EXCELLUS SMALL GROUP ENROLLMENT UNDERWRITING CHECKLIST

All forms listed below should be completed in their entirety and signed by the decision maker at the group. Incomplete or missing forms will result in a delay of your coverage starting by the effective date requested.

1. _____ **New Group Application Forms (5)** – Must be completed by all groups
2. _____ **Tax Returns and Business Documentation-** Must be submitted for all groups (See documentation requirements below).

   Note: For new businesses that have not filed their first **NYS45-ATT**, copies of the **W-4** may be submitted. Excellus also has a minimum income requirement for businesses of **$7,600.**

If you are submitting enrollment applications for partners or business owners not listed on the NYS45-ATT, then please submit one of the following:

- **Partnerships**: a copy of the most recent **1065 K-1** form for all partners showing 100% ownership of the business.
- **Corporations**: copy of the most recent **1120C, 1120E** or **1120S** form.
- **Charitable organizations**: IRS **form 990** is required unless exempt from filing tax returns from the IRS, then a copy of the exemption is required.

Note: If a business with 2 or more employees has been in operation for less than one year, a copy of the **DBA certificate, partnership certificate, certificate of incorporation** or other similar tax documentation verify the business is authentic.

3. _____ **Group Enrollment Form**- Must be completed and signed by each employee enrolling in coverage. A link for application is attached to the plan summary rate sheet.
4. _____ **Waiver of Group Coverage Form**- Must be completed by **all** employees **not** enrolling in coverage.
5. _____ **Signed Rate Sheet for selected plan**- Must be completed by all groups and can be downloaded from Chamber website. It is attached to the plan summary.
6. _____ **Pediatric Dental Coverage Attestation Form**- Must be completed by groups **declining** pediatric dental coverage. Otherwise plan will include pediatric dental rider for **all** employees as mandated by health care reform.
7. _____ **Company check payable to Greater Rochester Chamber of Commerce for premium. Forms without payment will not be processed.**

Upon completion; email, fax or mail all forms along with check to:

Patrick LoMando
Greater Rochester Chamber of Commerce
150 State Street, Suite 400
Rochester, NY 14614
Phone: (585) 256-4644
Fax: (585) 263-3679
Email: Patrick.LoMando@GreaterRochesterChamber.com

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New Group Application

Instructions:
Please complete the form below. Be sure to read the instructions in italics as not all sections apply to your group.
For reference, please review the checklist at the end of this document to ensure all applicable information is submitted.

Section 1: Group Information

1. Group/Business name or DBA name (if applicable):

2. Legal entity name, if different than group name:

3. EIN/TIN: | SIC Code:

4. Most group health plans are governed by ERISA with the exception of some religious organizations and government entities.
If you are NOT governed by ERISA, please indicate: ☐

5. Effective Date of Coverage:

6. What was your group's renewal date with your previous health insurance carrier?

7. Business Physical Address:

City: | State: | ZIP: | County:

Telephone No.: ( ) | Fax No.: ( )

8. What is the nature of your business or organization?

9. Address of Company Headquarters (if different):

City: | State: | ZIP: | County:

Telephone No.: ( ) | Fax No.: ( )

10. Company Officer's Name** | Title:

Email Address:

11. Group Contact Name: | Title:

Group Contact Address (if different than above):

Group Contact Telephone Number:

Group Contact Email Address:

12. Who sponsors the group health coverage? (Check one) ☐ Employer ☐ Union ☐ Trustees of Fund ☐ Association ☐ Other:

13. Organization Type: ☐ C Corp ☐ S Corp ☐ Partnership ☐ Nonprofit ☐ Local Government
☐ State Government ☐ Church Group ☐ Trust ☐ Other:

Please select if your company is Publicly Traded or Privately Held: ☐ Publicly Traded ☐ Privately Held

14. List Owner(s)/Partner(s):

15. Indicate how your company is organized as: ☐ Stand Alone ☐ Parent ☐ Subsidiary ☐ Local Plant/Office/Division ☐ Other:

