



SMALL GROUP BUSINESS APPLICATION

(For small employers – 2 to 50 employees – headquartered in the 29 counties of Western 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 _____ Other _____
State of Inc.

*List the Name of each Partner or Owner below:

A. _____

C. _____

B. _____

D. _____

GROUP ELIGIBILITY/ENROLLMENT POLICY INFORMATION

- Do you wish to cover: Domestic Partners Act 4 Dependent(s) - to age 30
- Number of hours employees must work per week to be considered eligible for coverage: _____
- 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: _____
- 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.

- 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
- 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
- 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.
- 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
- Please provide your average number of employees on all your business days during the preceding calendar year: _____
- 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.

