BlueCross BlueShield
BluePlus
of Minnesota

Independent licensees of the Blue Cross and Blue Shield Association

An independent licensee of the Blue Cross and Blue Shield Association

Delta Dental Plan of Minnesota

Small Employer Reform Application (2-50)

A. EMPLOYER INFORMATION – Please print all information in black or blue ink.

1. Company Name
2. Contact Person (Group Leader)

3. Address *Street* *City* *State* *Zip Code* *County*

4. Billing Address (if different than above) *Street* *City* *State* *Zip Code*

5. Telephone Number ( )
6. Fax Number ( )
7. Company Web Site
8. Company Email Address

9. Type of Ownership
☐ Proprietorship ☐ Partnership ☐ Corporation
10. Nature of Business
11. Years in Business

12. Federal Tax ID # Are all employees paid wages under this Federal Tax ID #? ☐ Yes ☐ No If **No**, explain

13a. Current Group Carrier (Include current bill copy. State "none" if no current group coverage.) ____________

13b. 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. How many employees work outside the State of Minnesota?

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

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

____________ b. How many hours a 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. Medical 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 health plans.

☐ **A. Aware Gold®**
☐ **B. Aware Gold with Copay**
☐ **C. Comprehensive Major Medical with Copay** ☐ $20 copay ☐ $25 copay
☐ **D. Comprehensive Major Medical with Deductible** ☐ $300 ☐ $500 ☐ $1,000 ☐ $2,000
☐ **E. Preferred Gold℠**
☐ **F. Preferred Gold Limited with Copay 90/10**
☐ **G. Preferred Gold Limited with Copay 80/20**
☐ **H. Preferred Gold Limited with Deductible** ☐ $300 ☐ $500 ☐ $1,000 ☐ $2,000

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 MII Life Inc., you must complete additional HSA or HRA account forms.

☐ **I. HDHP 100 compatible with HSAs** Deductible: ☐ Low ☐ Middle ☐ High (Family) ☐ High (Embedded)
☐ **J. HDHP 80 compatible with HSAs** Deductible: ☐ Low ☐ Middle ☐ High (Family) ☐ High (Embedded)
☐ **K. HDHP compatible with HRAs** ☐ $1,000 ☐ $1,500 ☐ $2,500

Small Employer Mandated Health Plans:

☐ **L. Copay Plan** ☐ BCBSM ☐ Blue Plus ☐ **M. Deductible Plan** ☐ BCBSM ☐ Blue Plus

II. Dental Coverage (select only one dental plan)

☐ **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 Preventive** (group size 5-50)
Participation Level: ☐ Medical Lock ☐ 100/100 ☐ 100/75 ☐ 80/80
☐ **D. Comprehensive Standard** (group size 5-50/$1000 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. Life, Accidental Death and Dismemberment (AD&D) and Disability Coverage

☐ **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** (Minimum $50 - Maximum $500. Must select life coverage with these products. Benefits cannot exceed 66⅔% of base salary for Flat Amount coverage.)
☐ $ ______ Flat Amount ☐ 60% of Earnings **Benefit Period:** ☐ 13 weeks ☐ 26 weeks

☐ **E. Disability Connect** (Available as a stand alone product. Contact MII Life to apply for long term benefit periods.)
☐ 50% of monthly covered earnings **Benefit Period:** ☐ 13 weeks ☐ 26 weeks
☐ 60% of monthly covered 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, MII Life, Incorporated 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.

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

Telephone Number	Fax Number	Email Address
( )	( )	