If applicable, provide company information for any commonly owned or related businesses:

Company Name:

City: | State: | ZIP: | County:

Number of total employees at related company: | Number of hours per week an employee must work to be eligible for insurance:

16. Are the owners and their spouses the only policy holders on the group coverage? ☐ Yes ☐ No

17. Is there a group medical plan in place in addition to the products offered through Excellus BCBS? ☐ Yes ☐ No

If Yes, indicate plan type: ☐ New York State of Health ☐ Other:

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New Group Application

Section 2: Billing *(if your premium bills should be sent to the same group contact and address above, skip this section.)*			
1. Address:			
City:	State:	ZIP:	County:
Telephone No.: ( )		Fax No.: ( )	
2. Billing Contact Name/Title (if different):			
Billing Contact Telephone Number:			
Billing Contact Email Address:			

Section 3: Regulatory Employer Information	
1. Average number of owners and employees (all FT and PT) at all locations in the prior calendar year (for reporting purposes).	
2. Did you employ 20 or more employees who worked at least 20 weeks in the current year or prior year? (for Medicare Secondary Payer determination)	☐ Yes ☐ No
3. Did you employ 100 or more employees on 50% or more of your business days in the current year or prior year? (for Medicare Secondary Payer determination)	☐ Yes ☐ No
4. Do you employ any Vermont residents who work at employer locations in Vermont, or are telecommuting from their home?	☐ Yes ☐ No
If yes, how many?	

Section 4: Minimum Participation Requirements & Group Size Determination		
Please note: The minimum number of hours for employees to be eligible for groups with 100 or fewer employees is 20; for groups with 101 or more employees the minimum hours is 17.5. Minimum participation requirement (only applies to small groups) outside of open enrollment is 50% of eligible employees or 75% of net eligible employees. If the group does not meet the 50% of eligible employee requirement waivers may be requested to determine net eligible participation.	Employees Specific to Excellus BCBS	All other locations and/or plans*
Medical Eligibility (for minimum participation requirements)		
1. Number of eligible active employees/owners:		
2. Number of retirees (not on Medicare) eligible for the employer group plan:		
3. Number of individuals enrolled in COBRA and/or the Young Adult option:		
4. Total eligible: (Question 1 + Question 2 + Question 3)		
5. Total enrolled in the health plan:		N/A
6. Participation percentage: (Question 5 / Question 4)		
Medical Group Size Determination (Groups with 100 or fewer FTE's, in prior calendar year, are small groups and groups with over 100 FTE's are large group)		
7. How many full-time employees (30 hours or more per week) did you employ during the previous calendar year?		
8. How many part-time employees (fewer than 30 hours per week) did you employ during the previous calendar year?		
9. Total number of employees during the previous calendar year for reporting purposes: (Question 7 + Question 8)		
Full Time Equivalent Calculation		
10. Total number of part-time hours worked by all part-time employees during the previous calendar year:		N/A
11. Total number of part-time hours worked during the previous calendar year divided by 1440: (Question 10 /1440)		
12. Total number of full-time employees and full-time equivalents for group size determination: (Question 7 + Question 11)		

**This column is only to be completed if your company has multiple locations and/or multiple plans.*
Only include those eligible for health insurance with other insurance carriers that are NOT eligible to enroll in the Excellus BCBS plan.

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New Group Application

Instructions: *Please complete the table below indicating how much premium is contributed from the employer towards the group health insurance. For each type of product (next to product name) please note the employee contribution class structures at the company and how the employer group contributes towards those employee monthly premiums, i.e. dollar amount or percentage.*

Below are the most commonly used contribution classes:

A001 - All Active Employees A002 - Hourly A003 - Salaried A004 - Management A005 - Non-Management A006 - Union A007 - Non-Union A008 - Full-Time A009 - Part-Time R001 - Retired Non-Medicare Eligible Z001 - Custom Class/Other

