GROUP APPLICATION

Complete this application in black or blue ink.

DO NOT USE A PENCIL OR A HIGHLIGHER.

HIPAA COMPLIANT

GROUP INFORMATION

Proposed Effective Date _____ Group Number _____

Group Name _____ Federal Tax ID _____

Subsidiaries & Affiliates _____

Bargaining Units/Union Affiliates _____

Main Office Address _____ Mailing Address _____

City _____ State _____ County _____ Zip Code _____

E-mail Address _____ Phone # _____

Group Administrator _____ Fax # _____

Nature of Business _____ SIC Code _____ Years in Business _____

Name of Prior Carrier _____ Policy # _____

CONTRIBUTION

The Employer is required to contribute at least 25% of the total health benefits premium. This includes retiree coverage if applicable.

EMPLOYER CONTRIBUTION

	Employee	Employee & Child	Employee & Spouse	Employee & Children	Family	Retired
Percentage OR						
Dollar Amount •						

• (If contributing dollar amounts, the dollar amount must equal at least 25% of the premium)

EMPLOYER MUST COMPLETE THE FOLLOWING

What is your average number of employees for the preceding calendar year? _____

(This includes full-time, part-time and seasonal employees)

	Full-Time	Part-Time	Seasonal	COBRA	Retired*	Total	Eligible	Enrolled	Waiving	Spouses Waiving	Total
Number of Employees (Medical)											
Number of Employees (Dental)											

*Retirees are not eligible under this program unless there is a formalized nondiscriminatory employer sponsored retirement program in effect. If so, please attach a description of the retirement program.

ELIGIBILITY

Eligibility is the minimum number of hours an employee must work per week to be eligible for coverage. Highmark WV permits an employer to define the minimum number of hours as between 20 to 40 hours per week.

☐ are the hours per week an employee must work under the Group Plan to be eligible for coverage.

Please note, current employees working less than the number of hours listed who subsequently begin working the required number of hours must complete the probationary period before becoming eligible for coverage.

PROBATIONARY PERIOD

The Probationary Period is the time (in months) an employee must work before being eligible for coverage. Probationary Periods greater than 12 months are not permissible.

Check One:
- ☐ Eligible on the date of hire (51+ groups only).
- ☐ Eligible on the first day of the month after date of hire.
- ☐ Eligible on the first day of the month after ☐ months of service. (Days are not permissible).

Check One:
- ☐ Probationary period is waived for all eligible employees on the group's initial effective date.
- ☐ Probationary period is applied for all eligible employees.

BENEFIT SELECTION OPTIONS

If your group is a new group or is making a benefit change, a copy of the applicable quote must be attached to this application.

SUPER BLUE PLUS 2000 - Contract Year Deductible Plan

		Deductible	Coinsurance (80%/20%)	Drug
	Option 1	$100/200	$1,000/2,000	30%, $10 minimum copay
	Option 2	$250/500	$1,000/2,000	30%, $10 minimum copay
	Option 3	$500/1,000	$1,000/2,000	30%, $10 minimum copay
	Option 4	$1,000/2,000	$1,000/2,000	30%, $10 minimum copay
	Option 5	$2,500/5,000	$2,500/5,000	30%, $25 minimum copay

SUPER BLUE PLUS 2004 - Contract Year Deductible Plan

		Deductible	Coinsurance (80%/20%)	Drug
	Option 6	$1,000/2,000	$1,000/2,000	50%, $25 minimum copay
	Option 7	$3,000/6,000	$1,000/2,000	50%, $25 minimum copay
	Option 8	$5,000/10,000	$1,000/2,000	50%, $25 minimum copay

WV SMALL BUSINESS PLAN - Contract Year Deductible Plan

(restrictions apply & must complete affidavit)

		Deductible	Coinsurance (80%/20%)	Drug
	Option 9	$1,000/2,000	$1,000/2,000	50%, $25 minimum copay
	Option 10	$3,000/6,000	$1,000/2,000	50%, $25 minimum copay
	Option 11	$5,000/10,000	$1,000/2,000	50%, $25 minimum copay

SUPER BLUE PLUS 2010 Plan - Contract Year Deductible Plan

		Deductible	Out-of-Pocket Max Excluding Deductible (80%/20%)		Drug		Drug
	Option 12	$500/1,000	$3,000/6,000		30%		50%
	Option 13	$1,000/2,000	$3,000/6,000		30%		50%
	Option 14	$1,500/3,000	$3,000/6,000		30%		50%
	Option 15	$2,500/5,000	$3,000/6,000		30%		50%
	Option 16	$5,000/10,000	$3,000/6,000		30%		50%
			(70%/30%)				
	Option 17	$500/1,000	$4,500/9,000		30%		50%
	Option 18	$1,000/2,000	$4,500/9,000		30%		50%
	Option 19	$1,500/3,000	$4,500/9,000		30%		50%
	Option 20	$2,500/5,000	$4,500/9,000		30%		50%
	Option 21	$5,000/10,000	$4,500/9,000		30%		50%
			(80%/20% No Medical Copays)				
	Option 22	$1,000/2,000	$3,000/6,000		30% Only		Contract Year Only
	Option 23	$2,500/5,000	$3,000/6,000		30% Only		Contract Year Only

HIGH DEDUCTIBLE HEALTH PLAN - Contract Year Deductible Plan

(must review with Sales office)

		Deductible	Out-of-Pocket Max Excluding Deductible	Drug
	Option 24	$3,000/6,000	$2,500/5,000	50%, Subject to Deductible
	Option 25	$5,000/10,000	$5,000/10,000	50%, Subject to Deductible

NON-STANDARD BENEFITS

☐ **Option is only for groups sized 51+. If a Non-Standard benefit is selected, a copy of the proposal including rates must accompany this application.**

VISION

☐ Standard (for groups sized 10+)

☐ Non-Standard (for groups sized 51+) If a Non-Standard benefit is selected, copy of the proposal including rates must accompany this application.

