Highmark Inc. d/b/a Highmark Blue Cross Blue Shield | HM Health Insurance Company d/b/a Highmark Health Insurance Company | Highmark Choice Company

CERTIFICATION OF ELIGIBILITY TO COMBINE AND EMPLOYER GROUP SIZE

(For use by related entities subject to IRC § 414) Please consult your tax accountant (or legal counselor), if needed, to advise if your company falls under this rule and to obtain the applicable IRC Section 414 rule that applies.

Client Name:

I. RELATED ENTITY INFORMATION

Name of Related Entity	**Physical Address of each Related Entity** Physical Address (No. P.O. Box), City, State, Country, ZIP Code	**Employer ID Number (EIN)**	**SIC Code**

Plan Sponsorship:
☐ Private Entity (ERISA) ☐ Government Entity ☐ Church Entity ☐ Public Schools

Ownership Type (List businessowners/partner online below):
☐ Partnership ☐ Proprietorship ☐ C-Corporation: State of Inc. _____ ☐ S-Corporation State of Inc. _____ ☐ Other

List names of ALL business owners/partners: _____

II. GROUP ELIGIBLITY AND ENROLLMENT INFORMATION

1. This policy will cover eligible employees and their eligible dependents unless otherwise state in the comments section on the group application.
   Do you wish to make coverage available to Domestic Partners or Act 4 dependents?
   Check any/all that apply: ☐ Domestic Partners ☐ Act 4
2. Did the employer contribute at least 10% of the cost of employee coverage? ☐ Yes ☐ No
3. Number of hours employees must work to be eligible for coverage: _____
4. Probationary period for new employees:
   ☐ Hire Date
   ☐ First Day Following _____ Days (Cannot exceed 90 calendar days)
   ☐ 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: _____
5. Do you wish to waive the probationary period for all eligible employees on the group's initial effective date only?
   ☐ Yes ☐ No

III. RELATED ENTITY INFORMATION

Name of Related Entity	**Physical Address of each Related Entity** Physical Address (No. P.O. Box), City, State, Country, ZIP Code	**Employer ID Number (EIN)**	**SIC Code**

Plan Sponsorship:
☐ Private Entity (ERISA) ☐ Government Entity ☐ Church Entity ☐ Public Schools

Ownership Type (List businessowners/partner online below):
☐ Partnership ☐ Proprietorship ☐ C-Corporation: State of Inc. _____ ☐ S-Corporation State of Inc. _____ ☐ Other

List names of ALL business owners/partners: _____

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 the group application.

   Do you wish to make coverage available to Domestic Partners or Act 4 dependents?
   Check any/all that apply: ☐ Domestic Partners ☐ Act 4

2. Did the employer contribute at least 10% of the cost of employee coverage? ☐ Yes ☐ No

3. Number of hours employees must work per week to be eligible for coverage:

4. Probationary period for new employees: ☐ 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: _____

5. Do you wish to waive the probationary period for all eligible employees on the group's initial effective date only? ☐ Yes ☐ No

V. DECLARATION OF AGGREGATION STATUS & EMPLOYER GROUP SIZE

On behalf of the above related entities, the undersigned hereby certifies that all of the entities identified above are treated as a single employer under the Internal Revenue Code Section 414 (26 U.S.C. Sections 414(b) or (c)) at the time of this application for coverage. Highmark will not underwrite Affiliated Service Groups as defined in 26 U.S.C. Section 414(m).

The below is the applicable IRC Section 414 (aggregation) rule that they fall under.

_____ meets definition of _____ under Code Section _____
(Company Name) List Rule that applies (i.e., parent-subsidiary, brother-sister) (List Code)

The undersigned acknowledges and agrees that, for purposes of applying for or renewing health insurance coverage and compliance with applicable health care laws and regulations, the below client size is determined based on the average number of employees during the preceding calendar year, **collectively for all related entities**.

_____ Client Size

VI. DOCUMENTATION OF AGGREGATION STATUS

The undersigned acknowledges and agrees that Highmark may require tax or other supporting documents to support the representations made in this application, and that failure of the Client to provide such documents timely may result in the decision not to extend coverage to the Client or to modify the originally offered rating.

VII. AUTHORIZED SIGNATURE

The undersigned understands and agrees that Highmark will use the information contained in this application to determine rates for the Client. The undersigned hereby represents that he/she is authorized to submit this certification, that the information contained in this Certification Form is true and correct and that the above-identified Client agrees to indemnify, reimburse and hold harmless Highmark, and its designated agents, from any and all fines, penalties, interest, claims and/or other amounts that may become due arising out of any claim, action, litigation or regulatory proceeding involving or based upon a determination that the above identified related entities do not meet the Common Ownership and Affiliate Service Group Rules.

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 Name (Please Print) Title (Please Print)

_____ _____
Authorized Representative Signature Date

Note: This certification form, its disclosures and attachments are material facts upon which coverage will be issued or renewed. Any fraudulent statements, or intentional misrepresentations, made through use of the form may be the basis upon which coverage is not issued, renewed, or rescinded.

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.