BlueCross BlueShield Minnesota

Small Group Business Application

Complete this application in its entirety in blue or black ink. Do not use pencil or highlighter.

Group Submission Status

❑ New Business

❑ Existing Business Change (Check all that apply)
- ❑ Add or Change Medical Product (include application(s) or a list of subscribers to be transferred)
- ❑ Add or Change Supplemental Product ❑ Dental

❑ Other Changes (Check all that apply):
- ❑ Group Name/Address
- ❑ Ownership ❑ Member Eligibility
- ❑ eEnrollment ❑ eBilling

Complete all sections that apply and include explanations in Comments.

Requested Product Information

Effective Date:_____

Medical Product(s): Quote ID_____ Product Description _____
Quote ID_____ Product Description _____
Quote ID_____ Product Description _____
Quote ID_____ Product Description _____

Dental: Plan ID _____ Product Description _____

Does group wish to sign-up for electronic enrollment and billing transactions? ❑ Yes ❑ No

Spending Account(s) to be administered by SelectAccount®: ❑ HRA ❑ HSA ❑ FSA *(Attach Small Group HRA or HSA form, if applicable.)*

MII Life Inc., d.b.a. SelectAccount, is an independent company providing account administration services.

Employer/Group Information

Company/Legal Name/ Doing Business As (if different from legal name)				Federal Tax I.D./E.I.N.
Physical Address (No P.O. Box)	City	State	County	Zip Code
Mailing Address ❑ Same as physical address above	City	State	County	Zip Code
Contract Signer Name		Title		
Phone Number ( )	Fax Number ( )			
Nature of Business		SIC Code		Years in Business

NOTE: If Correspondence/Billing contacts are different, attach a sheet of paper with names, titles, addresses, phone numbers.

1. Is the above company affiliated with other entities that are to be treated as a "single employer" under the Internal Revenue Code section 414 aggregation rules (e.g., controlled group corporations, entities under common control, etc.)? ❑ Yes ❑ No

   If **Yes**, please list ALL affiliated company names and their locations (city and state) that are part of the "single employer", including those NOT included in this application for coverage.

   _____

   _____

   IMPORTANT: If applying for coverage for multiple (aggregated) entities, please attach a letter from your legal counselor or tax accountant citing names of all related entities and the applicable IRC section 414 rule as evidence that they are to be treated as a "single employer". Also, please complete an ADDENDUM (page 4) for additional companies included in this application for group coverage. Companies that are not aggregated must apply for separate group health plans, by completing individual Small Group Business Applications.

2. Do you currently have a group medical plan? ❑ Yes (Current Carrier Name _____) ❑ No
3. Plan Sponsorship: ❑ Private Entity (ERISA) ❑ Government Entity ❑ Church Entity ❑ Public Schools
4. Ownership Type: ❑ Partnership* ❑ Sole Proprietorship* ❑ Corporation_____ ❑ Other _____
   State of Inc.

   *List the Name of each Partner or Owner below:

   A. _____ C. _____

   B. _____ D. _____

Group Eligibility and Enrollment Information

1. Do you wish to cover Domestic Partners? ❑ Yes ❑ No
2. Number of hours employees must work per week to be considered eligible for coverage: _____
3. New employees are eligible to enroll on: ❑ Hire Date ❑ First Day Following ____ Days (**Cannot** exceed 90 calendar days) - **OR** -
   First Day of Next Month Following (Check one): ❑ Hire Date ❑ 30 Days ❑ 60 Days
   (If hourly and/or probationary period requirements vary by employee class, please explain in Comments section).
4. Do you have Union employees that have coverage through a separate Union organization? ❑ Yes ❑ No
   (If Yes, please attach a copy of union bargaining agreement or health carrier invoice that identifies all covered union employees.)
5. Please enter applicable employee counts below:

	Active Employees			COBRA			Other (e.g., disabled)		
	Medical	Vision	Dental	Medical	Vision	Dental	Medical	Vision	Dental
Number Eligible		N/A			N/A			N/A	
Number Enrolling		N/A			N/A			N/A	
Number Waiving		N/A			N/A			N/A	

Employer Medical Contribution(s)

	Employee*	Employee & Spouse	Employee & Child	Employee & Children	Family
Percentage OR Dollar Amount					

Enter amounts for all members to be covered.

* The employer is required to contribute at least 50% of the employee's total monthly premium.

MSP and ACA Group/Market Size Employee Counts

Questions 1 and 2: For Medicare Secondary Payer (MSP) questions, include all employees, regardless of the number of hours worked, whether or not they were on your health plan. **Question 3:** For purposes of determining group size, the number of full-time employees and full-time equivalents an employer has in the previous calendar year determines whether the employer is small or large for the next year.

Important Note: If you have affiliated companies that are to be treated as a "single employer", refer to following information. Please aggregate all employees collectively for all related entities that are part of a controlled group of corporations in your group with employees of groups that are part of (a) controlled group of corporations, (b) partnership, proprietorship, etc. under common control or (c) affiliated service group. Refer to Internal Revenue Code Sections 52(a) & (b) and 414(m) for MSP purposes (questions 1 & 2) and Internal Revenue Code Section 414 for ACA group/market size determination (questions 3a, 3b and 3c).

