❑ Add Mini-COBRA Group *(2 - 19 employees)*
- ❑ Add Federal COBRA Group *(20 or more employees)*
- ❑ Add Act 4 Group *(Dependent(s) to age 30)*
- ❑ Pool to Pool Movement - Current Group No(s). _____
- ❑ Updates *(Group Name/Address, Ownership, Renewal Eligibility Changes, Change to ePlatform, etc.) Complete all sections that apply and include explanations in Comments.*

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

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

Lifestyle Returns? . . . . . ❑ Yes ❑ No ❑ Not Applicable

Group Information

Check if this group is a ❑ Single Employer or ❑ Part of a Common Ownership (separate applications for each business are required).

If Common Ownership, are taxes filed consolidated for all commonly owned companies? . . . . . ❑ Yes ❑ No

Company/Group Name | **Federal Tax I.D./E.I.N.**

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**

Address *(If different than Physical Location above)* | **City** | **State** | **County** | **Zip Code**

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

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

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)*

Current Medical Coverage: Uninsured? ❑ Yes ❑ No *(if "No," then name of other carrier):* _____

Plan Sponsorship: ❑ Private Entity (Erisa) ❑ Government Entity ❑ Church Entity

Ownership Type: ❑ Partnership* ❑ Proprietorship* ❑ Common Ownership* ❑ Corporation: _____ *State of Incorporation*

* Name of each Partner, Owner or Commonly Owned Business Entity:

1. _____ 3. _____

2. _____ 4. _____

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			Early Retirees * (under age 65)			Other † (e.g., disabled)		
	Medical	Vision	Dental	Medical	Vision	Dental	Medical	Vision	Dental	Medical	Vision	Dental
Number Eligible												
Number Enrolling												
Number Spousal 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					

Employee Counts/MSP Information

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:

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. If you answered Yes" to question #2 and if you have 20 or more full-time equivalent employees, do you elect to contract with Highmark Health Insurance Company's (HHIC) Third Party COBRA Administrator to administer your COBRA? . . . . . ❑ Yes ❑ No
4. If you **do not** wish to contract with HHIC's Third Party COBRA Administrator, who will administer your COBRA benefits?

   ❑ Self-Administered **or** ❑ Direct with _____

   (fill in with COBRA Administrator)

5. 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

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.

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