



## Group Application for Balanced Funding\* and Stop Loss Coverage\*\*

Please Type or Print – Must be completed in full.

### APPLICANT INFORMATION

Full Legal Name of Applicant (to appear on Policy)		Authorized Representative		
Federal Tax ID/EIN	Phone Number		Fax Number	
Physical Address (No P.O. Box)	City	State	County	Zip Code + 4
Mailing Address (if different than above)	City	State	Zip Code + 4	
Contract Signor Name	Title		Email	
Nature of Business	SIC Code		Years in Business	
1. Plan Sponsorship: <input type="checkbox"/> Private Entity (ERISA) <input type="checkbox"/> Government Entity <input type="checkbox"/> Church Entity <input type="checkbox"/> Public Schools				
2. Ownership Type (List business owners/partners on line below): <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> C- Corporation: <input type="checkbox"/> S - Corporation: <input type="checkbox"/> Other: State of Inc. _____ State of Inc. _____ (e.g., Non-Profit) _____				

### REQUESTED PRODUCT INFORMATION

<b>Balanced Funding Products offered by Highmark Blue Shield</b> Effective Date: _____ Medical Product(s): Product Name _____ Product Name _____ Do you currently have a group/individual medical plan? <input type="checkbox"/> Yes (Current Carrier Name) _____ <input type="checkbox"/> No Are you currently self-insured? <input type="checkbox"/> If, Yes (Current TPA Name(s) ) _____ <input type="checkbox"/> No	<b>Fully Insured Ancillary Products offered by Highmark Blue Cross Blue Shield</b> Vision: Quote ID _____ Product Name _____ Dental: Plan ID _____ Product Name _____ <input type="checkbox"/> Tier 2 or <input type="checkbox"/> Tier 4 Rates <input type="checkbox"/> \$1000 or <input type="checkbox"/> \$1500 max
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### GROUP ELIGIBILITY AND ENROLLMENT INFORMATION

1. This plan will cover eligible employees and their eligible dependents unless otherwise stated in the comments section on Page 3.

2. Do you wish to make coverage available to domestic partners or Act 4 dependents? Check any/all that apply.  
☐ Domestic partners  
☐ Act 4 Dependents  
\*Additional documentation is required for domestic partner and Act 4 dependent verification.

3. Number of hours employees must work per week to be eligible for coverage: \_\_\_\_\_

4. Probationary period for new employees: ☐ Hire Date ☐ First Day Following \_\_\_\_\_ Days (**Cannot** exceed 90 calendar days)  
- **OR** - First Day of Next Month Following (Check one): ☐ Hire Date ☐ 30 Days ☐ 60 Days (If hourly and/or probationary period requirements vary by employee class, please explain in Comments section).

5. Do you wish to waive the probationary period for all eligible employees on the group's initial effective date only? ☐ Yes ☐ No

\* Balanced Funding products are offered by Highmark Blue Shield, an independent licensee of the Blue Cross Blue Shield Association.

\*\* Stop loss coverage is offered by HM Life Insurance Company. HM Life Insurance Company is a separate company that does not provide Blue Cross and/or Blue Shield products or services. HM Life Insurance Company is solely responsible for the Stop-Loss insurance coverage.  
This is an application for both Highmark Administrative Services and HM Life Insurance Company Stop Loss Insurance Coverage.

## FEDERAL AND STATE MANDATE REQUIREMENTS

### Group Size Determination

1. Is the Applicant affiliated with other entities that have a separate Federal Tax I.D./ E.I.N. and are to be treated as a “single employer” under the Internal Revenue Code Section 414 aggregation rules (If you are unsure how to answer this question, please seek assistance from your tax accountant or legal counsel).

☐ Yes - If affiliated entities are to be included in this application and are enrolling in coverage, attach a Certification of Eligibility to Combine and Employer Group Size Form completed by an authorized representative of the company. The form must include all affiliated entity names and Employer Identification Numbers (EIN).

