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: September 22, 2015

Group Information Form

Failure to respond may result in your policy being canceled.

Please answer questions using blue or black ink, in capital letters staying within the provided boxes.

SECTION ONE

GENERAL GROUP INFO

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

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

3. Tax Identification Number (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: ☐
 *Note: For more information about ERISA, please visit **http://www.dol.gov/compliance/laws/comp-erisa.htm**

5. Group Number: ☐☐☐☐☐☐☐☐

6. Business physical address: Street Address: ☐
 City: ☐ State: ☐☐ Zip: ☐☐☐☐☐ County: ☐

7. Address of company headquarters (if different than physical address): Street Address: ☐
 City: ☐ State: ☐☐ Zip: ☐☐☐☐☐ County: ☐

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

9. Organization type (check one): 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: ☐

10. List owner(s) / partner(s): ☐

11. Indicate if your company is organized as a: Stand Alone: ☐ Parent: ☐ Subsidiary: ☐ Local Plant / Office / Division: ☐ Other: ☐
 If applicable, provide related company info: Company name: ☐
 City: ☐ State: ☐☐ Zip: ☐☐☐☐☐ County: ☐
 Number of Total Employees at Related Company: ☐☐☐☐ EIN/TIN: ☐☐ – ☐☐☐☐☐☐☐

12. Number of hours per week an employee must work to be eligible for insurance? ☐☐

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

14. Is there a group medical plan in place in addition to the products offered through Excellus BCBS? Yes ☐ No ☐ Plan Type: New York State of Health ☐ Other ☐

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Group Information Form

Failure to respond may result in your policy being canceled.

SECTION TWO

REGULATORY EMPLOYER GROUP INFO

1. Average number of owners and employees at all locations (all FT and PT employees) for prior year: ☐☐☐☐☐
2. Did you employ 20 or more employees who worked at least 20 weeks in the current year or prior year? 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? 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, please provide the number of such employees: ☐☐☐☐☐

SECTION THREE

ELIGIBILITY GROUP INFO

Medical Eligibility	Specific to Excellus BCBS	All Other Locations and/or Plans*
1. Number of eligible active employees and owners**:	☐☐☐☐	☐☐☐☐☐
2. Number of retirees (not on Medicare) eligible for the employer group plan:	☐☐☐☐	☐☐☐☐☐
3. Number of individuals enrolled in COBRA/New York continuation of coverage and/or the young adult option:	☐☐☐☐	☐☐☐☐☐
4. Total number of eligible individuals for group health insurance coverage (Question 1 + Question 2 + Question 3): **Existing Policies** - If the total number of eligible individuals is three or fewer, a copy of your most recent NYS-45 is required.	☐☐☐☐	☐☐☐☐☐
5. Total number enrolled in the health plan:	☐☐☐☐	N/A
6. Participation percentage (Question 5 ÷ Question 4):	☐☐☐☐	☐☐☐☐☐

Medical Full Time Equivalent Calculation	Specific to Excellus BCBS	All Other Locations and/or Plans*
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 full and part-time employees (Question 7 + Question 8):	☐☐☐☐	☐☐☐☐☐
Only complete questions 10-12 if question 9 is more than 100 (See GIF instructions - calculation aid for further assistance)		
10. Total number of part-time hours worked by all part-time employees during the previous calendar year:	☐	☐
11. Total number of full-time equivalents (Question 10 ÷ 1,440):	☐☐☐☐	☐☐☐☐☐
12. Total number of full-time employees and full-time equivalents (Question 7 + Question 11):	☐☐☐☐	☐☐☐☐☐

If your company offers a dental and/or Medicare plan through Excellus BCBS, please complete the appropriate supplemental form(s) including the employer contribution for these products.

*This portion 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.

** The minimum number of hours for groups with 100 or fewer employees is 20 hours and 17.5 hours for groups with over 100 employees.

Group Information Form

Failure to respond may result in your policy being canceled.

Group/Business Name:

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 (copay, HDHP, etc) please note the employee contribution class structures at the company and how the employer group contributes towards those employee's monthly premiums, ie 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 Type			**Contribution Type**		**Employer Contribution by Tier** (Enter percent or dollar amount below)			
Product Name	Subgroup Number	Class Name	$	%	Employee	Employee & Spouse	Employee & Child(ren)	Family

HSA/HRA Employer Contribution

Product Type		**Contribution Type**				**Employer Contribution by Tier** (Enter percent or dollar amount below)			
Product Type	Product Name	Subgroup Number	Class Name	$	%	Employee	Employee & Spouse	Employee & Child(ren)	Family
HSA ☐ HRA ☐									
HSA ☐ HRA ☐									

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** __ / __ / ____ — **Phone Number** ___ - ___ - ____

Print Name

Email Address

A nonprofit independent licensee of the Blue Cross Blue Shield Association

EX-AGIF-LV Revision Date: 09/18/2015

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Supplemental Form: Dental

Failure to respond may result in your policy being canceled.

Dental Eligibility	Specific to Excellus BCBS	All Other Locations and/or Plans*
1. Does your group offer a Dental Insurance product from Excellus BCBS? Yes ☐ No ☐	N/A	N/A
2. Number of eligible active employees and owners (The minimum number hours for groups with 50 or fewer eligible employees is 20 hours, and 17.5 hours for groups with 51 or more eligible employees.):	☐☐☐☐	☐☐☐☐☐
3. Number of retirees (not on Medicare) eligible for the employer group plan:	☐☐☐☐	☐☐☐☐☐
4. Number of individuals enrolled in COBRA/New York continuation of coverage and/or the young adult option:	☐☐☐☐	☐☐☐☐☐
5. Total number of eligible individuals for group dental insurance coverage (Question 2 + Question 3 + Question 4):	☐☐☐☐	☐☐☐☐☐
6. Total number enrolled in the dental plan:	☐☐☐☐	N/A
7. Participation percentage (Question 6 ÷ Question 5):	☐☐☐☐	☐☐☐☐☐
8. 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:	☐☐☐☐☐

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

Dental Employer Contribution

Product Type			**Contribution Type**		**Employer Contribution by Tier**			
Product Name	Subgroup Number	Class Name	$	%	Employee	Employee & Spouse	Employee & Child(ren)	Family
☐☐☐☐☐☐☐☐☐☐☐	☐☐☐☐	☐☐☐☐☐☐☐	☐	☐	☐☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	☐☐☐☐	☐☐☐☐☐☐☐	☐	☐	☐☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐☐

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**

☐☐☐ – ☐☐☐ – ☐☐☐☐ **Phone Number**

Print Name

Email Address

EX-AGIF-LV Revision Date: 09/18/2015

If your company offers a dental and/or Medicare plan through Excellus BCBS, please complete the appropriate supplemental form(s) including the employer contribution for these products.

*This portion 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.

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: _____________________________________

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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