



Small Employer Reform Application

(Employers with 2-50 employees)

A Employer information - Please print all information in black or blue ink.

1. Company Name					2. Contact Person (Group Leader)	
3. Address	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>County</i>	
4. Billing Address (if different than above)		<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	
5. Telephone Number ()	6. Fax Number ()	7. Company Web Site		8. Company Email Address		
9. Type of Ownership <input type="checkbox"/> Government/School <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation		10. Nature of Business		11. Years in Business		
12. Federal Tax ID # _____			Are all employees paid wages under this Federal Tax ID #? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No, explain: _____						
13 a. Current Group Carrier (Include current bill copy. State "none" if no current group coverage.) _____						
b. If you have current group coverage, what is the current coverage waiting period for new employees? _____						

B Participation/eligibility information

Yes No 1. a. Is the headquarters of your business located in Minnesota? If **No**, provide address of headquarters: _____

Yes No b. Are you a member of a controlled group? If **Yes**, please provide the company name, address and number of employees, owners and partners, for all members of the controlled group: _____

Yes No c. Did you employ an average of 2-50 persons, including owners and partners, who worked at least 20 hours per week during the preceding calendar year?

d. Current number of employees, including owners and partners, working 20 or more hours per week.

e. Number of all health plan and non-health plan, full and part-time employees for reporting Federal Medicare Secondary Payer data. **INCLUDE** all employees working 20 or more consecutive weeks of the current or previous year. **EXCLUDE** Early Retirees, Retirees and COBRA.
Select one: 1-19 total employees 20-99 total employees 100 or more total employees

f. How many employees work outside the state of Minnesota?

Yes No g. Do you have any leased, temporary, seasonal, or independent contract employees who are applying for this group coverage? If **Yes**, provide names: _____

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2. a. Who is eligible for coverage? (example: all full-time employees, management, nonunion...)

_____ b. How many hours per week does an employee have to work to be considered eligible for coverage?

c. Coverage waiting period (select one): NONE 30 days 60 days 90 days

Benefits will begin on (select one): Date of hire (only available with NONE)

First day after completion of waiting period

(Not available with NONE)

First day of the month after completion of waiting period

_____ 3. a. What is the total number of employees eligible for coverage based on your requirements?

_____ b. How many eligible employees are applying?

_____ c. How many eligible employees are waiving due to other group coverage, MCHA, Medicare, Medical Assistance or General Assistance Medical Care?

_____ d. How many employees will be in their coverage waiting period on the group's requested effective date? (Submit applications for all employees in a waiting period. Their coverage will be effective upon completion of their waiting period.)

Yes No 4. Is your business currently providing group coverage for any eligible employees or dependents due to a leave of absence, disability, or continuation/COBRA extension? If Yes, provide names: _____

5. Employer Contribution (the employer must contribute at least 50% of the employee's premium)

	Health	Life/AD&D	Dental	Disability
Employee:	_____ %	_____ %	_____ %	_____ %
Dependent:	_____ %	_____ %	_____ %	

Yes No 6. Do you want to provide domestic partner coverage? If Yes: same gender same and opposite gender

_____/_____/_____ 7. Requested effective date. Please allow one (1) month for processing. No existing coverage should be cancelled until written notice of approval of this application is received by the employer.

C Benefit selection

I. Blue Cross and Blue Shield of Minnesota (Blue Cross) and Blue Plus Coverage

Is the group applying for a dual choice health benefit plan? YES NO

- If Yes, only select one base plan. We will include rates in the offer for the available matching plans.
- If No, you can request to receive rates in the offer for six (6) health plans.

A. Aware Gold®

B. Aware Gold with Copay

C. Blue Value \$1,500 \$2,500

D. Comprehensive Major Medical with Copay

E. Comprehensive Major Medical with Deductible \$300 \$500 \$750 \$1,000 \$2,000

F. Preferred Gold Limited with Copay 80/20

G. Preferred Gold Limited with Deductible \$500 \$1,000 \$2,000

H. Freedom 1-2-3 Accord Network \$750 \$1,500 Value Network \$750 \$1,500

Minnesota law allows the Freedom 1-2-3 plan to exclude the following benefits that are otherwise required to be covered by Minnesota Law: services from a doctor of chiropractic; dietary treatment of phenylketonuria (PKU); hair prosthesis (wigs); services for behavioral health mental health and chemical dependency/substance abuse; antipsychotic drugs and drugs used to treat behavioral health mental health and chemical dependency/substance abuse; treatment for temporomandibular joint (TMJ) disorder and craniomandibular disorder; bariatric surgery; and infertility/assisted reproduction treatment. In addition, Freedom 1-2-3 plan has modified the following benefit: anesthesia and hospital charges for dental care are covered for a child under age five (5) only.