☐ No

For purposes of this determination, please count all employees for each month in the preceding calendar year. This includes full-time, part-time, seasonal/intermittent, and in/out-of-area employees – who were issued a W-2; regardless of whether they were eligible to enroll, and/or participated in the group health plan. Exclude owners and working family members (who do not qualify as common law employees), 1099 independent contractors and retirees.

**IMPORTANT: If you answered Yes to question 1 please count all employees collectively for all related entities that are to be treated as a “single employer” under the Internal Revenue Code Section 414 aggregation rules. These aggregation rules apply to all questions in this section.**

### Medicare Secondary Payer Employee Count

For Medicare and Secondary Payer (MSP) purposes, count all employees. This includes full-time, part-time, seasonal/intermittent, in/out-of-area employees, all leased employees and employees that are not working but receiving disability payments (which for non-government employers are subject to FICA). **Note:** If you answered Yes to question 1 under Group Size Determination section above, please refer to the instructions in the IMPORTANT note above in the Group Size Determination section.

1. In the **PRECEDING** calendar year, did you have at least:

a. **20 or more employees** for each working day of 20 or more calendar weeks? ☐ Yes ☐ No ☐ Applicant did not exist

b. **100 or more employees** during 50% or more of your regular business days? ☐ Yes ☐ No ☐ Applicant did not exist

2. As of today's date in the **CURRENT** calendar year, did you have at least:

a. **20 or more employees** for each working day of 20 or more calendar weeks? ☐ Yes ☐ No ☐ Unknown, enough time has not expired

b. **100 or more employees** during 50% or more of your regular business days? ☐ Yes ☐ No ☐ Unknown, enough time has not expired

### Cobra/Mini-Cobra Information

1. How many full-time equivalent employees did/do you employ?

Preceding Calendar Year \_\_\_\_\_

Current Calendar Year \_\_\_\_\_

2. Within the preceding calendar year, did you have 20 or more full-time equivalent employees on at least 50% of your typical business days?

☐ Yes ☐ No ☐ Applicant did not exist

PRODUCER INFORMATION (Agent/Broker)		
General Agency Name	Agent Name - Must be appointed with Highmark and HM Life	
Tax ID Number	Business Telephone Number	Email
Should single sign-on, on-line access to this client be added to your existing login? <input type="checkbox"/> Yes <input type="checkbox"/> No		License Number(s) – <i>Please attach a copy, if not on file.</i>
Highmark Sales Representative:		HM Life Sales Representative:

Highmark Blue Shield ONLINE CONTRACT AVAILABILITY
<p><b>Applicant agrees that its request for logon credentials to the <a href="https://highmarkblueshield.com">Highmarkblueshield.com</a> secure portal constitutes Applicant's acceptance of the parties' Master Health Services Agreement and any amendment thereto (collectively, the "Health Plan Contract") in electronic format only.</b></p> <p>Such request must be sent directly to <a href="mailto:CCBS_OnlineContracts@HIGHMARK.COM">CCBS_OnlineContracts@HIGHMARK.COM</a>; which shall provide confirmation of Applicant's election along with the logon credentials in a return email. Applicant understands and agrees that, as a part of this process, emails from CCBS will be the only notification Applicant will receive regarding contract updates.</p> <p>Applicant further acknowledges and agrees that payment of fees in connection with the Health Plan Contract and any later amendment thereto in will be deemed its acceptance of all terms and conditions of the Health Plan Contract and/or later amendment. Applicant further acknowledges that it is responsible to immediately report any changes to its contact email address to its Highmark Broker or Sales Representative. Note: Applicant may revoke this election and receive paper copies of documents at any time, without charge. To update how Applicant receives its Health Plan Contract information from Highmark at any time, please contact the appropriate Highmark Broker or representative.</p> <p>OPT-OUT SELECTION: <input type="checkbox"/> Applicant does not agree to receive the Health Plan Contract in electronic format.</p>

SUMMARY OF BENEFITS AND COVERAGE FOR BALANCED FUNDING MEDICAL PLANS FROM HIGHMARK BLUE SHIELD
<p>To help you make an informed choice, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about any health coverage option in a standard format. You can view an SBC for each available product at <a href="http://www.highmark.com/Sales/#!/sbcs">www.highmark.com/Sales/#!/sbcs</a></p>

