[3800 Centerpoint Dr.
Suite 940
Anchorage, AK 99503-5825]

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

SMALL GROUP MASTER APPLICATION

Application is made to Premera Blue Cross Blue Shield of Alaska (hereafter referred to as "we," "us," or "our") for a new Health Care Contract, the provisions of which shall be made available to all eligible classes of employees.

Your group cannot be enrolled prior to our receipt date of this completed and signed application

GROUP NAME _____

GROUP ID _____
(Completed by Premera Blue Cross Blue Shield of Alaska)

1. REQUESTED EFFECTIVE DATE

2. GROUP INFORMATION

A. Legal Name

Common Name ***Note:*** *Required if Legal Name exceeds 43 characters and spaces, otherwise, optional.*

B. Employer Identification Number (EIN) NAICS #

C. Physical Address City State ZIP

D. Mailing Address ☐ Same as Physical Address ☐ Separate Address, complete the following:
Street/ P.O. City State ZIP

E. Billing Address ☐ Same as Mailing Address ☐ Same as Physical Address ☐ Separate Address, complete the following:
Street/ P.O. City State ZIP

F. Billing Contact ☐ Mr. ☐ Mrs. ☐ Ms. Title
Phone No. ( ) - E-mail Address

G. Group Benefit Administrator ☐ Mr. ☐ Mrs. ☐ Ms. Title
Phone No. ( ) - E-mail Address

H. Subgroup Structure Does your group have a specific subset of membership that is to be allocated to a different billing location or entity?
☐ No ☐ Yes If yes, provide the following if different than above.
Subgroup Name Employer Identification Number (EIN)
Subgroup Billing Contact ☐ Mr. ☐ Mrs. ☐ Ms. Subgroup Benefit Contact ☐ Mr. ☐ Mrs. ☐ Ms.
Mailing Address
Street/ P.O. City State ZIP
Billing Address ☐ Same as Mailing Address
Street/ P.O. City State ZIP

I. If subject to COBRA, do you use a COBRA Administrator?
☐ No ☐ Yes, complete the following: ☐ Same as Billing Address and Contact Person
COBRA Administrator Billing Address
City State ZIP
COBRA Administrator Contact ☐ Mr. ☐ Mrs. ☐ Ms. Title
Phone No. ( ) - Fax No. ( ) - E-mail Address

3. CURRENT COVERAGE INFORMATION

A. Is this plan intended to replace any existing coverage? ☐ No, go to next section ☐ Yes, complete the following:

1. **Name(s) of current medical carrier(s)** _____ Length of coverage: _____
2. **Name(s) of current dental carrier(s)** _____ Length of coverage: _____

4. GROUP ELIGIBILITY

A small employer is an employer who employed an average of at least 1 but not more than 50 common law employees on business days during the preceding calendar year and who employs at least 1 common law employee on the first day of the current plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. Sole proprietors with no common law employees and self-employed individuals are not eligible to purchase (or renew) small group plans.

A. Did the group employ an average of 1-50 or fewer employees during the previous calendar year? ☐ No ☐ Yes

B. Is the company's headquarters located in the State of Alaska? ☐ No ☐ Yes

If No, please contact your Sales Representative for assistance.

5. EMPLOYEE ELIGIBILITY REQUIREMENTS

A. Employees in One Class

Note: *Class of employees must be based on bona fide employment-based classifications consistent with your usual business practice.*

1. Choose one: ☐ All Employees ☐ Salaried ☐ Hourly ☐ Part-time ☐ Full-time

2. Minimum Hours**:** _____

***Note:** Employees must work at least **20 hours** per week to qualify for health coverage. The group may choose to set the minimum number of work hours per week higher for employees to be eligible.*

3. ☐ Exact date of hire, **OR**

☐ First of the month following:	☐ Date of hire	☐ 30 days	☐ 60 days
☐ Next Day following:	☐ Date of hire	☐ 30 days	☐ 60 days

B. Employees Differentiated by Class

Use section above for the first class and this section for the second class

1. Choose one: ☐ Salaried ☐ Hourly ☐ Part-time ☐ Full-time

2. Minimum hours: _____

3. ☐ Exact date of hire, **OR**

☐ First of the month following:	☐ Date of hire	☐ 30 days	☐ 60 days
☐ Next Day following:	☐ Date of hire	☐ 30 days	☐ 60 days

