



SMALL GROUP BUSINESS APPLICATION

(For small employers — 2 to 50 contracts — headquartered in the 29 counties of Western Pennsylvania)

ALL NON-SHADED FIELDS ARE MANDATORY AND MUST BE COMPLETED

(1) GROUP SUBMISSION STATUS:

- New to Blue
- Add new Vision Product to existing Group
- Add New Medical Group Option
 - Total Transfer (with Supplemental if applicable) - please cancel old Group (refer to (9) PRIOR GROUP NUMBER)
 - Partial Transfer (with Supplemental if applicable)

Note: If current Group has Supplemental Coverage and is transferring, complete Type of Program Sold including Supplemental Lines of Business.

(2) TYPE OF PROGRAM SOLD:

Open Access

- PPOBlue High Option I
- PPOBlue High Option II
- PPOBlue Enhanced
- PPOBlue Standard
- PPOBlue 90/70
- PPOBlue \$500 Deductible
- PPOBlue Split Copayment 100/80
- PPOBlue Split Copayment Low Cost 90/70
- PPOBlue High-Deductible Value
- PPOBlue \$2,500 High-Deductible Value
- PPOBlue Value Plus 250
- PPOBlue Value Plus 500
- PPOBlue (HDHP 100/80 \$1,500 Deductible Value Option)
- PPOBlue (HDHP 100/80 \$2,600 Deductible)
- PPOBlue (HDHP 90/70 \$2,600 Deductible)
- PPOBlue (HDHP 90/70 \$3,500 Deductible)
- PPOBlue (HDHP 80/60 Value Option)
- PPOBlue (HDHP 100/80 \$1,250 Deductible Value)
- PPOBlue (HDHP 100/80 \$2,000 Deductible Value)
- EPOBlue Essential
- PPOBlue \$750 Deductible Value
- PPOBlue \$1,000 High-Deductible Value
- PPOBlue \$1,500 High-Deductible Value

Managed Care

- KeystoneBlue HMO

Traditional

- ClassicBlue Traditional
- ClassicBlue Comprehensive 750/1000
- Signature65 (Select Associations Only)

Open Access Out-of-Area

- Out-of-Area PPO High Option II
- Out-of-Area PPO Standard
- Out-of-Area PPO High-Deductible Value
- Out-of-Area PPO Value Plus 500
- Out-of-Area PPO (HDHP 100/80 \$2,600 Deductible)

Supplemental

- Fashion Advantage Option I
- Fashion Advantage Option V
- Fashion Advantage Gold Option I
- Fashion Advantage Gold Option V
- Other Vision _____

(3) LIFESTYLE RETURNS Yes No

NOTE: Lifestyle Returns can only be added to Open Access Plans and KeystoneBlue HMO.

(4) QUOTE ID:

(5) EFFECTIVE DATE	DISTRICT	TERRITORY	REPRESENTATIVE
--------------------	----------	-----------	----------------

(6) BUSINESS NAME:	(7) E.I.N.	NEW GROUP NUMBER	CLIENT NUMBER
--------------------	------------	------------------	---------------

(8) ASSOCIATION / POOL:	(9) PRIOR GROUP NUMBER:
-------------------------	-------------------------

(10) PRIOR MEDICAL COVERAGE:
 UNINSURED: YES NO - IF "NO," COMMERCIAL CARRIER: _____

(11) BUSINESS ADDRESS (PHYSICAL LOCATION):	(12) CITY:
--	------------

(13) STATE:	(14) ZIP+4:	(15) COUNTY:	(16) PHONE:
-------------	-------------	--------------	-------------

(17) E-MAIL ADDRESS:	(18) INDUSTRY TYPE:	(19) SIC:
----------------------	---------------------	-----------

(20) SEND CONTRACTS TO: _____

(21) HIGHMARK AGENCY NAME & TELEPHONE NUMBER	(22) HIGHMARK AGENCY NUMBER:
1. _____	_____
2. _____	_____

(23) PRODUCER NAME & TELEPHONE NUMBER:	(24) PRODUCER NUMBER:
1. _____	_____
2. _____	_____

(25) OWNERSHIP TYPE: CORPORATION PARTNERSHIP PROPRIETORSHIP GOVERNMENT OTHER (SPECIFY): _____

IF INCORPORATED, STATE OF CORPORATION: _____

IF A PARTNERSHIP OR PROPRIETORSHIP, LIST THE NAMES OF EACH PARTNER OR OWNER:

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

(26) PLAN SPONSORSHIP: <input type="checkbox"/> PRIVATE ENTITY (ERISA) <input type="checkbox"/> GOVERNMENT ENTITIES (NON-ERISA) <input type="checkbox"/> PUBLIC SCHOOLS (NON-ERISA) <input type="checkbox"/> CHURCH ENTITY (NON-ERISA)	(27) GROUP ADMINISTRATOR:
--	---------------------------

(27) GROUP ADMINISTRATOR:	(28) TITLE:
---------------------------	-------------

ALL NON-SHADED FIELDS ARE MANDATORY AND MUST BE COMPLETED

(29) EMPLOYER PAYS

_____ % OF THE INDIVIDUAL COST
\$ _____ TOWARD THE TOTAL COST
_____ % OF THE FAMILY COST
\$ _____ TOWARD THE FAMILY COST

(30) PLEASE LIST BILLING CONTACT NAME:

PLEASE LIST BILLING ADDRESS:

COMPANY SIZE

_____ (31) Current Number of Full-Time Employees _____ (32) Current Number of Part-Time Employees

_____ (33) Total Number of Seasonal/Intermittent Employees for current calendar year

_____ (34) Total Number of Full-Time Employees enrolling in coverage.

(35) In determining who is an employee for this purpose, the Federal government counts all employees who work under a common ownership or corporation and who are subject to FICA taxes. (If you are exempt from FICA taxes, count employees who would be subject to FICA taxes if the exemption did not apply.) This includes individuals employed:

- Locally and out of the area
- Full-time, part-time, intermittently and/or on a seasonal basis

- a. In the preceding calendar year, did you have at least 20 or more employees for each working day or 20 or more calendar weeks?
 YES NO Company did not exist
- b. As of today's date in the current calendar year, did you have at least 20 or more employees for each working day of 20 or more calendar weeks?
 YES NO Unknown, enough time has not expired
- c. In the preceding calendar year, did you have at least 100 or more employees during 50% or your regular business days?
 YES NO Company did not exist
- d. As of today's date in the current calendar year, did you have at least 100 or more employees during 50% of your regular business days?
 YES NO Unknown, enough time has not expired

(36) Does the company have a probationary period for new employees? YES NO

(37) If YES, coverage begins the first day of the month following _____ DAYS _____ MONTHS

(38) Does the company wish to include eligibility coverage for Domestic Partners? YES NO

(39) Are there any employees eligible for Medicare? YES NO

PRODUCT MIX

(40) Other Carrier Offered? NO YES If YES, Carrier Offered: _____
Product Offered: _____

(41) REMARKS: _____

(42) EMPLOYER AUTHORIZED SIGNATURE _____

I, the undersigned, have the authority to represent this business and recognized the agency (or agencies) listed in "box 21" as our exclusive Producer of Record (P.O.R.) for all Highmark Blue Cross Blue Shield products and they will receive any and all commissions included in the rates. I understand that all underwriting and participation guidelines must be met and that rates are **not binding** until approved by Highmark Blue Cross Blue Shield. Any need for additional information could impact the effective date of coverage, the rates quoted, or the ability to offer group insurance coverage. Furthermore, all underwriting and participation guidelines must be met throughout the duration of the insurance contract and Highmark reserves the right to re-confirm compliance with these guidelines at anytime in the future. 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. I acknowledge and agree that any personally identifiable health information ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office. **I further acknowledge and agree that Highmark may disclose enrollment, disenrollment, summary health and/or premium billing information requested by the P.O.R. for purposes of inputting, updating and/or reviewing the same for the above-identified business.**

Name _____ **Title** _____

Signature _____ **Date** _____

Please return form to:

Highmark Blue Cross Blue Shield • Small Group Submissions • 120 Fifth Avenue, Suite 1025 • Pittsburgh, PA 15222-3099