COMMENTS

FRAUD STATEMENT
<p><b>Any person who knowingly and with intent to defraud any insurance company or other person by filing 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 subjects such person to criminal and civil penalties.</b></p>

### APPLICANT UNDERSTANDS AND AGREES THAT FOR HIGHMARK ADMINISTRATIVE SERVICES:

I, the undersigned, hereby represent that I have the authority to bind the Applicant and to make this application for administrative services. I further represent that the agency (or agencies) listed above is our appointed Producer of Record (POR) for all Highmark products and they will receive any and all commissions included in the rates.

**I further acknowledge and agree that subject to the terms of the applicable General Producer Agreement in place with POR, Highmark may disclose enrollment, disenrollment, summary health and/or billing information requested by the POR for purposes of inputting, updating and/or reviewing the same for the above - identified business.**

I also understand that the POR may be eligible to receive additional compensation for achieving specified sales goals. The POR named above will remain the POR until I notify Highmark of a change, or until my Highmark administrative services terminates.

In addition, I understand that all Highmark underwriting and participation guidelines must be satisfied in order for the Applicant to be eligible for the requested administrative services and that payment requirements are not binding until approved by Highmark. I further understand that any need for additional information may impact the effective date of coverage, the quoted required payments, or the ability to offer the requested administrative services.

It is also acknowledged that the Applicant has the right to review and examine the administrative services only contract issued by Highmark which provide for the administration of group coverage requested and that payment of the required monthly amount due following the contract(s) issuance shall be deemed acceptance of all terms and conditions of the insurance contract(s) unless Applicant notifies Highmark of any changes, mistakes, or discrepancies within the thirty (30) day period that follows.

Furthermore, Applicant acknowledges that all applicable underwriting and participation guidelines must continue to be met throughout the term of the insurance contract(s) involved and that Highmark reserves the right to request information necessary to reconfirm compliance with these guidelines at any time.

### APPLICANT UNDERSTANDS AND AGREES THAT FOR HM LIFE INSURANCE COMPANY STOP LOSS COVERAGE:

The stop loss insurance requested and requested effective date must be approved by HM Life Insurance Company as under our current rules and practices. All options and special requests are subject to Home Office approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Our approval is subject to receipt of Disclosure, if required, the first month's premium, final census, Claim Information, and any other information requested in connection with this application. Failure to do so will result in approval being denied or delayed until a later date.

Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that HM Life Insurance Company, or our authorized agent, disapproves this Application, its sole obligation shall be to refund such sum to the Applicant. Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until so notified.

Final premium rates will be determined on the basis of Disclosure, if required, Claim Information and the actual composition of persons covered by the underlying employee benefit plan on the requested effective date. Should subsequent information become known which, if known as of the date specified by HM Life Insurance Company, or our authorized agent, would have affected the rates, deductibles, terms or conditions for coverage, we will have the right to revise the rates, deductibles, terms or conditions, by providing written notice to the Applicant. The Policy, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

A signed and dated summary plan document describing the underlying employee medical plan must be submitted within 60 days of the Requested Effective Date. If the description of the benefits or plan provisions differs from what was initially utilized to underwrite the risk, the premium rates and aggregate retention factors may be subject to re-rating, retro-active to the requested effective date.

The stop loss insurance which is the subject of this Application is a reimbursement contract, and the Applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this Application.

Issuance of the Policy is in reliance of the data, including Disclosure, census and Claim Information, submitted to us, and payment of the first month's premium; subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for HM Life Insurance Company's approval of the requested stop loss insurance.

*By typing your name on the signature line, you understand you are creating an electronic signature that carries the same legal obligations as a written signature and you will be bound by the terms and conditions set forth in this document.*

Printed Name of Applicant's Authorized Representative or Contract Signor

Authorized Representative/Contract Signor Title

Signature of Applicant's Authorized Representative or Contract Signor

Date

Signature of Licensed Producer

Printed Name of Producer

Date

## Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。  
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.