DENTAL

☐ Dental (for groups sized 10+)

COBRA INFORMATION

1) How many full-time equivalents did/do you employ? PRIOR YR: _____ CURRENT YR: _____

2) _____ YES / _____ NO — Within the last year, did you have 20 or more full and/or part-time employees on at least 50% of your typical business days?

3) _____ YES / _____ NO — If you answered "yes" to question #2 and if you have 20 or more full time equivalent employees, do you elect to contract with Highmark WV's Third Party COBRA Administrator to administer your COBRA benefits?

4) If you do NOT wish to contract with Highmark WV's Third Party COBRA Administrator, who will administer your COBRA benefits?
_____ Self-Administered OR _____ Direct with (fill in COBRA administrator)

5) List your COBRA eligible members below with the applicable Qualifying Event and Date of Event. Attach separate paper if necessary.

COBRA ELIGIBLE MEMBER NAME	QUALIFYING EVENT	DATE OF EVENT

MEDICARE INFORMATION

1) _____ YES / _____ NO — In the PRECEDING year, did your group employ at least 20 or more full and/or part-time employees for 20 or more calendar weeks?

2) _____ YES / _____ NO — In the CURRENT year, does your group employ at least 20 or more full and/or part-time employees for 20 or more calendar weeks?

3) _____ YES / _____ NO — Within the last year, did you have 100 or more full and/or part-time employees on at least 50% of your typical business days?

4) _____ YES / _____ NO — Are there any employees over age 65? If YES, complete the table below as indicated. Attach separate paper if necessary.

NAME	DOB	SSN	PART A ELIGIBILITY DATE	PART B ELIGIBILITY DATE

5) _____ YES / _____ NO — To the best of your knowledge, are any of your employees or their dependents disabled? If "YES", complete the table below as indicated. Attach separate paper if necessary or attach a report with the following information:

NAME	NATURE OF DISABILITY	DATE OF DISABILITY	ACTIVELY AT WORK (Y/N)	LAST DATE OF WORK

GROUP POLICY INFORMATION

1) ☐ YES ☐ NO Within the last year, did your organization participate in a multiple employer group health plan in which there was at least one employer who had 100 or more full and/or part-time employees for 50% of your typical business days?

2) ☐ YES ☐ NO Do you have a formal Short-Term Disability program? If "YES", indicate carrier below.

3) ☐ YES ☐ NO Do you have a formal Long-Term Disability program? If "YES", indicate carrier below.

4) ☐ YES ☐ NO If you answered "YES" to #3, does your Long-Term Disability program provide group health benefits at the same contribution level as full-time employees?

If "NO", what is YOUR (**Employer**) contribution level? ☐ % or $ ☐

5) ☐ YES ☐ NO Do you have a formalized nondiscriminatory employer sponsored retirement program? If YES, attach documentation of the program.

6) ☐ YES ☐ NO Do you file an IRS/Department of Labor form 5500A for your health benefits? If "YES", list the reporting period months for the form filing: FROM ☐ TO ☐

Person to receive 5500 information:

Name: _____

Phone Number: _____ Fax Number _____

7) ☐ YES ☐ NO Have you completed the IRS/SSA/HCFA Data Match questionnaire?

8) ☐ YES ☐ NO Is your Group Health Plan established or maintained for its Employees by a federal, state, or local government, governmental agency, or instrumentality?

9) ☐ YES ☐ NO Is your plan established or maintained for its Employees by a church or by a convention or association of churches?

10) ☐ YES ☐ NO If you answered "YES" to question #9, does your plan qualify as tax exempt under the Internal Revenue Code Section 501(C)(3)?

11) ☐ YES ☐ NO Is your Plan/Group governed by the Employee Retirement & Income Security Act of 1974 (ERISA)?

12) ☐ YES ☐ NO I attest that the contribution rate for the plan year covered by the renewal will not decrease more than 5% from the contribution rate in effect as of March 23, 2010.

IMPORTANT: Please do not cancel your current health care coverage unless and until you have received written acceptance from Highmark WV. This Group Application is not a contract for health care benefits. The mere completion of this Group Application does not obligate Highmark WV to pay benefits for health care services. Highmark WV shall not be obligated to pay benefits for health care services unless and until this Group Application is accepted in writing by an officer of Highmark WV and only as long as the Group continues to qualify under the terms of the Group Contract with Highmark WV, including timely payment of premiums.

Signature: Witness:

_____
Full or Corporate Name of Applicant

_____ _____
Authorized Signature and Title Representative of Highmark WV

Signed at _____ on _____
date

Highmark WV's policy of equal employment opportunity is to recruit, hire, promote, re-assign, compensate, and provide training for all job classifications without regard to race, color, religion, sex, age, national origin, handicap, or veteran status including Vietnam-era veterans and all disabled veterans.

This agreement is subject to the provisions of Executive Order 11246, as amended and the regulations at 41 CFR parts 60-1 through 60-60, and 38 USC 2012 and section 603 and the regulations at 41 CFR parts 60-250 and 60-741, which are herein incorporated by reference.

Agent of Record

I hereby recognize _____ (print name) to receive credit for this application according to company rules and regulations, provided she/he is licensed by the State Insurance Department of West Virginia.