



SMALL GROUP BUSINESS APPLICATION

For small employers headquartered in Northeastern Pennsylvania

SECTION 1: COMPANY INFORMATION				
Company Name		Tax ID Number	Effective Date	
Nature of Business		SIC Code	Years in Business	
Address (Physical)		City	County	State Zip
Address (Mailing) <input type="checkbox"/> Same as physical address		City	County	State Zip
Ownership Type <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> C-Corporation <input type="checkbox"/> S-Corporation <input type="checkbox"/> Non-profit <input type="checkbox"/> Government				
Names of all business owners (including partners, shareholders, stockholders, officers, directors) 				
Contract Signor		Phone Number	Email Address	
Current Health Insurance Carrier (group/individual)				
SECTION 2: COMPANY SIZE				
AFFORDABLE CARE ACT CLIENT/MARKET SIZE DETERMINATION				
<p>A small employer is defined as any employer with 50 or fewer average total number of employees during the prior calendar year. An employee is any person employed and receiving a W-2 form, and can be full-time, part-time or seasonal.</p> <p>If an employer is part of a “controlled group” under IRS rules (IRC section 414), then the companies are considered a “single employer” and all employees from each individual company are included in the count of average total number of employees for purposes of determining the appropriate market segment.</p> <p>To calculate the average total number of employees during the prior calendar year, add the total number of employees for each month, and then divide the yearly total by 12.</p> <p>1. What is your average total number of employees during the prior calendar year: _____</p> <p>2. Are you part of a “controlled group” as defined under IRS rules (IRC section 414)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If you answered “yes” to question 2 and you are enrolling related entities, the Certification of Eligibility to Combine and Employer Group Size Form must be completed.</i></p>				

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, First Priority Health, First Priority Life, or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross 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.

MEDICARE SECONDARY PAYER EMPLOYEE COUNT

For Medicare Secondary Payer (MSP) purposes, all employees are included in the count. This includes full-time, part-time, seasonal, and leased employees; and employees who are not working but are receiving disability payments (which for non-government employers are subject to FICA).

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 didn't exist
 - b. 100 or more employees during 50% or more of your regular business days?
 Yes No Company didn't 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 Company didn't exist
 - b. 100 or more employees during 50% or more of your regular business days?
 Yes No Company didn't exist

COBRA/MINI-COBRA

1. How many full-time equivalent employees did you employ in the preceding calendar year? _____
2. How many full-time equivalent employees do you currently employ? _____
3. Did you have 20 or more full-time equivalent employees on at least 50% of your typical business days in the preceding calendar year? _____

SECTION 3: GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. Number of hours an employee must work to be considered full-time and eligible for coverage: _____
2. New hire waiting period:

<input type="checkbox"/> Hire date	First day following:	First day of next month following:
	<input type="checkbox"/> Hire Date	<input type="checkbox"/> Hire Date
	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 30 Days
	<input type="checkbox"/> 60 Days	<input type="checkbox"/> 60 Days
	<input type="checkbox"/> 90 Days	
3. Do you want to waive the new hire waiting period for all eligible employees upon the company's initial effective date with Highmark? Yes No
4. Do you want to make coverage available to Act 4 dependents? Yes No
 (If yes, additional documentation may be required)

Note: This Highmark policy will cover eligible employees, their dependents and spouses, and domestic partners in accordance with company-specific policies. Additional documentation is required for domestic partner enrollment.

SECTION 4: COMPANY ADMINISTRATION

Primary Contact (Group Administrator)	Phone Number	Email Address
Highmark small group customers automatically receive online access to contracts, and enrollment and billing capabilities. If anyone other than the primary contact needs this access, please indicate the additional contacts below.		
Contact	Phone Number	Email Address
Contact	Phone Number	Email Address

SECTION 5: PRODUCER OF RECORD

General Agency:	If this client should be added to an existing multi-client access username(s)/login ID(s), provide the following information:
Agency:	
Producer:	
Producer Signature:	

Name: _____

Username/Login ID: _____

Name: _____

Username/Login ID: _____

SECTION 6: PLAN SELECTIONS

BLUECARE PPO PLANS

BlueCare PPO plans are available to companies headquartered in the following Northeastern Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming, and Monroe

- BlueCare PPO \$0 Gold
- BlueCare PPO \$0 Platinum
- BlueCare PPO \$0 Silver
- BlueCare PPO \$1000 Gold
- BlueCare PPO \$1250 Gold
- BlueCare PPO \$1400 Gold
- BlueCare PPO \$1500 Gold
- BlueCare PPO \$1550 Gold
- BlueCare PPO \$2000 1x Gold
- BlueCare PPO \$2000 Gold
- BlueCare PPO \$250 Platinum
- BlueCare PPO \$2500 Gold
- BlueCare PPO \$2600 Silver
- BlueCare PPO \$3000 1x Silver
- BlueCare PPO \$3000 Gold
- BlueCare PPO \$3000 Silver
- BlueCare PPO \$4000 Gold
- BlueCare PPO \$500 Gold
- BlueCare PPO \$500 Platinum
- BlueCare PPO \$5000 1x Gold
- BlueCare PPO \$5000 Silver
- BlueCare PPO \$5400 Bronze
- BlueCare PPO \$750 Platinum
- BlueCare QHD PPO \$1600 Gold
- BlueCare QHD PPO \$3200 Silver

