Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
PO Box 30270
Salt Lake City, Utah 84130-0270

Group Master Application - For Group Size 100+

Please complete and submit this application to our office **no later than 15 days prior to the effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate sheet of paper.

Requested Effective Date _____

SECTION A - GROUP INFORMATION			
Group's Legal Name		Group Number	
Doing Business As (DBA)	Name to be used by Regence ☐ Legal ☐ DBA	Company Structure ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Other _____	
Employer Federal (EIN) and State (if applicable) Tax ID Numbers		Location of Business Headquarters	
SIC Code and Industry Description			
Name and Title of President, Owner, CEO		Group's Primary Language (if other than English)	
Physical Business Address **Required** (No PO Box or PMB)		Mailing Address (if different from Physical Business Address)	
County	Phone Number ( ) Fax Number ( )	County	Phone Number ( ) Fax Number ( )

GROUP ADMINISTRATOR		
Name (First, MI, Last)		Title
Phone Number ( )	Fax Number ( )	E-mail Address

SECTION A - GROUP INFORMATION (continued)

BILLING

Do you require separate billing invoices? ☐ No ☐ Yes **(If yes, please complete Additional Billing section below)**

Billing Name to be used by Regence ☐ Legal ☐ DBA	Contact and Title (if different than group administrator)
Billing Address (include Attention line if applicable)	Phone Number ( ) Fax Number ( )

Payment Type
☐ Pay by Check ☐ Surepay (EFT) **Please submit Surepay document**

Additional Billing Name to be used by Regence	Contact and Title (if different than group administrator)
Billing Address (include Attention line if applicable)	Phone Number ( ) Fax Number ( )

Payment Type
☐ Pay by Check ☐ Surepay (EFT) **Please submit Surepay document**

ENROLLMENT METHOD AND EMPLOYER CENTER

Enrollment Method

Please indicate your enrollment method by checking the desired option from the listing below.	**Initial or Open Enrollment** with Regence	**Ongoing Enrollment** with Regence
Spreadsheet **Note: Only available for Initial Enrollment**	☐	
Regence Online Enrollment When selecting Regence Online Enrollment, would you like to allow your employees to enroll themselves? ☐ No ☐ Yes **Regence Marketplace** Would your group like to use the online Regence Marketplace? ☐ No ☐ Yes What is the annual Defined Contribution amount for your employees?_____ (If amount depends on employee class, please submit on separate page)	☐	☐
ANSI 834	☐	☐
Paper Enrollment Forms	☐	☐

Employer Center

Employer Center Primary Group Administrator: Name (First, MI, Last)	E-mail Address	Phone Number ( )

If more than two Employer Center Secondary Group Administrators are required, indicate the number desired _____

SECTION B - PRODUCER (AGENT) INFORMATION

Agency Name	Producer's E-mail Address	
Producer's Name	Producer's Phone Number	Producer's Number
Secondary Producer's Name	Secondary Producer's Phone Number	Secondary Producer's Number

Producer's Medical Commission:	Commission Split %:
☐ Flat _____ % ☐ PEPM $ _____ ☐ PMPM $ _____ ☐ None	Producer #1 _____ % Producer #2 _____ %
Producer's Dental Commission:	Commission Split %:
☐ Flat _____ % ☐ PEPM $ _____ ☐ PMPM $ _____ ☐ None	Producer #1 _____ % Producer #2 _____ %

SECTION C - FEDERAL MANDATES

COBRA:

Group subject to COBRA? ☐No ☐Yes**

COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (January - December), with the exception of federal government plans and church plans. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

**If you are subject to COBRA, do you utilize a COBRA third party administrator (TPA)? ☐No ☐Yes

If yes, who is your COBRA administrator _____

Please indicate if your COBRA TPA is providing any of these services by checking the appropriate box(es).

☐ Regence billing sent directly to the TPA for COBRA participants. (Be sure to complete the additional billing information above in Section A for this TPA.)

☐ TPA submits COBRA Enrollment and Dis-Enrollment directly to Regence.

