Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Healthy New York New Group Application

HNY, Commercial Health, Dental, and Vision Products

See Instructions for details regarding completion of this form.

Section 1: Group Information- Required for All Submissions

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

2. Legal Entity Name: _____

3. Tax Identification Number (EIN/TIN): _____ 4. SIC Code: _____

5. Most group health plans are governed by ERISA with the exception of some religious organizations and government entities.
   If your group is NOT governed by ERISA, please check this box: ☐ ERISA Plan Year, if applicable: _ _ / _ _ / _ _ _ _

6. Requested Effective Date: _ _ / _ _ / 20_ _

7. Company Officer's Name: _____ Title: _____ Telephone: (____) ____ - _____

8. Group's Health Plan Sponsor (Check one): ☐ Employer ☐ Union ☐ Trustees of Fund ☐ Association ☐ Other: _____

9. Organization Type (Check one): ☐ Sole Owner ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust
   ☐ Local Government ☐ State Government ☐ Public Entity ☐ Nonprofit ☐ Church Group ☐ Other: _____

10. List of Owners/Partners/Shareholders and Percentage of Ownership:

    1. Name: _____ % Owned _____ 4. Name: _____ % Owned _____

    2. Name: _____ % Owned _____ 5. Name: _____ % Owned _____

    3. Name: _____ % Owned _____ 6. Name: _____ % Owned _____

11. Do you have any commonly owned businesses or affiliates that qualify as a single employer under subsection (b), (c), (m), or (o) if the Internal Revenue Code Section 414? ☐ Yes ☐ No If yes, please complete below.

    1. Legal Entity Name: _____ Number of Employees: _____ EIN/TIN: _____ State: _____

    2. Legal Entity Name: _____ Number of Employees: _____ EIN/TIN: _____ State: _____

12. Indicate company organization:
    ☐ Standalone ☐ Parent ☐ Subsidiary ☐ Local ☐ Plant/Office/Division ☐ Other: _____

13. Does your group have employees living outside the Excellus BCBS service area who are enrolling in coverage? ☐ Yes ☐ No
    If yes, requires prior review by Underwriting. Please list worksite/physical locations below:

    1. Physical Location/Worksite Name: _____ Address: _____ # Enrolling: _____

    2. Physical Location/Worksite Name: _____ Address: _____ # Enrolling: _____

14. Does your group offer any other health plans in addition to the products offered through Excellus BCBS? ☐ Yes ☐ No

    A. If yes, what carrier issues these health policies? _____
    B. Are any issued through the New York State of Health? ☐ Yes ☐ No
    C. Number Enrolled in other plan(s): _____

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Section 2a: Addresses and Contacts- Required for All Submissions

1. Group Contact: Name: _____ Title: _____ Telephone: (___) ____ - _____

Email: _____

Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (____) ____ - _____ Fax: (___) _____ - _____

2. Business Physical Address: Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (____) ____ - _____ Fax: (___) _____ - _____

3. Headquarters Address: (if same as physical address, check here ☐ Other, please provide below

Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (____) ____ - _____ Fax: (___) _____ - _____

4. Mailing Address: (Same as: ☐ Physical ☐ Headquarters Otherwise, complete the information below

Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (____) ____ - _____ Fax: (___) _____ - _____

5. Billing Address and Contact: _____ Title: _____

Email: _____

Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (____) ____ - _____ Fax: (___) _____ - _____

Section 2 b: COBRA Administration

Your medical plan includes continuation of coverage through COBRA administrative services provided by Lifetime Benefit Solutions. If you wish to opt out of embedded COBRA administration, please complete the information below. If you would like to add COBRA eligible plans, please contactLifetime Benefit Solutions at lifetimebenefitsolutions@lifetimebenefitsolutions.com.

