Highmark Inc. d/b/a Highmark Blue Shield | HM Health Insurance Company d/b/a Highmark Health Insurance Company | Highmark Benefits Group

SMALL GROUP BUSINESS APPLICATION

For small employers headquartered in Southeastern 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)* ☐ *Same as physical address*	City	County	State	Zip

Ownership Type

☐ Partnership ☐ Sole Proprietorship ☐ C-Corporation ☐ S-Corporation ☐ Non-profit ☐ 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

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.

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.

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.

1. What is your **average total number of employees** during the prior calendar year: _____
2. Are you part of a "controlled group" as defined under IRS rules (IRC section 414)? ☐ Yes ☐ No

*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.*

Health Benefits or health benefit administration may be provided by or through Highmark Blue Shield, Highmark Health Insurance Company or Highmark Benefits Group, 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.

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:
   ☐ Hire date

   First day following:
   ☐ Hire Date
   ☐ 30 Days
   ☐ 60 Days
   ☐ 90 Days

   First day of next month following:
   ☐ Hire Date
   ☐ 30 Days
   ☐ 60 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: Name:
Agency:	
Producer:	Username/Login ID:
Producer Signature:	Name:
	Username/Login ID:

SECTION 6: PLAN SELECTION(S)

PPO BLUE PLANS

PPO Blue plans are available to companies headquartered in the following Southeastern Pennsylvania counties: Bucks, Chester, Delaware, Montgomery, and Philadelphia

- ☐ PPO Blue $0 100/80 Platinum
- ☐ PPO Blue $0 100/80 Gold
- ☐ PPO Blue $500 100/80 Gold
- ☐ PPO Blue $1000 100/80 Gold
- ☐ PPO Blue $1400 100/80 Gold
- ☐ PPO Blue Qualified $1600 100/80 Gold
- ☐ PPO Blue Qualified $2400 95/75 Gold
- ☐ PPO Blue $2500 100/80 Gold
- ☐ PPO Blue Qualified Embedded $3200 1x 100/80 Gold
- ☐ PPO Blue $3500 100/80 Gold
- ☐ PPO Blue $0 100/80 Silver
- ☐ PPO Blue 3800 70/50 Silver
- ☐ PPO Blue Qualified Embedded $4250 100/80 Silver
- ☐ PPO Blue PPO $4500 100/80 Silver
- ☐ PPO Blue Qualified Embedded 7350 100/80 Bronze

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

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 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 HighmarkBlueShield.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