PO Box 1991, Wilmington, DE 19899-1991
www.Highmarkbcbsde.com

NEW GROUP CHECKLIST – GROUPS 1 to 50 (DSGIT)

***Important*: Please include ALL applicable documents (for medical coverage) *at time of submission*.**

Group Name: _____ Effective Date: _____

- ❑ **Small Group Business Application** – Fully completed, signed and dated **by an authorized group representative**.

- ❑ **Affiliated Companies** – Multiple entities that are to be treated as a **"single employer"** must provide the following:
  - **ADDENDUM** (Page 3 of group application) for all in-area aggregated entities seeking coverage.
  - An attestation letter from the group's accountant or tax attorney which **cites all companies by name and the applicable IRC section 414 aggregation rule.**

- ❑ **Enrollment/Waiver Forms** – Include forms for ALL eligible employees confirming enrollment/waiver of coverage for subscribers and dependents and attach copies of COBRA election notices for all COBRA beneficiaries.

- ❑ **Rate Sheet(s)** (for chosen medical products)

- ❑ **Copy of Most Recent Quarterly UC-8 (or YTD Payroll)** – Using the codes below, the UC report (or payroll) must be annotated, signed and dated **by the employer** to denote each employee's eligibility. (Annotated year to date payroll registers that identify ALL employees are acceptable for UC exempt businesses (e.g., nonprofit entities).

ELIGIBLE	
Code	**Definition**
E	Employee meets hourly and waiting period requirements
NH	New Hire has met probationary period (If not shown, write name and hire date on report.)
W	Waiving for spousal, other carrier or no coverage
O	Owner
C	COBRA Continuant (If not shown, write name on report.)

INELIGIBLE	
Code	**Definition**
I	Part-time, Seasonal, Temporary Employee
P	New Hire on probation - not yet eligible (If not shown, write name and hire date on report.)
L	Laid Off Employee - include first day of lay off
T	Terminated - include termination date
U	Union – covered under a separate bargaining agreement

- ❑ **Ownership Tax Documentation**
  - Schedule C (Sole Proprietorship), Schedule F (Farms) or Schedule E (Rental Businesses)
  - Form 1065 and Schedule K-1s (Partnerships, LLC or LLP)
  - Form 1120S (S Corporation - 1st page only) – OR – Form 1120 (C Corporation - 1st & 2nd pages)
  - Form 990 (Religious/Non-Profit Organizations)

- ❑ **New "Start-up" Businesses**
  - SS-4 Application **and** the EIN Assignment Form
  - Minimum 30 days of payroll for ALL employees annotated by employer (if UC-8 report has not been filed). Not applicable for owner-only groups that do not have any employees.

- ❑ **First Month's Premium Check** (personal check not permitted)

- ❑ **Current Year Delaware Business License** (or Professional Business License or 501(c) (3) Nonprofit Exemption Certification issued by the IRS)

- ❑ **HSA or HRA Group Set-up Form** (for accounts to be administered by Highmark Delaware)

- ❑ **Data Collection Form** (if employer elects enrollment and/or billing transactions via the Employer Portal)

- ❑ ***MyBenefits* Forms** – Please refer to *MyBenefits* Checklist for additional documentation requirements.

BENEFITS CONNECTION

HIGHMARK. Delaware

SMALL GROUP BUSINESS APPLICATION

(For employers with 50 or fewer employees headquartered in Delaware)

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

GROUP SUBMISSION STATUS

☐ New Business

Current Client or Group No(s) _____

☐ Product Changes:

	Add	Change*	Renew"As Is"	Cancel
Medical	☐	☐	☐	☐
Vision	☐	☐	☐	☐
Dental	☐	☐	☐	☐

*Include enrollment forms to report changes, if not signed up for eEnrollment.

☐ Add 2nd Medical Option
☐ Market/Movement (Renewing as a small group)
☐ Add Mini-COBRA Group (2 - 19 employees)
☐ Add Federal COBRA Group (20 or more employees)
☐ Other (e.g., Group Name/Address, Ownership, Eligibility Changes, etc. — Complete all applicable sections and explain in Comments section.)