COBRA Administrator Name: _____

Address 1: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (____) ____ - _____ Fax: (___) _____ - _____

Address 2: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (____) ____ - _____ Fax: (___) _____ - _____

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Section 3: Healthy New York Regulatory Information / Eligibility Requirements

A. How many total FTE employees did your business employ over the prior calendar year? 50 or fewer total FTE employees? Yes ☐ No ☐
B. Within the last 12 months, has your business provided health insurance that included both medical and hospital benefits (other than Healthy NY) to the class of employees that you are looking to cover? Yes ☐ No ☐
C. If the answer to previous question is Yes, did your business contribute more than $50 per employee per month toward the premium (or $75 if the business is located in Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, or Westchester counties)? Yes ☐ No ☐
D. Do at least 30% of the employees who will be offered coverage earn a total annual wage of $56,720 or less? Yes ☐ No ☐
E. Will your business contribute at least 50% of the Healthy NY premium on behalf of covered employees? Yes ☐ No ☐
F. Will your business offer Healthy NY coverage to all employees working 20 hours or more per week who earn annual wages of $56,720 or less? Yes ☐ No ☐
G. Will at least 50% of the class of employees who are offered Healthy NY coverage through your business actually enroll or have health insurance through another source? Yes ☐ No ☐
H. Will at least one employee be earning a total annual wage of $56,720 or less enroll in Healthy NY? Yes ☐ No ☐
I. Will your business be offering Healthy NY coverage to the dependents (Spouses, Domestic Partners, Children) of your employees? Employers are not required to contribute towards the Healthy NY premium for dependents. Yes ☐ No ☐

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Section 4: Individuals not listed on the NYS-45 ATT or other state equivalent - Required for all Submissions

Please list persons eligible for coverage who are not on the NYS-45-ATT/ other state equivalent. Eligible individuals include: partners or owners actively engaged in the business; COBRA/NYS continuants; new employees; and retirees if the group has a retiree policy in place. The group attests the individual(s) listed below work at least 20 hours/week at the above-named employer or are otherwise eligible for coverage under group health insurance issued by Excellus BCBS. Include an indicator by each name, per the instructions.

Name	Indicator	DOH or DOR	Name	Indicator	DOH or DOR

Section 5: Group Size Regulatory Information- Required for All Submissions

1. Total number of full-time employees and full-time equivalents at all locations, including subsidiaries and businesses under common control within the United States, in the prior calendar year: _____
2. Average number of employees and owners (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: _____

Section 6: Dental Information- Required for Dental Submissions

1. **Eligible Dental Employees**

Pooled experience groups have 50 or fewer eligible employees. Experience rated groups have 51 or more eligible employees. Contributory groups contribute 25% or more of the single rate. Non-contributory groups contribute less than 25% of the single rate. Either type of group must enroll a minimum of 2 contracts.

Employees Eligible for Excellus BCBS Offering

Total number of eligible employees (including active employees and owners, Retirees, and individuals enrolled in COBRA): _____

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Section 7: Employee and Retiree Eligibility- Required for All Submissions

1. Total Individuals Eligible for Group Health Insurance Coverage (see instructions): _____

2a. **Eligibility Policy for New Hires and Rehires** - please indicate the eligibility policy for both the newly hired and rehired employees by completing the table below. Below are codes for the most commonly used classes. *Waiting period for HNY product cannot exceed 45 days. Any custom waiting period must be approved by Underwriting prior to use.

Employee Class Options - If coverage is offered to more than one class, please choose from the pairings below:				
A001 - All Active Employees	A002 - Hourly A003 - Salaried	A004 - Management A005 - Non-Management	A006 - Union A007 - Non-Union	A008 - Full-Time A009 - Part-Time