OBRA:

Group subject to OBRA? ☐No ☐Yes

If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:

Group subject to TEFRA/DEFRA? ☐No ☐Yes

If the TEFRA/DEFRA status has changed within the past year, please indicate the Date of Change _____

If you employed 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

ERISA:

Group subject to ERISA? ☐No ☐Yes

If yes, is your plan year different than your renewal date? ☐No ☐Yes, list date _____

Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals covered by a health plan subject to ERISA, as well as most voluntarily established pension plans.

ERISA Plan Note: If you use the benefit booklet as a component of the summary plan description and want to investigate meeting your distribution requirement electronically, see 29 CFR §2520.104b-1(c) for the U.S. Department of Labor's electronic distribution safe harbor.

Schedule A / 5500:

Per section 104 of ERISA, your group may be required to file IRS Form 5500 (Schedule A).

Do you require information from us to help you complete your Schedule A / Form 5500? ☐No ☐Yes

If yes, this information will be provided based on your insurance contract period.

New Groups Only - Affordable Care Act Required Information:

In the previous calendar year (January - December) the average number of employees was _____. This employee count represents the calendar year of _____ (YYYY).

This count should include: full-time, part-time, seasonal and union employees that work inside or outside the state of Utah and employees worldwide from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees. Your employee count should **not** include contracted 1099 individuals.

SECTION D - OTHER CARRIER INFORMATION

1. Does your group have current medical/dental/pharmacy benefits?

   Medical: ☐No ☐Yes If yes, name of carrier _____ End date _____

   Dental: ☐No ☐Yes If yes, name of carrier _____ End date _____

   Pharmacy: ☐No ☐Yes If yes, name of carrier _____ End date _____

2. Will you be offering more than one medical/dental carrier to your employees?

   Medical: ☐No ☐Yes* If so and if any of your plan is insured, name of carrier(s) _____

   Dental: ☐No ☐Yes* If so and if any of your plan is insured, name of carrier(s) _____

   ***This option is not allowed in all instances.**

3. Does your group have Workers' Compensation coverage?

   ☐No ☐Yes If yes, name of carrier _____

SECTION E - GROUP ELIGIBILITY (for purposes of determining group classification)

Note: An "eligible employee" is defined as an employee who on a full-time basis worked 30 or more hours/week in the preceding calendar year.

1. Number of eligible employees in the preceding calendar year _____
2. Is the group affiliated with any other company (parent, subsidiary or other entity)? ☐No ☐Yes
   If yes, please explain _____
   Note: The Health Insurance Portability and Accountability Act of 1996 may require that all persons and/or entities treated as a controlled group or affiliated service group under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 be treated as a single employer.
3. Do you have eligible employees employed outside the State? ☐No ☐Yes If yes, please indicate below.
   Note: Group members who reside in the state of Hawaii are not eligible for coverage.

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

SECTION F - EMPLOYEE AND DEPENDENT ELIGIBILITY (for determining who is eligible for group benefits)

Note: The minimum number of hours worked for eligibility are 30 hours in a normal work week.

1. This plan covers employees working the minimum number of hours required for coverage.
   The minimum number of hours to be eligible for coverage are _____

2. This plan covers the following options: (check those that apply)

	Medical/ Pharmacy/ Vision	Dental
Employee and Dependents (children and either legal spouse or domestic partner). When offering Employee and Dependents coverage, this plan: ☐provides for Domestic Partners ☐does not provide for Domestic Partners	☐	☐
Employee Only (No Dependent coverage)	☐	☐
Employee and Children Only (No Spouse or Domestic Partner)	☐	

3. Probationary Periods:

Groups may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. **All employees must be accounted for.** (If there are no classes, please enter all information in space provided for Class 1).

