PREMERA BLUE CROSS

PO Box 3048, MS 732
Spokane, WA 99220-3048

Employer Group Application
Small Group (1-50)

Application is made to Premera Blue Cross (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	County
2.	Employer identification number (EIN)		North American Industry Classification System # (NAICS)	
	Washington state unified business identifier (UBI)		Ownership type. Select one. ❍ Corporation ❍ Partnership ❍ Proprietorship ❍ Non-profit ❍ Other	
3.	Mailing address	Select one. ❍ Same as physical address ❍ Separate address, complete below		
	Street/PO Box			
	City	State	ZIP code	County
4.	Billing address	Select one. ❍ Same as mailing ❍ Same as physical ❍ Separate address, complete below		
	Street/PO Box			
	City	State	ZIP code	County
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.	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 contact person			Title
	Phone – include area code	Extension	Mobile – include area code	
	Email address			
	COBRA administrator billing address			
	City	State	ZIP code	County

B. Current coverage information

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

❍ Yes. Complete this section. ❍ No. Go to the 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 employs an average of at least 1 but not more than 50 common law employees on business days during the previous calendar year and employs at least 1 common law employee on the first day of the current plan year.

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

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 will be based on the average number of employees that it's 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 aren't eligible to purchase (or renew) small group plans.

1.	Provide the average number of common law employees employed during the previous calendar year (January - December) _____
2.	Is the company's headquarters located in the State of Washington? Select one. ❍ Yes ❍ No. If no, there must be a Washington-based employee with signing authority.

D. Employer contribution and eligible employee participation requirements

1. **Minimum contribution/Participation requirements**
Note: If a group doesn't meet these requirements, then the employer may expect to enroll during the established and designated open enrollment period.

Group size	Employer Contribution for eligible employees	Eligible employee participation	Employer contribution for dependents	Dependent participation
Medical				
Up to 4 employees	100%	100%	50%	No required level
5–50 employees	50%	75%	No required level	No required level
Dental/Non-voluntary				
2–4 employees	50%	100%	No required level	Common enrollment with medical
5–50 employees	50%	Greater of 5 enrolled employees or 50% eligible employees	No required level	Optional
Dental/Voluntary				
5–50 employees	0–49%	Greater of 5 enrolled employees or 30% eligible employees	No required level	Optional

E.	Employee eligibility requirements					
	Minimum work hours and probationary period information					
	If all your employees must work the same hours, meet the same probationary period, and will have the same benefits options available to them, complete the information under the **All section** below. Otherwise, complete the applicable sections. **You can have no more than 3 classes.**					
1.	Complete the minimum work hours* and probationary period information for each designated class of employee. If you have differentiated your benefit coverage selection by class of employee on your Benefit Selection Worksheet, the same classes must be represented. *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.					
	☐ All (one class) Minimum hours _____	☐ Management Minimum hours _____	☐ Salaried Minimum hours _____	☐ Hourly Minimum hours _____	☐ Part-time Minimum hours _____	☐ Full-time Minimum hours _____
	☐ Exact date of hire or 1st of the month following:	☐ Exact date of hire or 1st of the month following:	☐ Exact date of hire or 1st of the month following:	☐ Exact date of hire or 1st of the month following:	☐ Exact date of hire or 1st of the month following:	☐ Exact date of hire or 1st of the month following:
	☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire
	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days
	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days
	Employer contribution for eligible employees Medical: _____% Dental: _____%	Employer contribution for eligible employees Medical: _____% Dental: _____%	Employer contribution for eligible employees Medical: _____% Dental: _____%	Employer contribution for eligible employees Medical: _____% Dental: _____%	Employer contribution for eligible employees Medical: _____% Dental: _____%	Employer contribution for eligible employees Medical: _____% Dental: _____%
	Employer contribution for dependents Medical: _____% Dental: _____%	Employer contribution for dependents Medical: _____% Dental: _____%	Employer contribution for dependents Medical: _____% Dental: _____%	Employer contribution for dependents Medical: _____% Dental: _____%	Employer contribution for dependents Medical: _____% Dental: _____%	Employer contribution for dependents Medical: _____% Dental: _____%
2.	**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, are 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 the total employees on payroll (1).	_____	_____
4.	Total number of employees not enrolling due to coverage under other group coverage or a government plan such as Medicare, Medicaid, CHAMPUS/Tricare, or Military.	_____	_____
5.	Eligible employees waiving enrollment without other group coverage as listed above. **Note:** Individual coverage is not a valid waiver.	_____	_____
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.	
	Is the group subject to COBRA? Select one. ❍ Yes ❍ No. Give the legal reason for exemption: _____
1.	**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" include full-time and part-time common law employees. Self-employed workers as defined in Internal Revenue Code (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 requirements 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.
2.	Is the group subject to the federal Medicare secondary payer (MSP) laws that prohibit discrimination against individuals with group coverage? Select one.
a.	❍ Yes. This plan will pay primary to Medicare as required by federal law. ❍ No. Under 20 employees.
	Provide the number of employees who now meet Medicare's definition of "employee" _____
b.	**Helpful hint:** These laws don't 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 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).
3.	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 a disability? Select one.
a.	❍ Yes. This plan will pay primary to Medicare as required by federal law. ❍ No. Under 100 employees.
	Provide the number of employees who now meet Medicare's definition of "employee" _____
b.	**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.
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

Important note: Benefit booklets are delivered electronically and are available online at premera.com.

I. Producer agreement to contract

You, the producer(s), 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.

General agency affiliation. Select one.

❍ Connexion Insurance Solutions ❍ ProPoint, LLC ❍ S4 Benefits

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

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 • We receive the initial month's premiums 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 certify 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 healthcare contract, including premiums, may be amended, or changed from time to time, upon our notice to you. All previous 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. 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.	The producer listed above will have access 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 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
3.	Premera Blue Cross must receive all completed enrollment materials by the 20th of the month of the following month's effective date. Materials received between the 11th and the 20th of the month may experience delays in receiving the following items: • Member ID cards • Access to pharmacy benefits • Benefit booklets • Initial billing statement
4.	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 their 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.
5.	New groups, with a plan effective date in the middle of their plan year, can request cost-sharing, such as deductible, coinsurance, and copay, amounts accrued prior to the plan effective date be credited to their new plan.
6.	I affirm the contribution and participant requirements in **Employer Contribution and Eligible Employee Participation Requirements** are followed. Applicable to groups renewing outside open enrollment.
7.	I affirm that this group has a physical location in the State of Washington, and I am authorized to sign on behalf of the group. Signature of group representative X _____ Group representative (print name) Print title Date signed MM/DD/YYYY **Note:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.