HIGHMARK DELAWARE

SMALL GROUP BUSINESS APPLICATION

(For small employers headquartered in Delaware)

I. GROUP SUBMISSION UPDATES

❑ New Business Update

❑ Existing Business Update

❑ Other (e.g., Ownership, Off-Cycle Benefit , Subsidiary and/or Buyout/Mergers, Federal Tax ID/EIN, COBRA Changes, etc. — **Complete all applicable sections and explain in Comments section.**)

II. REQUESTED PRODUCT INFORMATION

Effective Date: _____

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

Quote ID _____ Product Name _____

Quote ID _____ Product Name _____

Vision: Quote ID _____ Product Name _____

Dental: Plan ID _____ Product Name _____ ❑ Tier 2 Rates or ❑ Tier 4 Rates

❑ $1000 max or ❑ $1500 max

III. EMPLOYER/GROUP INFORMATION

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

Physical Address (No P.O. Box) | **City** | **State** | **County** | **Zip Code**

Mailing Address ❑ **Same as physical address above** | **City** | **State** | **County** | **Zip Code**

Contract Signor Name | **Title**

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

Nature of Business | **SIC Code** | **Years in Business**

1. Do you currently have a group/individual medical plan? ❑ Yes (Current Carrier Name _____) ❑ No

2. Ownership Type *(List business owners/partners on line below)*:

❑ Partnership ❑ Proprietorship ❑ C- Corporation: State of Inc._____ ❑ S - Corporation: State of Inc._____ ❑ Other: (e.g., NonProfit)

List the names of ALL business owners/partners:

_____ _____

_____ _____

3. By checking the "I agree" Opt-in selection and signing below, the Company/Group agrees to log onto the secure employer portal at HighmarkBCBSDE.com 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 understands that by making this selection, it will not receive paper copies of its health plan contract or any amendatory riders thereto. These documents will only be provided in electronic format. The Company/Group's Highmark Broker/representative will send a request to Highmark to create a secure employer portal login ID and password which will be sent directly to the Company/Group. 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.

Note: The Company/Group has the right to receive paper copies of documents, including health plan contracts and amendatory riders to its contract at any time, without charge. To update how the Company/Group receives its health plan contract information from Highmark at any time, please contact the appropriate Highmark Broker or representative.

OPT-IN SELECTION: ❑ I agree ❑ I do not agree

IV. GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. Do you wish to make coverage available to Domestic Partners at any time during the contract period? ❑ Yes ❑ No
   *If applicable, additional documentation is required for domestic partner verification.
2. Number of hours employees must work per week to be eligible for coverage: _____ (Must be between 20 to 30 hours)
   NOTE: Under Delaware law, employers must offer coverage to all full-time employees who normally work 30 or more hours per week. Therefore, the requirement **cannot** be greater than 30 hours and no less than 20 hours based on Highmark Delaware underwriting guidelines.
3. Probationary period for new employees. Please choose an option:
   ❑ Hire Date
   ❑ First Day Following: _____ Days (**Cannot** exceed 60 calendar days)
   ❑ First Day of Next Month Following: (Check one): ❑ Hire Date ❑ 30 Days
   Note: Probationary periods cannot exceed 60 calendar days.
4. Do you wish to waive the probationary period for all eligible employees on the group's initial effective date only? ❑ Yes ❑ No
5. Employer agrees to contribute at least 10% of the cost of employee coverage.

V. FEDERAL AND STATE REQUIREMENTS

Affordable Care Act Group/Market Size Determination

1. Is the above company affiliated with other entities that have a separate Federal Tax I.D./ E.I.N. and are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules (If you are unsure how to answer this question, please seek assistance from your tax accountant or legal counsel).

   ❑ Yes - If affiliated entities are to be included in this application and are enrolling in coverage, attach a Certification of Eligibility to Combine and Employer Group Size Form completed by an authorized representative of the company. The form must include all affiliated entity names and Employer Identification Numbers (EIN).

   ❑ No

   For group/market size determination, count all eligible employees who were employed on at least 50% of your business days in the PRECEDING calendar quarter. Count all employees who worked on a full-time basis that had a normal work week of 30 or more hours including owners, partners, and union employees. If you offer coverage to 1099 independent contractors that normally work 30 or more hours per week, please include them as well. EXCLUDE employees who work on a part-time, temporary and substitute basis.

   IMPORTANT: If you answered Yes to question 1, please count all employees collectively for all related entities that are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules. These aggregation rules apply to all questions in this section.