	Please place an X in the appropriate box below						
	Coverage is effective on the actual				**Coverage is effective on the first of the month following**		
	Date of Hire	30th Day	60th Day	90th Day	Date of Hire (see 3A below)*	30 Days	60 Days
Class 1:							
Class 2:							
Class 3:							

3A. *If Date of Hire (DOH) option is selected above, choose how Probationary Period will be administered:
☐Effective date will always be 1st of the month following DOH, even if DOH is the 1st of the month.
☐Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

3B. Is probationary period waived on group's initial enrollment: ☐No ☐Yes

3C. For employees transferring from part-time to full-time status, the probationary period specified above should apply.
☐Beginning on the date transferred to full-time status ☐Retroactive to the original date of hire

Note: Effective September 23, 2010, federal health reform prohibited employers from discrimination in favor of highly compensated individuals set forth in Internal Revenue Code section 105(h). Enforcement of this prohibition has been delayed until associated regulations or other guidance has been issued and it is unclear when that may occur. Regence is unable to determine whether a plan discriminates in a way that violates the federal reform provisions, both because guidance has not been issued and because it does not have access to information necessary to identify highly compensated individuals. Because this element of federal reform is intended to fine employers with discriminatory plans, Regence recommends that employers obtain tax and/or legal advice associated with maintaining any plan provision that may prove discriminatory.

SECTION G - EMPLOYER CONTRIBUTION

New groups may enroll without meeting a minimum employer contribution or group participation percentages.
Please note, however, that groups may not be renewed if they fail to meet either (or both) of the following contribution or participation standards at the time for their renewal.

Employer Contribution Level: There is a minimum employer contribution percentage of 75% towards the employee coverage and no minimum employer contribution percentage for dependents **or** the employer contribution may equate to at minimum 50% of the total cost of premium. Using the table below, please indicate whether the Employer Contribution is based by product (e.g., BluePoint, HSA Healthplan 3.0, etc.) or by class (e.g. hourly/salary etc.) and enter the percentage amount **or** dollar amount that the employer will pay towards the monthly rate of the elected coverage type (medical/dental).

☐ By Product	Option 1, specify product _____		Option 2, specify product _____		Option 3, specify product _____	
☐ By Class	Class 1		Class 2		Class 3	
Coverage Type	Medical/ Pharmacy/Vision	Dental	Medical/ Pharmacy/Vision	Dental	Medical/ Pharmacy/Vision	Dental
Employee	% or $	% or $	% or $	% or $	% or $	% or $
Dependent	% or $	% or $	% or $	% or $	% or $	% or $

SECTION H - GROUP PARTICIPATION

Participation Requirements: There is a minimum participation requirement of 75% of eligible employees (line 5 below) after consideration of valid waivers after consideration of valid waivers and at least 50% of the total eligible employees (line 3) must participate.

1. Total number of employees on payroll regardless of hours worked (Do not include individuals participating on COBRA). ..... + _____
2. Less individuals not eligible for coverage on this plan (account for each of these individuals in one of the following that best applies):
   a) Number of employees working fewer than the minimum hours (as selected in Section F - Employee Eligibility). ..... – _____
   b) Number of employees who are fulfilling their New Hire Probationary Period (as selected in Section F - Employee Eligibility). ..... – _____
   c) Number of employees who are seasonal, substitute or temporary. ..... – _____
   d) Number of individuals who are paid solely via IRS Form 1099. ..... – _____
   e) Number of employees whose class is ineligible for coverage under this plan. Please enter the description of your group's ineligible class _____ , if union, please provide a copy of the union roster. ..... – _____
3. Equals sub-total number of employees eligible to enroll. ..... = _____

Using the number of employees eligible to enroll (from line 3 above), continue for each type of coverage (Medical/Dental) elected:	Medical	Dental
4. Less number of employees who are waiving for **other qualifying coverage.**	–	–
5. Equals total number of employees eligible to enroll.	=	=
6. Less number of employees who are **declining coverage. (No other qualifying coverage).**	–	–
7. Equals number of employee applications submitted **(new groups)** / number of employees on coverage on the effective date **(renewing groups)**.	=	=
8. Employees participation percentage (line 7 divided by line 5).	%	%
9. Number of subscribers and/or their dependents covered by your group under COBRA.		
10. Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.		

SECTION I - ACKNOWLEDGMENTS AND CERTIFICATIONS

If you have any questions about the benefits and services that are covered, provided, limited or excluded under the group coverage(s) to which this application applies, please contact your Sales Representative before signing this application.

Note: The Company as used here means the group applying for coverage as indicated in Section A of this application.

