HIGHMARK® Delaware

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highmarkbcbsde.com

GROUP APPLICATION FORM
Small Business Group Health Insurance Program

PART I: ABOUT YOUR COMPANY

1. Company's legal name: SIC #

2. Trading as or doing business as:

3. Company contact person and title:

4. Place of operation (street address, city, state, zip code):

5. Billing address (street address, city, state, zip code):

6. Phone number (include area code):
   7a. Fax number (include area code):
   7b. e-mail address:

8. Was your company enrolled with Highmark Blue Cross Blue Shield Delaware under a different name in the past? ☐ Yes ☐ No
   If yes, indicate the month and year when that coverage was terminated:

9. Are there any commonly-owned subsidiaries or affiliates (Common ownership exists when one or more individuals or companies have controlling interest in two or more separate business entities. Close affiliation exists where there are indications of overlapping ownership of similar or interdependent entities or where employees are shared. Highmark DE reserves the right to make these determinations on a case-by-case basis.)?

   ☐ Yes ☐ No If yes, please list:
   Company name(s):

   Health insurer(s) name(s):

10. **Company Information.** Please provide the following information as it applies to your company:

    Federal Employer Identification Number: _____

    If a for-profit company: Our company possesses a valid Delaware business license and/or professional license.

    If a non-profit company: Our company possesses a valid declaration of tax-exempt status and a Federal taxpayer Identification Number from the IRS.

    Is your company subject to federal:

    TEFRA/DEFRA (20 or more employees)? ☐ Yes ☐ No

    COBRA legislation (20 or more employees)? ☐ Yes ☐ No If Yes, is your Cobra Administrator ☐ Highmark DE (Cobra Serv) or Other (please provide name) _____

11. Company Effective Date: Requested effective date for account coverage:

    Month, day, year: _____/_____/_____

    • Highmark DE coverage will become effective either the 1st or the 16th of the month.

    • Highmark DE must receive completed paperwork at least 15 days before the requested effective date.

IMPORTANT!

Do not cancel in-force policies until we notify you that we have accepted your company's application for coverage and have informed you of the policy effective date.

ENR-177 (5-12)

PART II: CONTRIBUTION AMOUNT, EMPLOYEE GUIDELINES

A. Contribution Amount: (Indicate a dollar or percentage amount.)
Our Company will contribute _____ of the premium for Individual coverage and _____ of the premium for Family coverage.

B. Employee Guidelines

Waiting Periods

1. Our waiting period for initial employee eligibility will be _____ days (0–60).
2. Our waiting period for employer premium contribution will be _____ days (0–365).

Start / End Dates (select one):

☐ Date of hire; satisfaction of waiting period; termination, or
☐ First of the month following date of hire; satisfaction of waiting period; termination.

PART III: SELECT YOUR PLAN OPTIONS

A. Please choose 2 plan options for your group.

Standard

☐ IPA Standard $10 with $5 or 25% RX

Basic

☐ IPA Basic $10 with no Rx

Blue Care® IPA Benefits	**Rx Plan Option No.**
☐ IPA $15/$25 100	_____
☐ IPA $20/$40 100	_____
☐ IPA $30/$60 100	_____
Blue Choice PPO Benefits	
☐ PPO $15 $0 Ded. 90/70	_____
☐ PPO $25 $500/$1,500 80/60	_____
☐ PPO $30 $3,000/$6,000 80/60	_____
Simply Blue EPO Benefits	
☐ EPO 100 $250	_____
☐ EPO 100 $500	_____
☐ EPO 100 $1,000	_____
☐ EPO $15 $0 Ded. 90	_____
☐ EPO $25 $500/$1,500 80	_____
☐ EPO $15 $1,000/$2,000 80	_____
☐ EPO $15 $2,000/$4,000 80	_____
☐ EPO $30 $3,000/$6,000 80	_____
Simply Blue EPO Value Option Benefits	
☐ EPO $750 80	_____
☐ EPO $1,500 80	_____

Dental Benefits

Indicate your dental benefits choice(s), if applicable:

☐ Traditional or ☐ Blue Dental–DHMO/PPO or ☐ None

Vision Benefits

☐ BlueVision Premier _____

Medicare Benefits

Indicate the Medicare Supplement program your company wishes to offer retirees, if applicable:

☐ Secure ☐ Special Medicfill® ☐ Special Medicfill® with $10/$25/$50 RX

☐ None

Blue Advantage (HSAs and HRAs)

The following are high deductible health plans that are compatible with a Health Savings Account and a Health Reimbursement Arrangement. Please contact your broker or call one of or Highmark Blue Cross Blue Shield Delaware Marketing representatives at 800.572.4400 for additional details and/or assistance.

	Rx Plan Option No. (HRA only)
HSAs	
☐ HSA PPO $1500/$3000 100/80	_____
☐ HSA EPO $1,350/$2,700 100*	_____
☐ HSA EPO $1,500/$3,000 100	_____
☐ HSA EPO $2,000/$6,000 100*	_____
☐ HSA EPO $2,500/$7,500 100	_____
☐ HSA EPO $5,000/$10,000 100	_____
☐ HSA EPO $1,500/$3,000 ***Hybrid***	_____
☐ HSA EPO $3,000/$6,000 ***Hybrid***	_____
HRAs	
☐ HRA PPO $1,500/$3,000 100/70	_____
☐ HRA PPO $2,000/$6,000 100/70	_____
☐ HRA EPO $1,500/$3,000 100	_____
☐ HRA EPO $2,000/$6,000 100	_____
☐ HRA EPO $2,500/$7,500 100	_____
☐ HRA EPO $5,000/$15,000 100	_____
☐ HRA EPO $5,000/$15,000 80	_____
HRA Alternative Option Benefits	
☐ EPO HRA $25 $2,500/$5,000 80	_____

Will you be offering an HSA and/or HRA with your HDHP? ☐ Yes ☐ No

Will the HRA have automatic claims rollover? ☐ Yes ☐ No

Please Note:

- HSA Plans have the Integrated Drug Card option only.
- HRA Plans have a choice of a 3-tier drug card option.