ProductType	Employee Class	Number of Hours	New (N), Rehire (R), or Both (B)	Probationary Period
HNY		20 *Minimum hours per week that an employee must work to be eligible		☐ Date of hire/rehire ☐ First of month following date of hire/rehire ☐ 30 days following date of hire ☐ 45 days following date of hire ☐ Other*: _____
HNY		20 *Minimum hours per week that an employee must work to be eligible		☐ Date of hire/rehire ☐ First of month following date of hire/rehire ☐ 30 days following date of hire ☐ 45 days following date of hire ☐ Other*: _____
Commercial Medical ☐ Same as HNY? Skip to Section 6, if no please complete the following:				☐ Date of hire/rehire ☐ First of month following date of hire/rehire ☐ 30 days following date of hire ☐ 60 days following date of hire ☐ 90 days following date of hire ☐ Other*: _____
Dental ☐ Same as HNY? Skip to Section 6, if no please complete the following:				☐ Date of hire/rehire ☐ First of month following date of hire/rehire ☐ 30 days following date of hire ☐ 60 days following date of hire ☐ 90 days following date of hire ☐ Other*: _____
Vision ☐ Same as HNY? Skip to Section 6, if no please complete the following:				☐ Date of hire/rehire ☐ First of month following date of hire/rehire ☐ 30 days following date of hire ☐ 60 days following date of hire ☐ 90 days following date of hire ☐ Other*: _____

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*For Commercial Medical Group Use Only - Retiree Not Applicable to Healthy NY:

Retiree Eligibility:	Does your group provide health insurance to retirees? ☐ Yes ☐ No If yes, please complete the following:	
Codes for common retiree classes:	**R001**	**R002**
	Retired Non-Medicare Eligible	Retired Medicare Eligible

Class Name:	Minimum Age to Retire (e.g. 55):	Years of Service to Qualify for Retiree Health Insurance (e.g. 10):

3a. **Medical Products - Employer Contribution (Monthly Amount)** (see instructions for an example):

A. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

B. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

C. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

D. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

3b. **HSA/HRA** - Employer Contribution **(Annual Amount):**

A. ☐ HSA Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

B. ☐ HRA Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

3c. **Dental Products - Employer Contribution (Monthly Amount):**

A. Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

3d. **Vision Products - Employer Contribution (Monthly Amount):**

A. Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

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Section 8: Broker of Record Information- Required if Group Appoints a Broker

Our company has appointed (name of agent), _____ (name of agency) _____

Whose business address is: _____ _____ _____ _____

Street City State ZIP

As the sole insurance representative for coverage provided to this company by Excellus BCBS effective: _ _ / _ _ / _ _ _ _

I understand that since our company has elected to purchase coverage from Excellus BCBS the above named agent may be entitled to base and/ or bonus compensation for our business.

This designation will remain in effect until we notify Excellus BCBS in writing to the contrary.

Section 9: Employer Attestation- Required for All Submissions

I certify that, to the best of my knowledge and belief and under penalty of perjury, all of the information contained within this application is true and complete.

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 $5,000 and the stated value of the claim for each such violation.

Employer Authorized Representative Signature: _____ Date: _ _ / _ _ / _ _ _ _

Print Name: _____ Email Address: _____

Section 10: Checklist of Required Information- All Submissions

- ☐ Healthy New York new group application
- ☐ Proof of payroll:
  - NYS-45, or other state equivalent. Notate employees as eligible, enrolling, waiving or not eligible. Notations should be based on the employer's eligible class(es).
  - Payroll – When NYS-45 is not available, an applicant does not appear on the NYS-45 or an applicant's wages do not support the minimum number of hours to be eligible
- ☐ Most recent business tax documentation when:
  - Related entities or parent/subsidiary companies exist
  - Owners/shareholders own multiple entities
  - There are multiple business locations, company is fully remote and/or HQ or physical location is unclear
  - Start-up business, operating less than one year and has not filed taxes
- ☐ 1094-c when:
  - Group is part of an applicable large employer
  - Group has 85 or more full-time equivalent employees
- ☐ Subscriber Application Forms
- ☐ Rate Sheet(s) and Benefit Summary
- ☐ If applicable:
  - Disabled Dependent Application
  - SHOP eligibility letter from NYS

Excellus BlueCross BlueShield will submit reports with respect to the benefit plan, in the time and manner required under Section 204 of the Transparency Provisions of the CAA and/or related regulations and/or other authoritative guidance issued under the CAA, on behalf of the group relating to pharmacy benefits and drug costs.