I certify that I am an officer or employee of the Company, that I am duly authorized to execute this application on behalf of the Company, and that the Company:

a) Authorizes any person or other entity to release to Regence BlueCross BlueShield of Utah (Regence) any information requested by Regence in connection with this application's processing.

b) Acknowledges, where permitted by law, that Regence may choose not to approve this application and any premium deposit will be returned if the application for group coverage(s) is not approved.

c) Acknowledges that coverage is not in effect until Regence accepts this application, establishes an effective date of coverage and issues the group contract(s) to the Company.

d) Acknowledges that, if it is approved by Regence, this application will form a part of the group contract(s) issued by Regence and agrees that the Company will be bound by the terms and the conditions of entire group contract(s).

e) Acknowledges that eligibility standards (e.g., waiting period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.

f) Acknowledges that it has selected the group coverage(s) to be offered to its employees, that its selection of this group coverage(s) was based upon written information provided by Regence, and that no broker, producer, or consultant was or is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.

g) Agrees to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Regence for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Regence, upon its request verifications of employee participation levels.

h) Agrees that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.

i) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.

j) Agrees to deliver, or otherwise make available to enrollees, all Regence paper or online member documents and other coverage-related materials upon request by Regence.

k) Agrees to make all coverage options available to all eligible employees and dependents who satisfy eligibility requirements.

l) Acknowledges that benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and Regence in accordance with the group contract(s).

m) Acknowledges that Regence must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc).

n) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither producers nor employees of Regence, that Regence does not provide health care services, and that Regence cannot guarantee any results or outcomes of care. We are responsible for the quality of health care you receive only as provided by law.

SECTION I - ACKNOWLEDGMENTS AND CERTIFICATIONS (continued)

o) Certifies under penalty of perjury that all statements made and information provided in this application are accurate and complete to the best of its knowledge or belief and acknowledges that Regence will rely in part on the information in this application as the basis for Regence's decision on whether to approve this application and issue any group contract(s). For the protection of all of Regence's members, fraud or misrepresentation of material facts by the Company may result in Regence taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, Regence will have the right to collect any claims payments or other damages. If Regence continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that Regence will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by Regence.

p) Agrees that any controversy or claim between the Company and Regence arising out of or relating to the group contract(s), or the breach thereof, whether involving a claim in tort, contract, or otherwise, shall be subject to final resolution through binding arbitration. The Company and Regence agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs, and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in Salt Lake County, Utah (UT), unless mutually agreed otherwise by the parties. If any enrollee or former enrollee (or person claiming to be an enrollee or former enrollee) makes any claim or brings any action or proceeding arising out of or relating to the group contract(s) to which Regence or the Company becomes a party, Regence and the Company agree to cooperate in the defense of such claim, action, or proceeding and to resolve any controversy or claim between Regence and the Company through arbitration under this paragraph only after the resolution of the enrollee's (or alleged enrollee's) claim.

q) Appoints the producer of record indicated in Section B - Producer (Agent) Information (if any) to represent it in matters of group coverage benefits provided by Regence. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.

r) Acknowledges that if the Company has a producer, that producer may receive bonuses, commissions, administrative services fees, or other compensation, including non-cash compensation from Regence. Incentives may be based on any of several factors, including the size of the Company's business, the products the Company purchases, the producer's volume of business with Regence, and other services the producer provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information please contact the producer for the Company.

Any accompanying foreign language version of this form is provided only as an accommodation or courtesy to the customer and this English language version shall control the resolution of any dispute or complaint.

WE'VE GONE GREEN! To be more environmentally conscious and in response to employer requests, we will attach one paper copy of the booklet (unless another quantity has been previously arranged) describing your plans benefits to your contract. Inform your plan participants that they can access the booklet electronically at Regence.com. Or, if preferred, you can contact your sales representative to order additional paper copies for distribution or can have any requesting plan participant request a paper copy by contacting customer service.

SIGNATURE

Group Authorized Signature ▶ _____

Print Authorized Name ▶ _____

Official Title ▶ _____

Signature Date ▶ _____