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 ❑ Vision

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

Complete all sections that apply and include explanations in the Comments section on page 3.

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 _____

Vision: Plan ID _____ Product Description _____

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	
Telephone Number	Fax Number	Email Address	
Nature of Business		SIC Code	Years in Business

NOTE: If Correspondence/Billing contacts are different, attach a sheet of paper with names, titles, addresses, telephone 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 For All Products

1. Is the headquarters of your business in Minnesota? ❑ Yes ❑ No If No, provide the address of headquarters:

   _____

2. Do you wish to cover Domestic Partners? ❑ Yes ❑ No
3. Number of hours employees must work per week to be considered eligible for coverage: _____
4. New employees are eligible to enroll on: ❑ Hire Date - **OR** - ❑ First Day Following (Check one): ❑ 30 Days ❑ 60 Days ❑ 90 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 on page 3).
5. 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.)
6. Eligibility for coverage of certain benefits under this contract and enrollment in plans is subject to group participation requirements based on the group's size. The following information will be used to determine group eligibility for medical, dental and/or vision plan(s). Please enter applicable employee counts below:

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

7. ❑ **I confirm.** Check this box to confirm that neither Employer nor any employee or enrollee will receive any premium or cost-sharing assistance for this policy, directly or indirectly, from any ineligible third party described on page 4.

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.

Employer Dental Contribution(s)

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

Employer Vision Contribution(s)

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

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).

MSP and ACA Group/Market Size Employee Counts - (continued)

MSP Questions

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

ACA/Group Market Size Employee Count Questions

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.** _____ = 0 total employees

Producer of Record		
Agency Name Walter Palmer Agency	Agency Number RI	Agency Telephone Number (612) 825-4990
Producer Name Walter J. Palmer	Producer Number 4310	Producer Telephone Number (612) 825-4990
Producer Signature	Producer Email Address wpalmer@healthinsurancemn.com	
General Agency Name Walter Palmer Agency	General Agency Number	General Agency Telephone Number (612) 825-4990
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 for medical only 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 contacting your employer or your employer's Agent or Broker, or by calling Customer Service at 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, dental, and/or vision 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; and (iii) Employer will timely provide information as requested by The Company with respect to its continued eligibility for coverage; and (iv) Applications for each eligible employee and dependent must receive prior approval by The Company before coverage becomes effective; and (v) no coverage will be effective until the first monthly charges have been paid in full. 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.

Company/Group Authorized Signature - (continued)

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 neither the medical plan nor the dental plan includes 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. 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. Employer understands that all The Company dental and/or vision guidelines must be satisfied in order for the Employer to be eligible for the dental and/or vision coverage requested. Employer acknowledges that dental and/or vision coverage may be cancelled or nonrenewed if participation requirements are not met. Employer understands that rates for medical, dental, and/or vision are not binding unless approved by The Company.

The Company may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly by ineligible third parties. "Ineligible third parties" include any person or entity from which The Company is not required by law to accept such third-party payments. This may include, for example, commercial entities, healthcare providers and suppliers, and other persons or entities with direct or indirect pecuniary interests. "Payments" include those made by any means, for example: cash, check, money order, credit card payment, electronic fund transfer, etc. If you have questions about this third party payment policy or whether The Company will accept premium and/or cost-sharing payments made by a specific person or entity, please contact your employer.

By providing your email address, you agree to receive communications and/or marketing materials related to the Plan(s) you selected and products offered by or made available from The Company and its affiliates. You may unsubscribe or change your email address at any time by following the instructions included in each email communication.

By providing your phone number, you expressly consent to accept and receive communications and /or marketing materials related to the Plan(s) you selected and products offered by or made available from The Company and its affiliates, via text message or voice call to your mobile device and to the cellular/mobile telephone number(s) that you provided to us.

WARNING: E-mail and text messaging transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. As the recipient of an email or text message from an unsecured email or device, The Company, does not accept liability for any errors or omissions in the contents of this message, which arise as a result of e-mail or text message transmission.

Employer acknowledges that it is not applying for this coverage in connection with an offer from any ineligible third-party to pay any premium or cost-sharing related to this plan.

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 this Page 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. _____

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 - **OR** - ❑ First Day Following (Check one): ❑ 30 Days ❑ 60 Days ❑ 90 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 the Comments section on page 3).
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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NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

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