1. In the PRECEDING calendar year, did you have at least:
   ❑ 20 or more employees for each working day of 20+ calendar weeks? ❑ Yes ❑ No ❑ Company did not exist
   - If yes, on what date did you first meet the threshold? _____
     Date must be between 5/20 and 12/31 of the calendar year

   ❑ 100 or more employees during 50% of your regular business days? ❑ Yes ❑ No ❑ Company did not exist
2. As of today's date in the CURRENT calendar year, did you have at least:
   ❑ 20 or more employees for each working day for 20+ calendar weeks? ❑ Yes ❑ No ❑ Not enough time has elapsed
   - If yes, on what date did you first meet the threshold? _____
     Date must be between 5/20 and 12/31 of the calendar year

   ❑ 100 or more employees during 50% of your regular business days? ❑ Yes ❑ No ❑ Not enough time has elapsed

3.**a.** Total number of full-time employees working 30 hours or more per week (130 hours per calendar month) in the previous calendar year _____

3.**b.** Total number of part-time hours worked by part-time employees in the previous calendar year _____ /1440 = _____ Full-time equivalents

3.**c.** Full-time employees from **3. a.** _____ + full-time equivalents from **3. b.** _____ = _____total employees

Producer of Record		
Agency Name	Agency Number	Agency Phone Number ( )
Producer Name	Producer Number	Producer Phone Number ( )
Producer Signature		
General Agency Name	General Agency Number	General Agency Phone Number ( )
Blue Cross Sales Representative		

NOTE: Please ensure that employer completed the "Small Group Business Enrollment Form" in its entirety.

Comments

Pediatric dental is an essential health benefit available for purchase through a separate contract. For additional information on available pediatric dental plans, please visit www.mnsure.org. Dental benefit coverage is provided by an independent company.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is available to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on the web at www.bluecrossmn.com or available free of charge when requested by calling Customer Service at (651) 662-8000 or 1-800-382-2000 toll free.

Company/Group Authorized Signature

I, the undersigned, hereby represent that I have the authority to bind the Employer/Group ("Employer") and to make this application for group medical and/or group dental coverage to Blue Cross and Blue Shield of Minnesota and/or Blue Plus ("The Company").

Employer understands and agrees that: (i) no coverage will become effective until the date specified by The Company after this application has been approved by The Company at its home office; (ii) the information provided in this application is complete and true and is the basis for the coverage to be issued, and that material misrepresentations of facts could result in termination of coverage. The Company cannot use the misrepresentation to cancel coverage that has been in effect for two (2) years or more. This time limit does not apply to fraudulent misrepresentations; (iii) applications for each eligible employee and dependent must receive prior approval by The Company before coverage becomes effective; and (iv) no coverage will be effective until the first monthly charges have been paid in full.

Employer agrees to allow The Company to review any of the Employer's records that The Company deems necessary to approve this application. It is also agreed that no agent or broker can approve this application, set an effective date, or waive or alter any provision of this application or any contracts issued. It is agreed that Employer will remit monthly charges for all covered employees and that failure to remit the required charges by the due date will result in termination of coverage.

Employer understands that the medical plan does not include coverage for the pediatric dental essential health benefit and that The Company has made the Employer aware of pediatric dental coverage available for purchase. For additional information on available pediatric dental plans, please visit www.mnsure.org.

Employer understands that any need for additional information may impact the effective date of coverage, the rates quoted, or the ability to offer the group coverage requested. Employer acknowledges that The Company has the right to adjust charges: (i) on a monthly due date for changes in the status of the group, including changes to eligibility or enrollment; (ii) on a monthly due date for fraud or misrepresentation by the contract holder, employees, or dependents; (iii) on an annual renewal; or (iv) on any date the provisions of the contract are changed. Written notice will be mailed to the contract holder's last address on our records at least 30 days prior to the date the adjustment becomes effective.

Employer understands that all The Company medical participation and contribution guidelines of The Company must be satisfied in order for the Employer to be eligible for the coverage requested and that rates are not binding until approved by The Company. Employer acknowledges that medical coverage may be cancelled or nonrenewed if participation is less than 75% or Employer does not contribute at least 50% of each employee's premium.

If this application is completed as an electronic or online application, both parties agree to conduct this transaction electronically.

Authorized Representative Name

Authorized Representative Title

Authorized Representative Signature

Date

Include a copy of the most recent Minnesota Quarterly Wage Detail Report and a bill copy if you have current group coverage.

ADDENDUM - Only Complete for Multiple (Aggregated) Businesses that are to be Treated as a "Single Employer".
(If more than three businesses are included in application, please copy addendum page.)
Company/Group Name:_____ (as shown on page 1).

Additional Company Information

Company/Group Name		SIC	Federal Tax I.D./E.I.N.	
Physical Address (No P.O. Box)	City	State	County	Zip Code

1. Plan Sponsorship: ❑ Private Entity (ERISA) ❑ Government Entity ❑ Church Entity ❑ Public Schools
2. Ownership Type: ❑ Partnership* ❑ Sole Proprietorship* ❑ Corporation ❑ Other _____

*List the Name of each Partner or Owner below:

A. _____ C. _____

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   (If hourly and/or probationary period requirements vary by employee class, please explain in Comments section).
4. Do you have Union employees that have coverage through a separate Union organization? ❑ Yes ❑ No
   (If Yes, please attach a copy of union bargaining agreement or health carrier invoice that identifies all covered union employees.)

Employer Medical Contribution(s)

	Employee*	Employee & Spouse	Employee & Child	Employee & Children	Family	
Percentage OR Dollar Amount						Enter amounts for all members to be covered.

* The employer is required to contribute at least 50% of the employee's total monthly premium.

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