Small Group Business Application

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

BlueCross BlueShield Minnesota

Group Submission Status

☐ New Business Effective Date: _____

☐ 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 Ancillary Product at Renewal: ☐ Dental ☐ Vision
- ☐ Midyear Upsell ☐ Dental ☐ Vision

☐ Other Changes (Check all that apply):
- ☐ Group Name/Address
- ☐ Ownership ☐ Client Eligibility

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

Employer/Group Information

Legal Name	DBA (if applicable)	Federal Tax ID/EIN

Physical Address (No P.O. Box)	City	State	County	ZIP

Mailing Address ☐ Same as physical address above	City	State	County	ZIP

Authorized Representative	Title

Telephone Number	Email Address

Nature of Business	SIC code	Date Business was Established

NOTE: If correspondence and billing contacts are different, attach a sheet of paper with names, titles, addresses, telephone numbers.

Employer/Group Information

1. Is the headquarters of the Employer/Group in Minnesota? ☐ Yes ☐ No If No, provide the address of headquarters:

   _____

2. Does the Employer/Group have any leased, temporary, seasonal, or independent contract employees who are applying for this group coverage? ☐ Yes ☐ No If Yes, provide names: _____
3. Does the Employer/Group have an Individual Coverage Health Reimbursement Arrangement (ICHRA)? ☐ Yes ☐ No
   If Yes, please provide the class(es) of employees who are eligible for the ICHRA. _____

   _____
4. Does the Employer/Group have union employees who 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. Is the above Employer/Group 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)? ☐ Yes ☐ No

   If Yes, please attach a completed Controlled Group Information form (X18207) and list ALL affiliated entities that are part of the "single employer", by name, federal tax ID/EIN and location (city and state) including those NOT included in this Application for coverage.

   _____

   _____

   Please Note: A letter from the Employer/Group's legal counsel or tax accountant may be requested. Companies that are not aggregated must apply for separate group health plans, by completing individual Small Group Business Applications.
6. Does the Employer/Group currently have a group medical plan? ☐ Yes (Current Carrier Name _____) ☐ No
7. Plan Sponsorship: ☐ Private Entity (ERISA) ☐ Government Entity ☐ Church Entity ☐ Public Schools
8. Ownership Type: ☐ Partnership ☐ Sole Proprietorship ☐ Corporation _____ ☐Other _____
   State of Inc.

   List the name of each partner or owner below:

   A. _____ C._____

   B. _____ D._____

Enrollment Information for All Products

1. Does the Employer/Group 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 (select one): ☐ Hire Date
   ☐ Next Day Following : ☐ 30 Days ☐ 60 Days ☐ 90 Days
   ☐ First Day of Next Month Following: ☐ Hire Date ☐ 30 Days ☐ 60 Days
4. ☐ **I confirm.** Check this box to confirm that neither Employer/Group 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.
5. 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., retiree)		
	Medical	Vision	Dental	Medical	Vision	Dental	Medical	Vision	Dental
Number Eligible									
Number Enrolling									
Number Waiving									

Contribution(s)

Employer Medical Contribution(s)

	Employee*	Dependents
Percentage		

Employer Dental Contribution(s)

	Employee	Dependents
Percentage		

Employer Vision Contribution(s)

	Employee	Dependents
Percentage		

*The Employer/Group is required to contribute at least 50 percent of the employee's total monthly medical premium.

MSP and ACA Employee Counts

Question 1: For Medicare Secondary Payer (MSP) question, include all employees, regardless of the number of hours worked.

Question 2: For purposes of determining group size, the number of full-time employees an Employer/Group has in the previous calendar year determines whether the employer is small or large for the next year.

Important note: If the Employer/Group has affiliated companies that are to be treated as a "single employer," refer to the following information. Please aggregate all employees collectively for **all related entities** that are part of a controlled group of corporations in the Employer/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) and (b) and 414(m) for MSP purposes (question 1) and Internal Revenue Code Section 414 for ACA market size determination (question 2).

MSP Question

1. **During this calendar year, how many full-time and part-time employees have been employed with the Employer/Group for at least 20 weeks or more?**
   - If 20 weeks haven't passed this year, answer using last year's information.
   - Include owners, partners and officers and full-time, part-time, seasonal, temporary, and union employees.
   - Do not include independent contractors (1099), retirees, and COBRA participants.

   ☐ The Employer/Group employed 1–19 total employees.
   ☐ The Employer/Group employed 20–99 total employees.
   ☐ The Employer/Group employed 100 or more total employees.

   See Centers for Medicare & Medicaid Services (CMS) guidelines for more information.

ACA Market Size Employee Count Question

2. **Total number of full-time employees working 20 hours or more per week in the previous calendar year** _____
   - Union employees for whom coverage is separately purchased under a collective bargaining agreement, international employees, and seasonal employees working 120 days or fewer in a year should be excluded from the total employee count.

