Excellus

Commercial Underwriting Package

Commercial health insurance coverage is available to employer, trust and association groups, subscribers and dependents that meet the qualifications specified in 4235 (c) (1) of the New York State Insurance Law and the Underwriting Guidelines of Excellus Health Plan, Inc, doing business as Excellus BlueCross Blue Shield ("Health Plan").

The attached documents must be completed by an Employer enrolling in the Health Plan's insurance.

Last Revised: July 9, 2013

Excellus
165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the Blue Cross Blue Shield Association

New Business Group Information Form

Section One: General Group Information

1. Group name or DBA name, if applicable: _____
2. Legal entity name, if different than group name: _____
3. List owner(s)/partners: _____

   List commonly owned businesses (if applicable): _____
4. Plan Year: _____
5. The majority of businesses' benefit plans are governed by ERISA with the exception of some religious organizations and municipalities. If you are **not** governed by ERISA, please indicate by checking the box to the right. ☐
   *Note: For information about ERISA, please see http://www.dol.gov/compliance/laws/comp-erisa.htm
6. Physical location of employer: _____
7. Physical location of company headquarters: _____
8. Person to contact with any questions regarding this form:

_____	_____	_____	_____
Name	Title	Phone #	Email Address
9. Description of business: _____ SIC code: _____ EIN/TIN #: _____
10. Type of group sponsor: (check one)

    Employer ____ Union ____ Trustees of Fund ____ Association ____ Other (please describe): _____
11. Organization type: (check one) State government ___ Local government ___ Church group ____
    Nonprofit ____ Trust ____ Publicly traded organization ____ Privately held corporation ____
    Privately held non-incorporated ____ Not-for-profit ____ Other (please describe): _____
12. If you are the sole owner of a business, place a check mark by the statement that is true:
    ___ This business offers coverage to owners, partners, and/or spouses and family only (no employees).
    ___ This business offers coverage to owners, partners and spouses, but also includes coverage for other employees, including common law employees.
13. Is coverage obtained through a Chamber Trust or Association (CTA), including a professional society?

    Yes ___ No ___ (check one)

    ___ Coverage is obtained as a result of employment in an employer group.
    ___ Coverage is obtained as a result of my professional credentials (e.g. MD license).
    CTA Name _____ Professional Society Name _____
14. Are you a subsidiary company? Yes ___ No ___ (check one)

    If yes, list parent company name & address _____
15. Are you a parent company with subsidiary companies? Yes ____ No ____ (check one)

    If yes, please attach a list of the related companies, the locations and the number of eligible employees working at each location
16. Are there any other medical plans in place for your group, other than products offered through Excellus BCBS?
    Yes ____ No ____ Type of plan _____Number of individuals enrolled in this other plan _____

Revision Date: 7/8/13

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PLEASE SUBMIT ALL REQUIRED UNDERWRITING DOCUMENTATION WITH THIS FORM

Section Two: Regulatory Information

	Medical	Dental
17. Group Size		
a) Total number of employees, owners, and partners at all locations	_____	_____
b) Total number of eligible full-time & part-time employees at all locations	_____	_____
c) Total number of eligible retirees at all locations	_____	_____
d) Total number of individuals enrolled due to COBRA/New York continuation of coverage, young adult option and surviving spouses at all locations	_____	_____
e) Total eligible **(e = b + c + d)**	_____	_____
f) Eligible individuals at other locations not eligible for the programs offered through our plan and/or on a union sponsored plan	_____	_____
g) Eligible employees declining coverage due to a valid waiver (please see instructions)	_____	_____
h) Individuals who are offered a Medicare eligible or Retiree Health Plan group product with our health plan. *If you have any individuals in this category complete the Medicare Questionnaire*	_____	NA
i) Net eligible for our health plan **(i = e – f – g – h)**	_____	_____
j) Eligible individuals enrolling in group products (**exclude** those enrolled in Medicare Advantage, a Retiree Health Plan, or with another carrier)	_____	_____
k) Group participation percentage **(k = (j ÷ i) x 100)**	_____	_____
18. Average number of total employees at all locations, during the *prior* calendar year	_____	NA
19. Do you employ any Vermont residents who work at employer locations in Vermont, including telecommuters working from their home in Vermont? Yes ____ No ____ (check one) If yes, please provide the number	_____	_____
20. Do you employ any other out-of-state residents who work at out-of-state employer locations other than Vermont? Yes ____ No ____ (check one) If yes, please provide the number	_____	_____

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, including the number of persons proposed for coverage who work at least the minimum required hours per week.

