HIGHMARK Delaware

SMALL GROUP BUSINESS APPLICATION

(For small employers – 1 to 50 employees – headquartered in the State of Delaware)

Complete this application in its entirety in blue or black ink.
Do not use pencil or highlighter.

GROUP SUBMISSION STATUS

❑ **New Business**

❑ Add Federal COBRA Group *(20 or more employees)*

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

Client Number: _____

❑ 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) ❑ Vision ❑ Dental

❑ Market Movement - Current Group No(s).

❑ Add Federal COBRA Group (20 or more employees)

❑ 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

Effective Date: _____

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

Quote ID _____ Product Description _____

Vision: Quote ID _____ Product Description _____

Dental: Plan ID _____ Product Description _____

MyBenefits Option: _____

Does Group Want: eBilling ❑ Yes ❑ No and/or eEnrollment ❑ Yes ❑ No (*If yes, please attach Data Collection Form.*)

Spending Accounts Administered by HHIC ❑ HRA ❑ HSA ❑ FSA (*Please attach Small Group HRA or HSA form, if applicable.*)

GROUP INFORMATION

Group is: ❑ A Single Employer ❑ Part of a Common Ownership or IRS Controlled Group having multiple businesses.

- Is a consolidated tax return filed for all businesses? ❑ Yes ❑ No *(If No, please explain in "Comment" section.)*

For Common Ownership and IRS Controlled Groups, complete the main body of the SGBA (pages 1-3) for the lead contract holder. Only complete the addendum (page 4) for additional companies that are enrolling as part of the lead group (e.g. if you have 3 groups, fill out the main body of the SGBA plus 2 copies of the addendum.)

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 Signatory (If Correspondence/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)

1. Currently providing medical coverage? ❑ Yes (Carrier Name _____) ❑ No
2. Plan Sponsorship: ❑ Private Entity (ERISA) ❑ Government Entity ❑ Church Entity
3. Ownership Type: ❑ Partnership* ❑ Sole Proprietorship* ❑ Corporation _____ (State of Inc.) ❑ Other _____

*List the Name of each Partner or Owner below:

A. _____ C. _____

B. _____ D. _____

GROUP ELIGIBILITY/ENROLLMENT POLICY INFORMATION

1. Number of hours employees must work per week to be considered eligible for coverage: _____
2. Other than full-time employees (defined in DE as working 30 or more hours per week), please check the box(es) below to indicate whether your company offers coverage to any of the following optional classes of employees:
   - ❑ Part-time employees (Must work at least 20 hours a week)
   - ❑ Disabled employees (covered prior to the disability and receiving disability compensation)
   - ❑ Seasonal employees (must work full-time 9 months out of the year)
   - ❑ Retirees (non-Medicare eligible)
   - ❑ Former Owners (non-Medicare eligible)
   - ❑ Independent Contractors
3. New employees are eligible to enroll: ❑ Hire Date ❑ First Day Following _____ Days ❑ First Day of the Month Following _____ Days
   NOTE: Probationary period cannot exceed 60 calendar days from the hire date
4. Do you have Union employees that have coverage through a separate Union organization? ❑ Yes ❑ No
   If Yes, please provide a copy of the bargaining agreement and/or health carrier subscriber listing.
5. 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 Waivers									
Number Opt-Outs									
Number Enrolling									

EMPLOYER MEDICAL CONTRIBUTION

	Employee*	**Employee & Spouse***	**Employee & Child***	**Employee & Children***	**Family***
Percentage OR Dollar Amount					

***All tiers must be completed for your contribution type.**

MSP AND GROUP SIZE EMPLOYEE COUNT 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.