REQUESTED PRODUCT INFORMATION

Effective Date: _____ (If electing My Benefits, enter IDs/Names below and additional product selections in My Benefits question that follows.)

Medical Product(s): Quote ID _____ Product Name _____

Quote ID _____ Product Name _____

Vision: Quote ID _____ Product Name _____

Dental: Plan ID _____ Product Name _____ ☐ Tier 2 or ☐ Tier 4

My Benefits Product Names: _____

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

Spending Account(s) to be administered by Highmark Blue Cross Blue Shield Delaware: ☐ HRA ☐ HSA ☐ FSA ☐ Using an Outside Vendor

(If administered by Highmark BCBS Delaware, please attach Small Group HRA or HSA form.)

EMPLOYER/GROUP INFORMATION

Company/Group 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 Signor Name | **Title**

Contract Signor Address (Must be in service area) | **City** | **State** | **County** | **Zip Code**

Phone Number ( ) | **Fax Number** ( ) | **E-Mail Address**

Nature of Business | **SIC Code** | **Years in Business**

NOTE: If Correspondence/Billing contacts are different, **please attach a separate sheet of paper with names, titles, addresses and 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 of corporations, entities under common control, etc.)? ☐ Yes ☐ No

   If **Yes**, please list all company names **and** their locations (city and state), including those NOT applying for coverage.

   _____

   _____

   ATTESTATION: If application includes multiple entities, please attach an attestation letter from your tax accountant (or legal counselor) citing all affiliated entity names and the applicable IRC Section 414 (aggregation) rule that they fall under **as evidence that they are to be treated as a "single employer"**. In addition, complete the ADDENDUM (page 3) to identify all companies included in this application. Non-aggregated companies must apply for separate coverage via separate group 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 names of ALL business owners/partners (or write 'NA' if business is solely owned by shareholders).

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 eligible for coverage: _____ (Must be between 20 to 30 hours)

   NOTE: Under Delaware law, employers must offer coverage to all full-time employees who normally work 30 or more hours per week. Therefore, the requirement **cannot** be greater than 30 hours and no less than 20 hours based on Highmark BCBS Delaware underwriting guidelines.
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									
Number Enrolling									
Number Waiving for Other Coverage									
Number Waiving for No Coverage									

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 10% of the total monthly premium.

MSP AND ACA GROUP/MARKET SIZE EMPLOYEE COUNTS

For Medicare Secondary Payer (MSP) purposes **(questions 1 and 2)**, please count all employees (full-time, part-time, seasonal/intermittent, and in and out of area employees - typically all W-2 employees). Also **INCLUDE** all leased employees and employees that are not working but receiving disability payments (which include non-government employers subject to FICA). For group/market size purposes **(question 3)**, count ALL full-time eligible employees who normally worked **30 or more** hours per week for at least 50% of the business days in the **preceding calendar quarter** and business owners/partners. Do **NOT** include part-time, temporary/seasonal employees and independent contractors not considered eligible for group coverage.

IMPORTANT: Please aggregate all employees collectively **for all related entities** 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 **(question 3)**.

1. In the **PRECEDING** calendar year, did you have at least:
   a. **20 or more** employees for each working day of 20 or more calendar weeks? ☐ Yes ☐ No ☐ Company did not exist then
      If yes, on what date did you first meet the threshold? ____/____/____ **Date must be between 5/20 and 12/31 of the calendar year**
   b. **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:
   a. **20 or more** employees for each working day of 20 or more calendar weeks? ☐ Yes ☐ No ☐ Unknown, enough time has not expired
      If yes, on what date did you first meet the threshold? ____/____/____ **Date must be between 5/20 and 12/31 of the calendar year**
   b. **100 or more** employees during 50% of your regular business days? ☐ Yes ☐ No ☐ Unknown, enough time has not expired
3. Please provide your total number of "eligible" employees (as described above) for the **PRECEDING** calendar quarter: _____

COBRA/MINI-COBRA INFORMATION

	Preceding Calendar Year:	Current Calendar Year:
1. How many full-time equivalent employees did/do you employ?		

2. Within the preceding calendar year, did you have 20 or more full-time equivalent employees on at least 50% of your typical business day?
   ☐ Yes ☐ No ☐ Company did not exist

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 names of ALL business owners/partners (or write 'NA' if business is solely owned by shareholders).