BLUECARE CUSTOM PPO PLANS

BlueCare Custom PPO plans are available to companies headquartered in the following Northeastern Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming, and Monroe

- BlueCare Custom PPO \$0 Gold
- BlueCare Custom PPO \$0 Platinum
- BlueCare Custom PPO \$0 Silver
- BlueCare Custom PPO \$1000 Gold
- BlueCare Custom PPO \$1250 Gold
- BlueCare Custom PPO \$1400 Gold
- BlueCare Custom PPO \$1500 Gold
- BlueCare Custom PPO \$1550 Gold
- BlueCare Custom PPO \$2000 1x Gold
- BlueCare Custom PPO \$2000 Gold
- BlueCare Custom PPO \$250 Platinum
- BlueCare Custom PPO \$2500 Gold
- BlueCare Custom PPO \$2600 Silver
- BlueCare Custom PPO \$3000 1x Silver
- BlueCare Custom PPO \$3000 Gold
- BlueCare Custom PPO \$3000 Silver
- BlueCare Custom PPO \$4000 Gold
- BlueCare Custom PPO \$500 Gold
- BlueCare Custom PPO \$500 Platinum
- BlueCare Custom PPO \$5000 1x Gold
- BlueCare Custom PPO \$5000 Silver
- BlueCare Custom PPO \$5400 Bronze
- BlueCare Custom PPO \$750 Platinum

AFFORDABLUE PPO PLANS

AffordaBlue PPO plans are available to companies headquartered in the following Northeastern Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming, and Monroe

- AffordaBlue \$1000 Gold
- AffordaBlue \$1500 Gold
- AffordaBlue \$250 Platinum
- AffordaBlue \$3000 Silver
- AffordaBlue \$500 Gold

LEHIGH VALLEY FLEX BLUE PLANS

Lehigh Valley Blue plans are available to companies headquartered in the following Northeastern Pennsylvania counties: Carbon and Monroe

- Lehigh Valley Flex Blue PPO 500 Gold
- Lehigh Valley Flex Blue PPO 1250 Gold
- Lehigh Valley Flex Blue PPO Qualified Embedded 3300 Silver

SPENDING ACCOUNT SELECTION(S)

HSA FSA Dependent Care FSA Limited FSA

Will your spending account(s) be administered by Highmark or an outside vendor? Highmark Outside Vendor

BLUE EDGE DENTAL SELECTION	BLUE EDGE VISION SELECTION
<input type="checkbox"/> Blue Edge Dental F-2W <input type="checkbox"/> Blue Edge Dental F-3W <input type="checkbox"/> Blue Edge Dental F-3Wo* <input type="checkbox"/> Blue Edge Dental F-4W <input type="checkbox"/> Blue Edge Dental F-8W <input type="checkbox"/> Blue Edge Dental P-10Wo <input type="checkbox"/> Blue Edge Dental F-3C <input type="checkbox"/> Blue Edge Dental Value 1 <input type="checkbox"/> Blue Edge Dental Value 2 <input type="checkbox"/> Blue Edge Dental Value 3 <input type="checkbox"/> Blue Edge Dental Value 4 * Not available for 2-9 Contracts Annual Max Selections <i>Not applicable to Value Plans</i> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 Network Selection <input type="checkbox"/> Advantage <input type="checkbox"/> Advantage Plus <input type="checkbox"/> Tier 2 rates <input type="checkbox"/> Tier 4 rates	<input type="checkbox"/> Designer <input type="checkbox"/> Basic <input type="checkbox"/> Value <input type="checkbox"/> Fashion <input type="checkbox"/> Basic <input type="checkbox"/> Value <input type="checkbox"/> Premier <input type="checkbox"/> Options <input type="checkbox"/> Voluntary <input type="checkbox"/> Non-Voluntary

SECTION 7: TERMS AND CONDITIONS

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>.

COMPANY AUTHORIZED SIGNATURE

(All references below to "Highmark" refer to the Highmark Company from which coverage is being requested.)

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. The Company/Group agrees to contribute at least 10% of the employee's cost of coverage. For new business submissions, Company/Group attests to the accuracy of the unemployment compensation report that will be submitted with this application. 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.

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 will log onto the secure employer portal at HighmarkBlueCrossBlueShield.com. 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.

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 any time.

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.

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.

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.

Contractor Signor Name (please print)

Contract Signor Signature

Date

SECTION 8: NOTES

SECTION 9: For Internal Use Only