PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
An Independent Licensee of the Blue Cross Blue Shield Association

3800 Centerpoint Drive, Suite 940
Anchorage, AK 99503

Employer Group Application
Small Group (1-50)

Application is made to Premera Blue Cross Blue Shield of Alaska (hereafter referred to as "we," "us," or "our") for a new healthcare contract, the provisions of which shall be made available to all eligible classes of employees. Your group can't be enrolled prior to our receipt date of this completed and signed application

Requested effective date MM/DD/YYYY

A.	Group information			
1.	Legal name			
	Common name or doing business as (DBA) name, required if legal name exceeds 43 characters and spaces.			
	Physical address (no PO Box/PMB)			
	City	State	ZIP code	
2.	Employer identification number (EIN)	North American Industry Classification System # (NAICS)		
3.	Mailing address	Select one. ❍ Same as physical address ❍ Separate address, complete below		
	Street/PO Box			
	City	State	ZIP code	
4.	Billing address	Select one. ❍ Same as mailing ❍ Same as physical ❍ Separate address, complete below		
	Street/PO Box			
	City	State	ZIP code	
5.	Group contact person	Title		
	Phone – include area code	Mobile phone – include area code		
	Email address			
6.	Billing contact person	Title		
	Phone – include area code	Mobile phone – include area code		
	Email address			

7.	**Subgroup structure** Does your group have a specific subset of membership that is to be allocated to a different billing location or entity? ❍ Yes. Provide the following if different than billing contact and address above. ❍ No			
	Subgroup name		Employer identification number (EIN)	
	Subgroup billing contact		Subgroup benefit contact	
	Mailing address	Street/PO Box		
	City		State	Zip code
	Billing address	Street/PO Box		
	City		State	Zip code
8.	Do you use a Consolidated Omnibus Budget Reconciliation Act (COBRA) administrator? Select one. ❍ Yes. Complete the information below. ❍ No. Use the same billing address and group contact person.			
	COBRA administrator name. This is the name of the company.			
	COBRA administrator billing address			
	City		State	Zip code
9.	COBRA administrator contact person			
	Phone – include area code	Extension	Mobile phone – include area code	
	Email address			

B. Current coverage information

Is this plan intended to replace any existing group coverage? Select one.

❍ Yes. Complete this section.
❍ No. Go to next section, Group eligibility.

1.	Current medical carrier's name:
	Group number
	Termination date MM/DD/YYYY
2.	Current dental carrier's name
	Group number
	Termination date MM/DD/YYYY

C. Group eligibility

A small group 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.

This count should include all full-time, seasonal, and union employees that work either inside or outside of the State of Alaska and employees worldwide from any affiliated company. Include business owners, corporate officers, and partners only if they are common-law employees. Contracted 1099 individuals should not be included. Common-law employees are defined under the Employee Retirement Income Security Act of 1974 (ERISA) and Internal Revenue Service (IRS) regulations, guidance, and case law. Consult with your legal counsel to ensure your employees are considered common-law employees under the law.

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 should 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.

Note: Individual coverage is a valid form of waiver.

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

2. Is the company's headquarters located in the State of Alaska? Select one.
- ❍ Yes
- ❍ No. Contact your sales representative for assistance.

D. Employer contribution and eligible employee participation requirements

Review the minimum employer contribution and participation requirements below. If a group does not meet these requirements, the employer can enroll during the designated open enrollment period.

Group Size	Employer Contribution	Participation	Employer Contribution	Participation
	Eligible Employees		Dependents	
Medical				
1 – 3 eligible employees	75%	100%	No required level*	Optional
4 – 50 eligible employees	50%	75%	No required level*	Optional
Non-voluntary Dental				
2 – 4 eligible employees	50%	100%	No required level*	Optional
5 – 50 eligible employees	50%	Greater of 5 enrolled employees or 50% of eligible employees	No required level*	Optional
Voluntary Dental				
2 or more eligible employees	0-49%	Greater of 5 enrolled employees or 30% of eligible employees	No required level*	Optional

Employer contribution levels

Provide the employer contribution amount (percentage) for the cost of eligible employee and dependent coverage.
***Note:** Employer contribution for dependent coverage cannot exceed the contribution for employee coverage.

	Medical	Dental
Employee contribution:	_________%	_________%
Dependent contribution:	_________%	_________%

Note: If the employer contributes 100% of the employee cost of coverage, then 100% participation is required of eligible employees without other coverage.