1. In the PRECEDING calendar year, did you have at least:
   ❑ 20 or more employees for each working day of 20+ calendar weeks? . . . . . ❑ Yes ❑ No ❑ Company did not exist
   - If yes, on what date did you first meet the threshold? ____/____/____
     Date must be between 5/20 and 12/31 of the calendar year

   ❑ 100 or more employees during 50% 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:
   ❑ 20 or more employees for each working day for 20+ calendar weeks? . . . . . ❑ Yes ❑ No ❑ Company did not exist
   - If yes, on what date did you first meet the threshold? ____/____/____
     Date must be between 5/20 and 12/31 of the calendar year

   ❑ 100 or more employees during 50% of your regular business days? . . . . . ❑ Yes ❑ No ❑ Company did not exist
3. Please provide your average number of employees on all your business days during the preceding calendar year: _____

   Note: The average number of employees may be determined by totaling all employees (full-time, part-time, seasonal/intermittent, and in and out of area employees) for whom you issued a W-2 that were employed on each of your business days during the preceding calendar year, and dividing that number by your total number of business days during that year. If your business is aggregated with one or more other businesses and treated as a single employer under subsection (b) controlled group corporations, (c) partnerships, proprietorships, etc., under common control, (m) employees of an affiliated service group, or (o) other regulations of section 414 of the Internal Revenue Code, please provide the combined total number of W-2 employees for all business that are included in the "single employer group" under the Internal Revenue Code.

COBRA INFORMATION

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

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 ❑ Company did not exist

*I understand that if I answer YES to this question, the company is subject to Federal COBRA and TEFRA/DEFRA legislation.

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
		( )

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 BCBS Delaware products and they will receive any and all commissions included in the rates.

I further acknowledge and agree that Highmark BCBS Delaware 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 BCBS Delaware of a change, or until my Highmark BCBS Delaware insurance coverage terminates.

In addition, I understand that all Highmark BCBS Delaware 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 BCBS Delaware. 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 BCBS Delaware 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 BCBS Delaware 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 BCBS Delaware 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.

SUMMARY OF BENEFITS 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.highmarkbcbsde.com/sbc/bcbsde_smallgroup.html

If you do not have online access, you can get a paper copy of an SBC free of charge by calling toll free, 1-800-572-4400.

Authorized Representative Name

Authorized Representative Title

Authorized Representative Signature

Date

Submit to: Highmark Inc. • Small Group Sales • 800 Delaware Avenue Suite 900 • Wilmington, DE 19801

Addendum - For Use with Common Ownership and IRS Controlled Groups Only.
Please complete one addendum for each additional company enrolling in the lead company.
Lead Company Name:_____ (as shown on page 1).

GROUP INFORMATION

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

Address (Physical Location – No P.O. Boxes) | **City** | **State** | **County** | **Zip Code**

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

Correspondence Contact (If Billing Contact is 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**

1. Do you have Union employees that have coverage through a separate Union organization? ❑ Yes ❑ No
   If Yes, please provide a copy of the bargaining agreement and/or health carrier subscriber listing.
2. Plan Sponsorship: ❑ Private Entity (ERISA) ❑ Government Entity ❑ Church Entity
3. Ownership Type: ❑ Partnership* ❑ Sole Proprietorship* ❑ Corporation _____ (State of Inc.) ❑ Other _____

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2. New employees are eligible to enroll: ❑ Hire Date ❑ First Day Following _____ Days ❑ First Day of the Month Following _____ Days
   NOTE: Probationary period cannot exceed 60 calendar days from the hire date

EMPLOYER MEDICAL CONTRIBUTION

	Employee*	Employee & Spouse*	Employee & Child*	Employee & Children*	Family*
Percentage OR Dollar Amount					

***All tiers must be completed for your contribution type.**

MSP AND GROUP SIZE EMPLOYEE COUNT 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.

1. In the PRECEDING calendar year, did you have at least:
   ❑ 20 or more employees for each working day of 20+ calendar weeks? .....❑ Yes ❑ No ❑ Company did not exist
   - If yes, on what date did you first meet the threshold? ____/____/____ **Date must be between 5/20 and 12/31 of the calendar year.**

   ❑ 100 or more employees during 50% 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:
   ❑ 20 or more employees for each working day for 20+ calendar weeks? .....❑ Yes ❑ No ❑ Company did not exist
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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 ❑ Company did not exist

*I understand that if I answer YES to this question, the company is subject to Federal COBRA and TEFRA/DEFRA legislation.