



Group Master Application – For Group Size 1-100

Please submit a complete and accurate application to our office **by the 15th of the month prior to the requested effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate sheet of paper.

Requested Effective Date _____

Group Number

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SECTION A – GROUP NAME & ADDRESS

Group's Legal Name:

Doing Business As (DBA):

Name to be used by Regence: Legal DBA

City of Business Headquarters

State of Business Headquarters

Federal Tax ID Number (EIN)

Address (include attention line if applicable)

Physical Address (required – no PO Box)

City

County

State

ZIP

Mailing Address (if different from physical)

City

County

State

ZIP

SECTION B – CONTACT INFORMATION

1. Executive Contact (President, Owner, etc.)

Name

Phone (area code required)
Ext.

Fax (area code required)

Title

Email

2. Group Administrator

Name

Phone (area code required)
Ext.

Fax (area code required)

Title

Email

SECTION C – BILLING INFORMATION

1. Billing Information

Billing Address (if different from mailing)

Contact Name (if different from group administrator)

Title:

Phone (area code required):

Ext.

City:

State:

ZIP:

Email:

Payment Method (for ACH Pull or Debit/Credit, you will be contacted once your group setup is complete):

ACH Pull ACH Push Check Debit/Credit (available to group size 1-50 only)



SECTION C – BILLING INFORMATION (continued)

2. Additional Billing Information – Complete only if there is more than one billing address. If you have more than two billing locations, submit that billing information on another page.

Billing/Business Name:			
Billing Address		Contact Name:	
		Title:	
		Phone (area code required):	Ext.
City:	State:	ZIP:	Email:
Payment Method (for ACH Pull or Debit/Credit, you will be contacted once your group setup is complete): <input type="checkbox"/> ACH Pull <input type="checkbox"/> ACH Push <input type="checkbox"/> Check <input type="checkbox"/> Debit/Credit (available to group size 1-50 only)			
3. Third Party Administrator – Complete only if a Third Party Administrator (TPA) is used.			
TPA Name:			
Address		Contact Name:	
		Title:	
		Phone (area code required):	Ext.
City:	State:	ZIP:	Email:
Does the group use this TPA for COBRA administration? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: Will the TPA submit COBRA enrollment/disenrollment directly to Regence? <input type="checkbox"/> No <input type="checkbox"/> Yes Will invoices for COBRA participants go to the TPA address listed? <input type="checkbox"/> No <input type="checkbox"/> Yes			

SECTION D – PRODUCER INFORMATION

1. Primary Producer (if only consulting, select “Consultant only” and do not enter commission values)

Producer’s Name (<input type="checkbox"/> Consultant only)	Producer’s Agency	Producer’s Number
Commission – Groups of 1-50	Commission – Groups of 51-100	
Medical: Standard Dental: Standard	Medical: <input type="checkbox"/> Flat _____% <input type="checkbox"/> None Dental: <input type="checkbox"/> Flat _____% <input type="checkbox"/> None	

2. Secondary Producer (if only consulting, select “Consultant only” and do not enter commission values)

Producer’s Name (<input type="checkbox"/> Consultant only)	Producer’s Agency	Producer’s Number
Commission Split – Medical: Primary Producer: _____% Secondary Producer: _____%		
Commission Split – Dental: Primary Producer: _____% Secondary Producer: _____%		

SECTION E – GROUP INFORMATION

1. General Information

SIC Code	Industry Description	Date Business Started
Type of Business (if LLC/LLP, choose the option that matches how the business files with the IRS): <input type="checkbox"/> S-Corp <input type="checkbox"/> C-Corp <input type="checkbox"/> Trust <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Nonprofit/Religious Org <input type="checkbox"/> Public/Govt Entity <input type="checkbox"/> Other: _____		
Does the group have any affiliated businesses? <input type="checkbox"/> No <input type="checkbox"/> Yes – Enter name(s) of affiliated businesses:		
Name of Workers’ Compensation Carrier (if none, please explain)		
Current Medical Carrier	Current Dental Carrier	
Will the group offer other coverage to its eligible employees? Medical: <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, then the group is not eligible for group medical coverage with Regence. Dental: <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, then the group is not eligible for group dental coverage with Regence.		