Your Prescription Drug Card Option Choice

Please indicate your drug option number in the blank space next to your medical plan selection(s).

Rx Plan Options:

1 $ 0/$20/$60 Rx Plan with no deductible
2 $10/$20/$35 Rx Plan with no deductible
3 $10/$25/$50 Rx Plan with no deductible
4 $15/$30/$60 Rx Plan with no deductible
5 $20/$60/$80 Rx Plan with no deductible
6 $15/$75/$100 Rx Plan with no deductible

*Integrated drug covered at 100% after deductible is met.

B. Applying for Pre-Existing Condition Waiver

☐ **YES**, I am applying for a waiver of pre-existing conditions and have included documentation of qualified previous coverage:
- HIPAA Certificate or a copy of the last bill from my previous carrier.
- Highmark DE reserves the right to request a copy of the benefit booklet from the previous carrier.

☐ **NO**, I will not submit documentation at this time. Please issue coverage without a pre-existing condition waiver. **I understand that claims may be denied due to pre-existing conditions.**

C. Check the box(es) below to indicate whether your company wishes to offer coverage to the following optional classes of employees meeting at least the minimum expectations as described in the *"Small Business Program Requirements"* pamphlet.

Part-time employees	☐ Yes ☐ No	Disabled employees	☐ Yes ☐ No	Former owners	☐ Yes ☐ No
Independent contractors working for your company	☐ Yes ☐ No	Retirees	☐ Yes ☐ No		
		Seasonal employees	☐ Yes ☐ No		

Please Note: If you are making changes to or offering coverage for the first time to the above classes of employees, please complete the enclosed "Addendum to the Group Application Form."

PART IV: THE MEMBER COMPANY AGREEMENT

ABOUT THE AGREEMENT: To receive health, vision and dental benefits from Highmark DE and remain eligible for them under this program, Member Companies must agree to participate in the Diamond State Group Insurance Trust and certify to understanding the conditions of participation.

- **Please read this Agreement carefully.**
- **Sign, date and return this Agreement to us.**

I UNDERSTAND THAT: Eligibility—Our Company satisfies eligibility requirements as described in the *"Small Business Program Requirements,"* pamphlet and will offer coverage to all full-time owners and employees working at least 30 hours per week.

Late Enrollees—Any employees, retirees or dependents who do not enroll when first eligible will be considered a late enrollee, and will be subject to a 12-month preexisting condition waiting period. They must complete a *Waiver of Coverage* form at the time that they are first eligible, and our Company will maintain copies on file after sending originals to Highmark DE.

I CERTIFY THAT:

- My Company understands the requirements to be an eligible member company, employee, dependent, or retired employee under the plan; and
- My Company and its enrolled employees, dependents and retired employees meet the eligibility requirements; and
- My Company understands and agrees to abide by the participation requirements (percentages of employees required to be enrolled) to be eligible for coverage under the plan; and
- My Company understands and agrees to permit Highmark DE to inspect our company's payroll, personnel, and business records in order to periodically confirm Company and enrollee eligibility; and
- My Company understands that if the Company or any person enrolled is ineligible for coverage, we will be responsible to Highmark DE for the difference between premiums and claims paid under the coverage; and
- My Company wants Highmark DE to provide HIPAA Certificates of Coverage upon an employee's termination of employment.

I CERTIFY THAT: I am authorized to represent my Company in the purchase and administration of the group insurance program.

TRUST PARTICIPATION: On behalf of my Company, we agree to be a Participating Member Company in the Diamond State Group Insurance Trust for group insurance available under the Trust. My Company agrees to abide by the terms, conditions and limitations of the Trust Agreement. We understand that:

- The Trust Agreement and the insurance policy are available for inspection during normal business hours at Highmark DE offices in Wilmington, Delaware.
- The principal duty of the Trustee is to hold the insurance policies that provide the insurance coverage.
- The Trustee is not the insurer.
- The insurance coverage, the determination of benefits and payments, and any other duties related to the coverage are the sole obligations of, and will be fulfilled by, Highmark DE in accordance with the terms of the group policy, and Highmark DE's underwriting and standard operating procedures.
- Neither the Trustee nor Highmark DE are acting as sponsors or Plan Administrator of any employee benefit plan as defined by ERISA.

On behalf of my Company, we apply for group health (vision and dental) coverage from Highmark DE through the Diamond State Group Insurance Trust. We agree that our Company will comply with all the terms and provisions of the group policies and any underwriting regulations that apply.

Acknowledged by (company representative's signature):	Date (month, day, year):
Company representative's printed name and title:	
Completed by (Highmark DE marketing representative or broker):	Date (month, day, year):
Broker's name and address:	

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Company Name:	Group Number:
Coverage Effective Date:	Date Approved and Released by Underwriting:

Health Rating Category:

☐ Preferred Plus ☐ Preferred ☐ Standard ☐ Transition Step 1 ☐ Transition Step 2 ☐ Transition Step 3

Original group granted waiver of preexisting condition waiting period?

☐ Yes ☐ Partial ☐ No

NOTES