Medical Employer Contribution

Product Name	Subgroup Number	Class Name	Type		Please list the percentage or dollar amount you contribute for these tiers:			
			$	%	Employee	w/ Spouse	w/Child(ren)	Family
			☐	☐				
			☐	☐				
			☐	☐				
			☐	☐				

HSA/HRA Employer Contribution

Type	Product Name	Subgroup Name	$	%	Employee	w/ Spouse	w/Child(ren)	Family
			☐	☐				
			☐	☐				

Medical Eligibility Policy for New Employees

Please specify the date on which a new employee will be eligible for coverage by checking the appropriate option:

	Type of employee: salaried, hourly, etc.	Please specify the standard rehire waiting period for eligibility for health insurance:
☐ Date of hire		☐ Same guidelines as a new hire
☐ First of the month following date of hire		☐ Date of rehire
☐ First of the month following 30 days of employment		☐ First of the month following rehire
☐ First of the month following 60 days of employment		☐ Other:
☐ 90 days after date of hire		
☐ Other:		

Minimum hours per week that an employee must work to be eligible:

☐ 17.5 hours (Large Group Only) ☐ 20 hours ☐ 25 hours ☐ 30 hours ☐ 40 hours ☐ Other

Section 5: Dental Eligibility Information (if applicable)

Dental Eligibility	Specific to Excellus BCBS	All Other Locations and/or Plans
1. Number of eligible active employees and owners:		
2. Number of retirees eligible for the employer group plan:		
3. Number of individuals enrolled in COBRA/ NY continuation of coverage and/or the young adult option:		

dental eligibility continued on next page

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New Group Application

Dental Eligibility *(continued)*	Specific to Excellus BCBS	All Other Locations and/or Plans
4. Total number of eligible individuals for group dental insurance coverage (Question 1 + Question 2 + Question 3).		
5. Number of eligible employees declining dental coverage due to a valid waiver:		
6. Net number of eligible employees for dental coverage (Question 4 - Question 5):		
7. Total number enrolled in the dental plan:		
8. Participation percentage (Question 7 / Question 6):		
9. Are there any other dental plans in place for your group in addition to the products offered through Excellus BCBS? ☐ Yes ☐ No	N/A	N/A

What carrier is your company's dental coverage with?	Number of individuals in this plan:

Dental Employer Contribution

Product Name	Subgroup Number	Class Name	Type		Please list the percentage or dollar amount you contribute for these tiers:			
			$	%	Employee	w/ Spouse	w/Child(ren)	Family
			☐	☐				
			☐	☐				

Dental Eligibility Policy for New Employees

Please specify the date on which a new employee will be eligible for coverage by checking the appropriate option:	Type of employee: salaried, hourly, etc.	Please specify the standard rehire waiting period for eligibility for health insurance:
☐ Date of hire		☐ Same guidelines as a new hire
☐ First of the month following date of hire		☐ Date of rehire
☐ First of the month following 30 days of employment		☐ First of the month following rehire
☐ First of the month following 60 days of employment		☐ Other:
☐ 90 days after date of hire		
☐ Other:		

Minimum hours per week that an employee must work to be eligible:

☐ 17.5 hours (Large Group Only) ☐ 20 hours ☐ 25 hours ☐ 30 hours ☐ 40 hours ☐ Other

Section 6: Individuals not listed on NYS-45-ATT, or other state equivalent (required for small group only).

Please list the individuals eligible for coverage who are not listed on the NYS-45-ATT, or other state equivalent. Eligible individuals include partners or owners of the business if actively engaged in the business, COBRA/NYS continuants, new employees, and retirees when it is the consistent policy of the business owner to cover retirees.

The group attests that the individual(s)listed below work at least 20 hours per week at the above-named employer or are otherwise eligible for coverage under a group health insurance plan to be issued by us. Include a notation for each person indicating new employee (E) with date of hire, partner (P), business owner (B), retiree (R), COBRA (C), or other (O) with explanation.

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New Group Application

Section 7: Broker of Record Information (if applicable)

This is to notify you that our company has appointed _____ (name of agent), whose business address is _____ _____(street, city, state, ZIP code) as our sole insurance representative, with respect to coverage provided to this organization by Excellus BCBS effective _____(month, date, year).

