Excellus

# 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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## 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):<br>**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.**

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*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.

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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<br>A003 - Salaried | A004 - Management<br>A005 - Non-Management | A006 - Union<br>A007 - Non-Union | A008 - Full-Time<br>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**



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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<br>A003 - Salaried | A004 - Management<br>A005 - Non-Management | A006 - Union<br>A007 - Non-Union | A008 - Full-Time<br>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** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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