C. Waive Probationary Period

Do you want to waive the probationary period for all current qualifying employees for this enrollment period? ☐ No ☐ Yes

6. EMPLOYER CONTRIBUTION AND EMPLOYEE PARTICIPATION REQUIREMENTS

A. Minimum Contribution / Participation Requirements

Group Size	Employer Contribution for Employees	Employee Participation	Employer Contribution for Dependents	Dependent Participation
Medical: 1 – 3 Eligible Employees	75%	100%	No required level*	Optional
Medical: 4 – 50 Eligible Employees	50%	75%	No required level*	Optional
Dental: 2 – 4 Eligible Employees	50%	100%	No required level*	Optional
Dental: 5 – 50 Eligible Employees	50%	Greater of 5 Enrolled Employees or 50% of Eligible Employees	No required level*	Optional
Dental – Voluntary: 2 or more Eligible Employees	0-49%	Greater of 5 Enrolled Employees or 30% of Eligible Employees	No required level*	Optional

Note: *Employer contribution for dependent coverage cannot exceed the contribution for employee coverage.*

B. Contribution Level

The Employer will contribute the following percentage toward the cost of eligible employee and dependent coverage:

	Medical	Dental
Contribution for Employees:	___	___
Contribution for Dependents:	___	___

***Note for 1-50 Groups:** If the employer contributes 100% of the employee cost of coverage, then 100% participation is required of eligible employees without other coverage.*

***Please note:** If a group does not meet the requirements above, the group may enroll during the next designated open enrollment period.*

7. EMPLOYEE ENROLLMENT

		Medical	Dental
A.	Total number of Employees on payroll regardless of hours worked: ***Note:*** *Count each employee in only* ***ONE*** *category.*		
B.	Employees not eligible to enroll: Employees working less than the minimum number of hours per week (in a probationary period, temporary or seasonal, or not in a covered class)		
C.	Employees not enrolling due to other coverage:		
D.	Total number of employees eligible to enroll: **Total** *(Employees on payroll – Employees not eligible to enroll – Employees not enrolling due to other coverage)*		
E.	Eligible employees waiving enrollment without other coverage		
F.	Total number of eligible employees enrolling:		
G.	Do you have eligible employees in Hawaii?*	☐ No	☐ Yes

Please note: **Employees who reside in the state of Hawaii are not eligible to enroll for coverage.*

8. FEDERAL REQUIREMENTS

Helpful Hint: We strongly urge you to consult legal counsel in answering the questions below. The summaries below are not intended to be or to replace legal advice on your particular group. It is the group's responsibility to inform Premera immediately if facts change which would cause the group's answers below to change.

A. Is the group subject to the federal Medicare Secondary Payer (MSP) laws (such as TEFRA) that prohibit discrimination against individuals with group coverage based on their (or a spouse's) current employment status who have Medicare due to age?

1. ☐ Yes. This plan will pay primary to Medicare as required by federal law.
☐ No. Under 20 employees.

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

Helpful Hint: *These laws do not apply to any employer who did not employ 20 employees or more for each working day in each of 20 or more calendar weeks in either the current* ***or*** *preceding calendar year. For these small group plans, Medicare pays primary to the group plan.*
"Employees" include all full-time and part-time employees as well as those employees on disability and subject to FICA taxes. Also count leased employees if they would be counted as employees under §414(n)(2) of the Internal Revenue Code (IRC), and count employees employed by an "affiliated service group" under IRC §414(m) or by employers considered to be a "single employer" under IRC §52(a) or (b).

B. Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a family member's) current employment status who have Medicare due to disability?

1. ☐ Yes. This plan will pay primary to Medicare as required by federal law.
☐ No. Under 100 employees.