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: _____ (Must be between 20 to 30 hours)
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.)

EMPLOYER MEDICAL CONTRIBUTION(S)

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

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 names of ALL business owners/partners (or write 'NA' if business is solely owned by shareholders).

A. _____ C. _____

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GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. Do you wish to cover Domestic Partners? ☐ Yes ☐ No
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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 10% of the total monthly premium.**

PRODUCER OF RECORD

Agency Name	Agency Number	Agency Phone Number
ALLEN INSURANCE GROUP	067	(302-654-3823
Producer Name	**Producer Number**	**Producer Phone Number**
W. BRADLEY ALLEN	5058	(302-654-3836

Producer Signature

General Agency Name	General Agency Number	General Agency Phone Number
		( )

Highmark Sales Representative

COMMENTS

BENEFITS CONNECTION - TPA

SUMMARY OF BENEFITS AND COVERAGE

To help you make an informed choice, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about any health coverage option in a standard format. You can view an SBC for each available product at www.highmark.com/SBC.

COMPANY/GROUP AUTHORIZED SIGNATURE

I, the undersigned, hereby represent that I have the authority to bind the Company/Group and to make this application for group insurance coverage. I further represent that the agency (or agencies) listed above is our exclusive Producer of Record for all Highmark Blue Cross Blue Shield Delaware (Highmark BCBS Delaware) products and they will receive any and all commissions included in the rates.

I further acknowledge and agree that Highmark BCBS Delaware may disclose enrollment, disenrollment, summary health and/or premium billing information requested by the Producer of Record for purposes of inputting, updating and/or reviewing the same for the above - identified business.

I also understand that the Producer of Record may be eligible to receive additional compensation for achieving specified sales goals. The Producer of Record named above will remain the Producer of Record until I notify Highmark BCBS Delaware of a change, or until my Highmark BCBS Delaware insurance coverage terminates.

In addition, I understand that all Highmark BCBS Delaware underwriting and participation guidelines must be satisfied in order for the Company/Group to be eligible for the coverage requested and that rates are not binding until approved by Highmark BCBS Delaware. I further understand that any need for additional information may impact the effective date of coverage, the rates quoted, or the ability to offer the group insurance coverage requested.

It is also acknowledged that the Company/Group has the right to review and examine the insurance contract(s) issued by Highmark BCBS Delaware which provide the group coverage requested and that payment of the premium amount due following the contract(s) issuance shall be deemed acceptance of all terms and conditions of the insurance contract(s) unless the Company/Group notifies Highmark BCBS Delaware of any changes, mistakes, or discrepancies within the thirty (30) day period that follows.

In addition, I understand that if the Company/Group purchases a qualified high deductible health plan (QHDHP) compatible with a health savings account (HSA) or a high deductible health plan (HDHP) compatible with a health reimbursement arrangement (HRA), including but not limited to an HSA Compatible or HRA Compatible product, and selects an HSA or HRA administrator other than Highmark BCBS Delaware to interface electronically **or** otherwise with a Highmark BCBS Delaware QHDHP or HDHP, or does not contribute all or any portion of the mandated HSA or HRA contributions, the Company/Group is solely responsible for administration of an HSA or HRA in accordance with the design of the purchased QHDHP or HDHP, as such administration affects the Company's/Group's responsibility for ensuring that such purchased QHDHP or HDHP and corresponding HSA or HRA complies with all applicable laws, including but not limited to the Patient Protection and Affordable Care Act of 2010 as amended, and guidance published thereunder.

Furthermore, the Company/Group acknowledges that all applicable underwriting and participation guidelines must continue to be met throughout the term of the insurance contract(s) involved and that Highmark BCBS Delaware reserves the right to request information necessary to reconfirm compliance with these guidelines at anytime.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Authorized Representative Name

Authorized Representative Title

Authorized Representative Signature

Date

Submit to: Highmark Blue Cross Blue Shield Delaware · PO Box 1991 · Wilmington, DE 19899-1991

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield Delaware which is an independent licensee of the Blue Cross Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4109.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. 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, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں(TTY: 711) ۔

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.