2. Please provide your **average** number of employees on all your business days during the **PRECEDING** calendar quarter: _____

Medicare Secondary Payer Employee Count

For Medicare and Secondary Payer (MSP) purposes, count all employees. This **includes** all eligible employees who were employed on at least 50% of your business days in the PRECEDING calendar quarter. Count all employees who worked on a full-time basis that had a normal work week of 30 or more hours including owners, partners, and union employees. If you offer coverage to 1099 independent contractors that normally work 30 or more hours per week, please include them as well. In addition, include all leased employees, part-time employees, and employees that are not working but receiving disability payments (which for non-government employers are subject to FICA). **Note:** If you answered Yes to question one in the Affordable Care Act Group/Market Size Determination section, please follow the instructions in the IMPORTANT note contained within that same section when answering questions one and two in this Medicare Secondary Payer Employee Count portion of the form.

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 did not exist
   b. **100 or more** employees during 50% or more 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:
   a. **20 or more** employees for each working day of 20 or more calendar weeks? ❑ Yes ❑ No ❑ Unknown, enough time has not expired
   b. **100 or more** employees during 50% or more of your regular business days? ❑ Yes ❑ No ❑ Unknown, enough time has not expired

Cobra/Mini-Cobra Information

1. How many full-time equivalent employees did/do you employ?

Preceding Calendar Year:	Current Calendar Year:

2. Within the preceding calendar year, did you have 20 or more full-time equivalent employees on at least 50% of your typical business days?
   ❑ Yes ❑ No ❑ Company did not exist

VI. ONLINE ENROLLMENT/BILLING TRANSACTIONS

1. Do you wish to sign up for online enrollment and/or billing transactions? ❑ Yes ❑ No
2. Spending Account(s) to be administered by Highmark Blue Cross Blue Shield Delaware:
   ❑ HSA ❑ FSA ❑ Using an Outside Vendor (If administered by Highmark Blue Cross Blue Shield Delaware, please attach Small Group HSA form.)

Contact Name _____

Contact Email _____

VII. PRODUCER OF RECORD

Agency Name

General Agency Name

Producer Name

Broker access:

Should this client be added to your on-line existing multi-client access?

❑ **Yes** ❑ **No**

Logon ID: _____

Should enrollment access be: ❑ **View** ❑ **Edit**

Billing Access: ❑ **Yes** ❑ **No**

Producer Signature

Highmark Sales Representative

VIII. 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.

IX. 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 for all Highmark Delaware products and they will receive any and all commissions included in the rates.

I further acknowledge and agree that Highmark Delaware may disclose enrollment, disenrollment, summary health and/or premium billing information requested by the Producer of Record for purposes of inputting, updating and/or reviewing the same for the above - identified business.

I also understand that the Producer of Record may be eligible to receive additional compensation for achieving specified sales goals. The Producer of Record named above will remain the Producer of Record until I notify Highmark Delaware of a change, or until my Highmark Delaware insurance coverage terminates.

In addition, I understand that all Highmark 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 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 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 Delaware of any changes, mistakes, or discrepancies within the thirty (30) day period that follows.

In addition, I understand that if the Company/Group purchases a qualified high deductible health plan (QHDHP) compatible with a health savings account (HSA) or a high deductible health plan (HDHP) compatible with a health reimbursement arrangement (HRA), including but not limited to an HSA Compatible or HRA Compatible product, and selects an HSA or HRA administrator other than Highmark Delaware to interface electronically **or** otherwise with a Highmark Delaware QHDHP or HDHP, or does not contribute all or any portion of the mandated HSA or HRA contributions, the Company/Group is solely responsible for administration of an HSA or HRA in accordance with the design of the purchased QHDHP or HDHP, as such administration affects the Company's/Group's responsibility for ensuring that such purchased QHDHP or HDHP and corresponding HSA or HRA complies with all applicable laws, including but not limited to the Patient Protection and Affordable Care Act of 2010 as amended, and guidance published thereunder.

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 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.

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.

Enrollment Applications: Eligible employees enrolling as indicated on the Unemployment Compensation report and/or payroll history and the enrollment spreadsheet have completed and signed an application (either hard copy or electronic) reflective of their respective enrollment decisions. The enrollment applications 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 are being kept on file and could be made available to Highmark, upon request.

Waiver forms: Eligible employees and/or their eligible dependent(s) who are waiving the coverage(s) must fully complete (including the waiver reason), sign, date and supply to Highmark the completed waiver form.

Authorized Representative Signature *(please hand sign if this is a paper request)*

Date

Authorized Representative Title

COMMENTS

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. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, 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).

ATTENTION: Si c’est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d’identité. (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.