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

Helpful Hint: *Generally, these laws apply to any employer that employed at least 100 employees on 50% or more of its working days in the preceding calendar year. See the helpful hint in* ***6A*** *above for a definition of "employee" for this purpose.*

C. Is the group subject to COBRA?

☐ Yes
☐ No. Give the legal reason for exemption: _____

Helpful Hint: *Generally, these laws apply to any non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year.*
"Employees" are full-time and part-time common-law employees. Self-employed workers as defined in IRC §401(c)(1), corporate directors, or independent contractors should not be counted unless they qualify as common-law employees. "Employees" may also include leased employees who qualify as common-law employees. Please see COBRA regulations at 26 CFR § 54.4980B-2 Q/A 5 for guidance on counting a part-time employee as a fraction of a full-time employee.

D. Is the group subject to ERISA?

☐ Yes. Enter the month the ERISA plan year ends: Month _____
☐ No. Give the legal reason for exemption: ☐ Government or Public Plan ☐ Church Plan

Helpful Hint: *Generally, ERISA applies to all employer health plans except governmental, public or church plans. Non-profit status alone does not exempt an employer from ERISA.*

9. GROUP MATERIALS

Important note: *Electronic copies of benefit booklets are available online at [www.premera.com]. One copy of the benefit booklet will be sent to the Group Administrator.*

10. PRODUCER AGREEMENT TO CONTRACT

A. You, the producer, certify that you have met with the group submitting this agreement and that you have fully explained its contents. You have discussed coverage, eligibility, the effect of misrepresentations, termination provisions and subscription charge billing administration.

Producer Signature	Date
Producer of Record (*Print Name*)	Producer Number
E-mail Address	Name of Firm/Agency

B. Producer Support Contact (s)

Contact Name (*Print Name*):	Contact Name (*Print Name*):
E-mail Address:	E-mail Address:
Phone Number:	Phone Number:

C. ☐ Split Commission

Secondary Producer Name

Secondary Producer Number Secondary Producer %

11. GROUP AGREEMENT TO CONTRACT

You, the group named in the Group Information section of this application, understand and agree to the following.

A. This application becomes part of the contract to provide health care coverage after:

- The application is signed by you;
- The application is received and approved by us; and
- We receive the initial month's subscription charges.

You may not assign this contract without our written consent. Any attempt to do so will not have any binding effect on us. You agree to promptly deliver materials and notifications, including benefit booklets, received from us to all covered employees. You also agree to provide notification regarding the plan's waiting period and special enrollment rights to all eligible employees before their enrollment. You attest to have read this application, and represent that all statements are true and complete. You agree to the terms and obligations stated in this application. It is understood that provisions of the Health Care Contract, including subscription charges, may be amended or changed from time to time, upon our notice to you. All prior applications, to the extent that you have not made changes to them in this application, remain in full force and effect. The complete application consists of this document and the completed Group Master Application Benefit Selections form.
The producer listed in the Producer Agreement to Contract section will remain effective until written notice is given by either party. We are authorized to pay, on your behalf, commission, if any, for which you are liable to the above named producer.

B. Do you elect and authorize Premera Blue Cross Blue Shield of Alaska to provide such information to the producer and producer support staff? ☐ No ☐ Yes

You may elect to allow the producer listed above to act as a group benefit administrator beginning on the group's effective date. This means that the producer /administrator will be able to access membership and billing functions, and obtain information about group members via the Web on behalf of the group. These functions may include, but are not limited to:

- Reinstate Terminated Members
- Inquire on Invoice
- Order ID Cards for an Individual or Whole Family
- Request Invoice
- Inquire on Eligibility
- View Group Demographic Information
- Search for a Member
- Enroll a Member
- Cancel a Member
- View Benefit Detail

C. New groups, with a plan effective date in the middle of their plan year, can request the cost-sharing (e.g. deductible, coinsurance and copay) amounts accrued prior to the plan effective date be credited to their new plan.

D. I affirm the contribution and participation requirements in the Employer Contribution and Employee Participation Requirements section are followed. *(Applicable to groups enrolling outside open enrollment.)*

E. I affirm that this group has a physical location in the State of Alaska, and I am authorized to sign on behalf of the group.

Signature of Group's Representative	Date
Group's Representative *(Print Name)*	Title

Please Note: *A person who, with intent to injure, defraud, or deceive, knowingly makes a false or fraudulent statement or representation in or with reference to an application for insurance, may be prosecuted under state law.*