PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Small Group Master Application (New Groups)

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.

Group name

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

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.	Group Benefit Administrator Title
	Phone No.( ) - E-mail Address
G.	Billing Contact 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 billing contact and address above.
	Subgroup Name Employer Identification Number (EIN)
	Subgroup Billing Contact Subgroup Benefit Contact
	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 Name

COBRA Administrator Name		
COBRA Administrator Billing Address		
City	State	ZIP
COBRA Administrator Contact		
Phone 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.

This count should include all full-time, part-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.

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

If all of your employees must work the same hours, meet the same probationary period, and will have the same benefit options available to them, complete sections A and C, skip section B.

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. All employees who normally work a minimum of   hours* per week, have satisfied the probationary period, are eligible.

   ***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. 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

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. All employees who normally work a minimum of hours* per week, have satisfied the probationary period, are eligible.

3. 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

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

Premera Blue Cross Blue Shield of Alaska minimum contribution / participation requirements (applicable to all small groups)

Group Size	Employer Contribution	Participation	Employer Contribution	Participation
	Employees		Dependents	
Medical				
1 – 3 Eligible Employees	75%	100%	No required level*	Optional
4 – 50 Eligible Employees	50%	75%	No required level*	Optional
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

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

Employer Contribution Levels
As the Employer, you 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.	Total number of employees not eligible to enroll employees working less than the minimum number of hours per week (in probationary period, temporary or seasonal, or not in a covered class)	________	________
C.	Total number of employees eligible to enroll Note: Calculated by subtracting total number of employees not eligible to enroll (B) from total employees on payroll (A)	________	________
D.	Total number of employees not enrolling due to coverage under other group coverage or a government plan (Medicare, Medicaid, CHAMPUS/Tricare, or Military)	________	________
E.	Eligible employees waiving enrollment without other group coverage (listed above) Note: Individual coverage is not a valid waiver	________	________
F.	Total number of eligible employees enrolling. Please enter participation level as percentage. Note: Participation level calculated by dividing the total number of employees enrolling (F) by the total number of eligible employees without other group coverage (C-D).	________	________
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

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."

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 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."

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 **A** above for a definition of "employee" for this purpose.

C. Is the group subject to COBRA? ☐ Yes ☐ No. Give the legal reason for exemption

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

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

Benefit Booklets: Electronic copies of your group's benefit booklets can be accessed through the secure employer website and are available online at premera.com.

ID numbers/cards: Member ID numbers will be available as soon as initial enrollment has been processed.ID cards will arrive approximately 7-10 business days later, but can also be accessed through the Premera mobile app.

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

C. ☐ Split Commission

Secondary Producer Name	Secondary Producer Number

Commissions are split between primary and secondary producer as follows: Primary: % Secondary: %

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 Small Group Benefit Selection Worksheet.

Paperwork received after the 10th of the month prior to the effective date may cause delays in receiving the following:

- Benefit booklets
- Access to benefits
- Initial billing statement

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? (Is the producer authorized as a Group Benefit Administrator?)	☐ 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
• Request Invoice	• Inquire on Eligibility	• View Group Demographic Information
• Search for a Member	• Enroll a member	• Cancel a member
• View Benefit Detail		

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.

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.)*

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.