E.	Employee eligibility requirements
	If you have one class of employees all employees must work the same hours, meet the same probationary period, and will have the same benefit options available to them, complete sections 1 and 3, and skip section 2. Otherwise, complete sections 1, 2 and 3.
1.	**Employees in one class** **Note:** Class of employees must be based on bona fide employment-based classifications consistent with your usual business practice.
a.	Choose one: ❍ All Employees ❍ Salaried ❍ Hourly ❍ Full-time
b.	All employees who normally work a minimum of ________ hours per week and have satisfied the probationary period are eligible.
c.	**Probationary period information** All eligible employees are effective on the: ❍ 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
2.	**Employees differentiated by class** **Note:** Use the section above for the first class and this section for the second class
a.	Choose one: ❍ All Employees ❍ Salaried ❍ Hourly ❍ Full-time
b.	All employees who work a minimum of ________ hours per week and have satisfied the probationary period are eligible.
c.	**Probationary period information** All eligible employees are effective on the: ❍ 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
3.	**Waive probationary period** Do you want to waive the probationary period for all current qualifying employees for this enrollment period? Select one. ❍ Yes ❍ No

F.	Employee enrollment		
		Medical	**Dental**
1.	Total number of employees on payroll (regardless of hours worked) **Note:** Count each employee in only one category	____________	____________
2.	Total number of employees not eligible to enroll **Note:** Employees working less than the minimum number of hours required per week, in a probationary period, temporary or seasonal, not in covered class.	____________	____________
3.	Total number of employees eligible to enroll **Note**: Calculated by subtracting total number of employees not eligible to enroll (2) from total employees on payroll (1)	____________	____________
4.	Total number of employees not enrolling due to group coverage under other group coverage, individual coverage or a government plan (Medicare, Medicaid, CHAMPUS/Tricare, or Military).	____________	____________
5.	Eligible employees waiving enrollment without other group coverage as listed above.	____________	____________
6.	Total number of eligible employees enrolling	____________	____________
	Enter participation level as a percentage **Note**: Participation level calculated by dividing the total number of employees enrolling (6) by the total number of eligible employees without other group coverage (3–4).	____________	____________
7.	Do you have eligible employees in Hawaii? Select one. ❍ Yes ❍ No **Note**: Employees who reside in the state of Hawaii are not eligible for coverage.		

G.	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 that would cause the group's answers below to change.
1. **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? Select one. ❍ Yes. This plan will pay primary to Medicare as required by federal law. ❍ No. Under 20 employees.
b.	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. "Employees" include all full-time 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).
2. **a.**	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? ❍ Yes. This plan will pay primary to Medicare as required by federal law. ❍ No. Under 100 employees.
b.	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 question **G.1** above for a definition of "employee" for this purpose.
3.	Is the group subject to COBRA? Select one. ❍ Yes ❍ No, give the legal reason for exemption: ____
	Helpful hint: Generally, these laws apply to any non-church employer that employed 20 employees or more employees on at least 50% of its working days in the preceding calendar year. "Employees" are full-time and 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.
4.	Is the group subject to the Employee Retirement Income Security Act (ERISA)? Select one. ❍ Yes. Enter the month the ERISA plan year ends: Month: _____________ ❍ No. Give the legal reason for exemption: ☐ Government or public plan ☐ Church plan ❍ Other. Please specify: ____
	Helpful hint: Generally, the Employee Retirement Income Security Act (ERISA applies to all employer health plans except governmental, public, or church plans. Nonprofit status alone does not exempt an employer from ERISA.

H. Group materials

Benefit Booklets are delivered electronically and are available online at premera.com.

Member ID numbers are available after enrollment is processed.

Member ID cards will arrive 7-10 business days after enrollment is processed and can be accessed through the Premera mobile app.

I. Producer agreement to contract

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 premium billing administration.

Producer of record

Producer signature X ______________________________	Producer of record (print name)	
	Date signed MM/DD/YYYY	Producer number
Producer email address	Name of firm/agency	
Effective the date producer is appointed for this group MM/DD/YYYY		

Producer support contact

Contact name (1)	Email address (1)
Contact name (2)	Email address (2)

Secondary producer and commission

Secondary producer name	Secondary producer number

❍ Split commission

Commissions are split between primary and secondary producers as follows:

Primary______% Secondary______%

J. Group agreement to contract

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

1.

This application becomes part of the contract to provide healthcare coverage after:

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

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 Benefit Selection Worksheet form.

Premera Blue Cross Blue Shield of Alaska must receive all completed enrollment materials by the 20*th* of the month of the following month's effective date. Materials received between the 11*th* and the 20*th* of the month may experience delays in receiving the following items:

- Benefit booklets
- Access to benefits
- Initial billing statement
- ID cards

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.

2.

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 include, but are not limited to:

- View benefit detail
- Inquire about eligibility
- Reinstate terminated members
- Invoices: inquire about or request invoices
- View group demographic information
- Order ID cards for an individual or whole family
- Members: search for members, enroll or cancel a member

Do you elect to allow Premera Blue Cross to provide such information described above to the producer? Select one.

❍ Yes ❍ No

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

4. I affirm the contribution and participant requirements in **Employer Contribution and Eligible Employee Participation Requirements** are followed. (Applicable to groups renewing outside open enrollment).

5. 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 representative	Group representative (print name)	
X ______________________________	Print title	Date signed MM/DD/YYYY

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.