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- I. Options Blue 100 HSA Single/Family Deductible \$1,600/\$3,200 \$2,100/\$4,200 \$3,000/\$6,000
 \$5,800/\$11,600
- J. Options Blue 100 HSA Embedded Deductible \$3,000/\$6,000 \$5,800/\$11,600
- K. Options Blue 80 HSA Single/Family Deductible \$1,600/\$3,200 \$2,100/\$4,200 \$3,000/\$6,000
- L. Options Blue 80 HSA Embedded Deductible \$3,000/\$6,000
- M. Options Blue 80 HRA \$1,500 \$2,500
- N. Options Blue 100 HRA \$3,000 \$5,000

If you select a health plan that is compatible with a Health Savings Account (HSA) or Health Reimbursement Account (HRA) and decide to set up a HSA or HRA with SelectAccount, you must complete additional HSA or HRA account forms.

Small Employer Mandated Health Plans

- O. Copay Plan Blue Cross Blue Plus P. Deductible Plan Blue Cross Blue Plus

II. Delta Dental Coverage (select only one dental plan)

Dental products are offered independently by Delta Dental and are not Blue Cross products. Delta Dental is solely responsible.

- A. Preventive Dental for small groups (group size 2-50/Medical Lock)
- B. Advantage Dental for small groups (group size 2-4/Medical Lock)**
- C. Delta Dental Premier - Preventive (group size 5-50)
Participation Level: Medical Lock 100/100 100/75 80/80
- D. Comprehensive Standard (group size 5-50/\$1,000 benefit)**
 Option I (\$25 Deductible) Option II (\$50 Deductible)
Participation Level: Medical Lock 100/100 100/75 80/80
 Orthodontic Benefit (only available with 10 or more enrolled employees)

**In order to be considered for 'prior dental coverage' rates you must provide the following information:

Current Dental Carrier: _____ Current Deductible: \$ _____ single \$ _____ family

III. USABLE Life Coverage

Life, AD&D, and disability products are offered independently by USABLE Life and are not Blue Cross products. USABLE Life is solely responsible.

- A. \$ _____ Flat Amount Life and AD&D Coverage (Minimum \$10,000 - Maximum \$100,000)
- B. Salary-based Life and AD&D Coverage (Minimum \$10,000 - Maximum \$100,000. All salaries are rounded to the next highest \$1,000, not to exceed \$100,000.)
 Group size 2-9 **Benefit:** 1x salary only option
 Group size 10-50 **Benefit:** 1x salary 2x salary
\$ _____ Maximum can be selected by the employer in \$5,000 increments, not to exceed \$100,000.
- C. Dependent Life Coverage
 Standard benefit
 Optional benefit (When dependent group term life insurance amounts exceed \$2,000, income is imputed to the employee and subject to Internal Revenue Code reporting.)
- D. Short-Term Disability Coverage (Groups with 2-9 eligible employees must select life coverage to be eligible for disability coverage. Minimum \$50 - Maximum \$500 for groups with 2-9 eligible employees. Minimum \$50 - Maximum \$750 for groups with 10-50 eligible employees. Benefits cannot exceed 66⅔% of base salary for Flat Amount coverage.)
 \$ _____ Flat Amount 60% of Earnings **Benefit Period:** 13 weeks 26 weeks

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D Employer representation (please read carefully)

The undersigned employer applies for coverage to Blue Cross and Blue Shield of Minnesota, Blue Plus, USABLE Life and/or Delta Dental hereinafter referred to as The Company.

The employer understands and agrees that: (1) no coverage will become effective until the date specified by The Company after this application has been approved by The Company at its home office; (2) the information provided in this application is complete and true and is the basis for the coverage to be issued, and that material misrepresentations of facts could result in termination of coverage. The Company cannot use the misrepresentation to cancel coverage that has been in effect for two (2) years or more. This time limit does not apply to fraudulent misrepresentations; (3) applications for each eligible employee and dependent must receive prior approval by The Company before coverage becomes effective; and (4) no coverage will be effective until the first monthly charges have been paid in full.

For purposes of this application, the employer understands and agrees that "employee" is defined to include only those individuals who are subject to FICA and other tax withholding, and perform services for compensation by the employer at least 20 hours per week. "Employee" does not include independent contractors, consultants, or shareholders that do not otherwise meet these criteria.

The employer agrees to allow The Company to review any of the employer's records that The Company deems necessary to approve this application. It is also agreed that no agent can approve this application, set an effective date, or waive or alter any provision of this application or any contracts issued. It is agreed that the employer will remit monthly charges for all covered employees and that failure to remit the required charges by the due date will result in termination of coverage.

We have the right to adjust charges: on a monthly due date for changes in the status of the group, including changes to waiting periods, eligibility, census, or health status; on a monthly due date for fraud or misrepresentation by the contractholder, employees, or dependents; on an annual renewal date for changes in the index rate; or on any date the provisions of the contract are changed. Written notice will be mailed to the contractholder's last address on our records at least 31 days prior to the date the adjustment becomes effective.

Please note if selecting a Freedom 1-2-3 plan: I understand that Freedom 1-2-3 excludes certain benefits that are otherwise required to be covered and I will distribute a Blue Cross-provided list of excluded or modified services to my employees prior to the effective date of coverage.

Employer Signature _____ Signature Date _____
 (Authorized Signature)

Authorized Signature Name (Please Print) _____

E Agent information - Be sure to provide your current fax number to receive offer.

Agent Name		Agency Code	Agent Number
		RI	
Telephone Number	Fax Number	Email Address	
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