Employer Authorized Representative Signature **Date** **Email Address** **Title**

Print Name

Revision Date: 7/8/13

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Employer Contribution Form

Group/Business Name____ Group Number______________________

Instructions: Please enter the percentage of premium contributed annually by the employer toward the group health insurance.
*Note: Be sure to fill out both tiers, regardless of whether there are subscribers in each. If your group contributes a flat dollar amount, please calculate the percentage based on the respective tier (ie Single, Family) premium amount and check the corresponding box.

Class Names	A001 – All Actives	A004 – Management	A007 – Non-Union	R001 – Retired Non-Medicare Eligible
	A002 – Hourly	A005 – Non-Management	A008 – Full-Time	R002 – Retired Medicare Eligible
	A003 – Salaried	A006 – Union	A009 – Part-Time	

		Employer Contribution Range - % (check box for each tier)											
		Single						**Family**					
Class Name	Product	0%	1-24%	25-49%	50-74%	75-89%	90-100%	0%	1-24%	25-49%	50-74%	75-89%	90-100%
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Class Name	Product	0%	1-24%	25-49%	50-74%	75-89%	90-100%	0%	1-24%	25-49%	50-74%	75-89%	90-100%
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Class Name	Product	0%	1-24%	25-49%	50-74%	75-89%	90-100%	0%	1-24%	25-49%	50-74%	75-89%	90-100%
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Only complete this section if an HSA/HRA is attached to any of the products listed above:

Product Type			**Annual Employer Contribution Toward HSA/HRA Deductible - %**					**Annual Employer Contribution - $**
Circle one	Class Name	Product	0-24%	25-49%	50-74%	75-89%	90-100%	
HSA HRA			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
Circle one	Class Name	Product	0-24%	25-49%	50-74%	75-89%	90-100%	
HSA HRA			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	

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

Employer Authorized Representative Signature | **Date** | **Phone Number**

Print Name | **Email Address**

Revision Date: 7/8/2013

Excellus

Eligibility Policy for New Employees

Group Name: _____

Group Number {If Assigned}: _____

Our Standard new hire waiting period for eligibility for health insurance is:

(Type of employee: salaried, hourly, etc.)

_____ Date of Hire _____

_____ First of the month following date of hire _____

_____ First of month following 30 days of employment _____

_____ First of month following 60 days of employment _____

_____ 90 days after date of hire _____

_____ Other _____
Must be approved by underwriting prior to submission

Our Standard rehire waiting period for eligibility for health insurance is:

_____ Same guidelines as new hire _____
_____ Date of rehire _____
_____ First of the month following rehire _____
_____ Other _____
Must be approved by underwriting prior to submission

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

_____ 20 hours _____
_____ 25 hours _____
_____ 30 hours _____
_____ 40 hours _____

Note:

- Employer can determine full time status as stated above but may not be less than 20 hours.
- Waiting period cannot exceed 90 days

The above policies have been submitted for business indicated above. I understand that these policies are accepted and must remain in effect for at least one full year before they are eligible to be changed.

Authorized Group Signature: _____

Date Signed:_____ Date Effective: _____

Excellus

ATTESTATION

I, _____, the _____
(Name) (Title)
at _____
(Name of Employer)

do hereby attest that:

For groups with 2 or more employees, including businesses with only one employee who is eligible for health insurance coverage. Please list the individuals eligible for coverage who are not listed on the NYS-45-ATT. 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 to cover retirees.

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.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I certify that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including that the persons proposed for coverage work at least 20 hours per week or are otherwise eligible for coverage.

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.

_____ _____
(Signature) (Date)

Creation date: 06/23/2009
Revised date: 07/08/2013

Excellus

Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Please Check All That Apply:

[ ] I waive my employer's group **health** insurance coverage for myself and my dependents (if any).

[ ] I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

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

[ ] 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.

Employee Signature: _____ Date: _____

Creation Date: 10/30/2009
Revision Date: 08/06/2010