I understand that if our company elects to purchase coverage from your company that _____ _____(name of agent) may be entitled to base and/or bonus compensation for our business.

This designation will remain in effect until we notify Excellus BCBS in writing to the contrary.

I certify that, to the best of my knowledge and belief and under penalty of perjury, all of the information contained within this application is true and complete.

I understand that 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 shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Employer Authorized Representative Signature:	Date:	Phone Number:
Print Name:	Email Address:	

Checklist for required information: (internal use)

Small Group:	Large Group:
☐ Deposit from business account/business check for first month's premium	☐ Group census (including DOB, gender, ZIP code, and coverage type)
☐ Proof of employment (NYS-45, or other state equivalents. In the case of a newly formed business payroll documentation is required.)	☐ Current and/or renewal premium rates through previous carrier
☐ Single owner: schedule C or schedule F	☐ Benefit summary of existing benefit plan
☐ Partnership: 1065 with K-1 forms from all partners	☐ Claims experience (by population and/or plan)
☐ Corporations: 1120 including shareholder section detail	☐ Benefit selections
☐ Subchapter S Corporation: 1120S with K-1 forms from all shareholders	
☐ Charitable organizations: form 990	
☐ Medicare eligible/ over 65 forms (when applicable)	
☐ Rate sheets/benefit summaries	
☐ Subscriber applications	
☐ Waivers (when applicable)	
☐ Handicapped dependent form (when applicable)	

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Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Health Plan (Product) Effective Date: _____

Please Check All That Apply:

[ ] I waive my employer's group **health** insurance coverage for myself and my dependents

[ ] I waive my employer's group **dental** insurance coverage for myself and my dependents

Reason for Waiving Coverage - Please Check One:

[ ] Covered through spouse's employer [ ] Covered through a parent's employer

[ ] Under 65 Retiree covered by previous employer's insurance program

[ ] Covered with another carrier through my group (coverage is not on NYS of Health exchange)

[ ] Other Please specify: _____

Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage
- At the time of my employer's open enrollment.

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

Employee Signature: _____ Date: _____

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ESSENTIAL PEDIATRIC DENTAL COVERAGE ATTESTATION FORM

For Small Group Employers

In an effort to make health care more accessible, the Affordable Care Act requires that all small group health plans provide coverage for a range of core services known as Essential Health Benefits, one of which is pediatric dental care for dependents to age 19.

To ensure our members of small group health plans have this essential coverage, Excellus BlueCross BlueShield has included pediatric dental coverage as part of your medical plan.

ATTESTATION

If all the members enrolled in your Excellus BCBS plan and each of their covered dependents have pediatric dental coverage from another plan not offered by Excellus BCBS, you have the option to decline the pediatric coverage offered through us.

By signing below, you are attesting that your group is already meeting the pediatric dental Essential Health Benefits requirements through another dental plan and you are requesting that Excellus BCBS remove the pediatric dental coverage embedded in your Excellus BCBS medical plan.

Excellus Group # _____

Employer Name _____

Name of the carrier issuing the standalone dental coverage _____

Effective date of plan _____

I certify that all of the members enrolled in our applicable Excellus BCBS plan and each of their covered dependents have (for the applicable plan year) coverage for pediatric dental EHBs through a NY State of Health™-certified standalone dental plan offered outside of the NY State of Health™ Marketplace.

Signature, Employer Representative: _____ Date: _____

Print Name: _____ Title: _____

Please return completed form via email to your dedicated account consultant or mail to:

[Rochester:
Excellus Health Plan, Inc.
Attn: Small Business Sales Department
165 Court Street
Rochester, NY 14647

Elmira:
Excellus Health Plan, Inc.
Attn: Small Business Sales Department
150 N Main Street
Elmira, NY 14901

Utica:
Excellus Health Plan, Inc.
Attn: William Virkler
12 Rhoads Drive
Utica, NY 13502]

8/2014