HIGHMARK® HEALTH INSURANCE COMPANY

SMALL GROUP BUSINESS APPLICATION

(For small employers – 2 to 50 employees – headquartered in the 21 counties of Central PA)

Complete this application in its entirety in blue or black ink.

Do not use pencil or highlighter.

GROUP SUBMISSION STATUS

❑ **New Business** (check all that apply)

❑ Add Act 4 Group (Dependent(s) to age 30) ❑ Add Mini-COBRA Group *(2-19 employees)* ❑ Add Federal COBRA Group *(20 or more employees)*

❑ **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
- ❑ Pool to Pool Movement - Current Group No(s).___________
- ❑ Add Mini-COBRA Group (2 - 19 employees)
- ❑ Add Federal COBRA Group (20 or more employees)
- ❑ Add Act 4 Group (Dependent(s) to age 30)
- ❑ 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: ____________

For New Business: Only a Quote ID is required (Product Description is optional)
- Underwriting will provide interim final rates for all medical products.

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

Quote ID ____________ Product Description ____________

Supplemental Product(s): Quote ID ____________ Product Description ____________

Quote ID ____________ Product Description ____________

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

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 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)

1. Current Medical Coverage: Uninsured? ❑ Yes ❑ No (if "No," then name of other carrier): ____________
2. Plan Sponsorship: ❑ Private Entity (Erisa) ❑ Government Entity ❑ Church Entity ❑ Non-Profit
3. Ownership Type: ❑ Partnership* ❑ 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. 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			Other † (e.g., disabled)		
	Medical	Vision	Dental	Medical	Vision	Dental	Medical	Vision	Dental
Number Eligible									
Number Enrolling									
Number 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					

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

EMPLOYEE COUNTS FOR MSP AND OTHER STATE/FEDERAL MANDATES

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 employee's 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 employee's 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 employee's 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. 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.
4. 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
5. Please provide your average number of employees on all your business days during the preceding calendar year: ________________
6. Please provide the total number of your employees that are currently eligible to participate in your group sponsored health care coverage(s): ________________

Note: 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

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**	**GA 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 Health Insurance Company (HHIC) products and they will receive any and all commissions included in the rates.

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 HHIC of a change, or until my HHIC insurance coverage terminates.

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**

Please return forms to:

Highmark • Attn: Producer Affairs (SP 6E) • P.O. Box 890089 • Camp Hill, PA 17089-0089

Addendum - For Use with Common Ownership and IRS Controlled Groups Only.
Please complete one addendum for each additional company enrolling in the lead group identified 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
( )	( )	

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)

1. Plan Sponsorship: ❑ Private Entity (Erisa) ❑ Government Entity ❑ Church Entity ❑ Non-Profit
2. Ownership Type: ❑ Partnership* ❑ Proprietorship* ❑ Corporation ________ State of Inc. ❑ Other ________

*List the Name of each Partner or Owner below:

A. ____________________ C. ____________________

B. ____________________ D. ____________________

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1. Number of hours employees must work per week to be considered eligible for coverage: ____________
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   ❑ Other: ____________

EMPLOYER MEDICAL CONTRIBUTION

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

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

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1. In the PRECEDING calendar year, did you have at least:
   ❑ 20 or more employee's 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.**

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5. Please provide your average number of employees on all your business days during the preceding calendar year: ____________
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   ❑ Yes ❑ No