Product Information

Medical: Select plan(s)

PLAN	BlueAccess℠ (Aware® Network)	High Value (High Value Network)	AdvanceHealth (AdvanceHealth Network)
	NETWORK and PLAN NUMBER		
Bronze $9,100 Plan (not HSA compliant)	☐ 618	☐ 550	
HSA Bronze $7,500 Plan	☐ 598	☐ 599	
HSA Bronze $7,050 Plan	☐ 624	☐ 656	
HSA Silver $6,100 Plan	☐ 628	☐ 561	
HSA Silver $5,550 Plan	☐ 640	☐ 554	
HSA Silver $4,850 Plan	☐ 645	☐ 660	
HSA Silver $4,400 Plan (non-embedded)	☐ 642	☐ 555	
Copay Silver $4,100 Plan	☐ 626	☐ 560	☐ 326
Silver $4,000 Plan	☐ 627	☐ 552	
HSA Silver $3,250 Plan	☐ 632	☐ 553	
Silver $3,000 Plan	☐ 625	☐ 551	
Silver $2,850 Plan	☐ 623	☐ 662	
HSA Gold $3,500 Plan	☐ 690	☐ 692	
HSA Gold $2,500 Plan (non-embedded)	☐ 653	☐ 558	
Copay Gold $2,000 Plan	☐ 652	☐ 557	☐ 329
Copay Gold $1,000 Plan	☐ 637	☐ 664	☐ 328
Copay Gold $500 Plan	☐ 635	☐ 556	☐ 327
Copay Platinum No Deductible Plan	☐ 655	☐ 559	☐ 330

Dental: Product Description _____

Vision: Product Description _____

Producer of Record

Producer must complete this section and sign below to be assigned as the Agent of Record and act on behalf of this Employer/Group.

Agency Name	Agency Code	
Producer Name	Producer Number	Producer Telephone Number
Producer Email Address	Blue Cross Sales Representative	

I attest I have reviewed the completed Application and certify I have met the requirements described in the Blue Cross and Blue Shield of Minnesota Agent Code of Conduct and my agent/agency agreement with Blue Cross. I further understand that I may not accept risk or pass on any eligibility requirements, make or alter the terms of the Application or policy or waive any contractual rights or requirements. I agree to retain a copy of the submitted Application for my records and to provide a copy of the submitted Application to Blue Cross upon request.

_____ _____

Producer Signature Date

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 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 the Employer/Group 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 at bluecrossmn.com or available free of charge when requested by contacting your Agent or Broker, or by calling the Group Leader Line at 1-877-293-7035.

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 Blue Plus ("Blue Cross").

Employer understands and agrees that: (I) no coverage will become effective until the date specified by Blue Cross after this Application has been approved by Blue Cross 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 Blue Cross with respect to its continued eligibility for coverage; and (iv) Applications for each eligible employee and dependent must receive prior approval by Blue Cross before coverage becomes effective; and (v) no coverage will be effective until the first monthly charges have been paid in full. Blue Cross 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.

Employer agrees to allow Blue Cross to review any of the Employer's records that Blue Cross 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 Blue Cross has made the Employer aware of pediatric dental coverage available for purchase. For additional information on available pediatric dental plans, please visit 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 Blue Cross 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 medical participation and contribution guidelines of Blue Cross must be satisfied in order for the Employer to be eligible for the coverage requested. Employer acknowledges that medical coverage may be nonrenewed if participation is less than 75 percent or Employer does not contribute at least 50 percent of each employee's premium. Employer understands that all Blue Cross 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 nonrenewed if participation requirements are not met. Blue Cross understands that rates for medical, dental, and/or vision are not binding unless approved by Blue Cross.

Blue Cross 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 Blue Cross is not required by law to accept such third-party payments. This may include, for example, commercial entities, health care 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. If you have questions about this third-party payment policy or whether Blue Cross will accept premium and/or cost-sharing payments made by a specific person or entity, please contact Blue Cross.

By providing an email address, Employer agrees to receive communications and/or marketing materials related to the plan(s) selected and products offered by or made available from Blue Cross and its affiliates. Employer may unsubscribe or change the email address at any time by following the instructions included in each email communication.

By providing a phone number, Employer expressly consents to accept and receive communications and /or marketing materials related to the plan(s) selected and products offered by or made available from Blue Cross and its affiliates, via text message or voice call to the mobile device and to the cellular/mobile telephone number(s) provided to Blue Cross.

Warning: Email 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, Blue Cross does not accept liability for any errors or omissions in the contents of this message, which arise as a result of email 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.

Employer understands and agrees by signing below, the Employer is granting authority to the Producer of Record designated above to sign any of Blue Cross's required authorization form(s) granting user access or entitlements to Blue Cross portals. Employer further understands and acknowledges that this authorization will remain in effect until Employer notifies Blue Cross to revoke authorization for the designated Producer of Record. 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 the Employer/Group has current group coverage.