SECTION E – GROUP INFORMATION (continued)

2. Deductible and Out of Pocket Accumulators – To properly credit amounts accumulated from the prior carrier, the group must confirm if amounts accumulated on the basis of a calendar year (January through December) or a plan year (matching your contract renewal period e.g., renewal month is April, accumulation starts April 1 and ends March 31).

Under the prior carrier, deductible and out of pocket amounts accumulated on the basis of a:

- calendar year.
- plan year. Enter dates for the plan year accumulators with prior carrier: _____

3. COBRA – Applies if group employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (excluding church and federal government groups). You may count a part-time employee as a fraction of a full-time employee.

Is the group subject to COBRA? No Yes

4. ERISA – Applies to most groups other than church and government entities.

Is the group subject to ERISA? No Yes

If yes, does ERISA plan year differ from your renewal date? No Yes, when does the plan year begin (MM/DD): _____

5. OBRA – Applies if group employed 100 or more employees (full-time and/or part-time) for at least 50% of the workdays of the preceding calendar year.

Is the group subject to OBRA? No Yes

6. TEFRA/DEFRA – Applies if group employed 20 or more employees (full-time and/or part-time) for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.

Is the group subject to TEFRA/DEFRA? No Yes

If status has changed in the last year, date of change: _____

7. Employee Counts for Affordable Care Act (ACA) Requirements – ACA requires us to record the group's (including all affiliates') average number of employees for the preceding **completed** calendar year. This count includes the following local & worldwide employees: full-time, part-time, seasonal, union workers, as well as business owners, corporate officers, and partners if they are also employees. The count does **not** include contracted 1099 individuals (i.e., independent contractors) or non-employees.

Average number of employees (for ACA) was _____ in the preceding **completed** calendar year 20 _____.

8. Independent Contractor Eligibility – Available only to groups of 1-50.

Will the group offer coverage to independent contractors? No Yes - If yes, include the contractors in questions 9 and 10 and complete the Independent Contractor Attestation Form.

9. Employee Counts – Eligible Employees for Group Size Determination – An “eligible employee” is defined as an employee who worked on a full-time basis and had a normal work week of 30 or more hours in the preceding calendar year. If the employer did not exist for the entirety of the preceding calendar year, estimate the average number of eligible employees in the current calendar year. Account for the number of eligible employees in the group and any affiliated businesses. Groups of 1-50: If the group is offering coverage to independent contractors, include all contractors in the number below.

Provide the average number of eligible employees in the preceding calendar year: _____

10. Employee Counts – Non-residents – Count of eligible employees outside the state. Groups of 1-50: If the group is offering coverage to independent contractors, include all contractors in the counts below. Employees residing in the state of Hawaii are not eligible.

State				
Number of Employees				

SECTION F – ADMINISTRATION

1. Eligibility – Changes may only be made at renewal. The plan covers employees working a minimum of 30 hours in a normal work week.

Who will be covered by this plan?

	Employee and dependents*	Employee and children only (no spouse/domestic partner)	Employee only (no dependents)
Medical/Pharmacy/Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	N/A	<input type="checkbox"/> [†]

*If choosing “**Employee and dependents**,” then children and legal spouse are included. Will the group also include domestic partners? No Yes

[†]**Employee Only Dental coverage** is available only if the group is electing **Employee Only Medical coverage**, or if the group is not electing any Regence Medical coverage (i.e., a Dental-only policy).



SECTION F – ADMINISTRATION (continued)

2. Qualification for Group Plan – To qualify for a group health plan at least one eligible employee must be employed. An employee, for this purpose, does not include an independent contractor or a sole proprietor of the sponsoring business. A sole proprietor’s spouse is not an eligible employee for this purpose unless he/she is working full-time for the sponsoring business with a normal work week of 30 or more hours.

Will the group have at least 1 eligible employee employed as of the effective date of coverage? No Yes

3. Probationary Period – A probationary period may not be waived or altered for a particular employee. Before adopting different probationary periods by employee class (hourly, salaried, etc.), consider seeking tax and/or legal advice. Premiums will be prorated for coverage effective dates other than the 1st of the month.

List classes below (if one class, make selection on line 1), then select an option indicating when coverage is effective.

Class (account for all eligible employees)	1 st of the month following:			On the actual:	
	Date of hire*	30 days	60 days	Date of hire	90 th day
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If choosing “1st of the month following the date of hire,” employees hired on the 1st of the month are effective on the:
 date of hire.
 1st of the next month.

Part-time employees transferring to full-time will start their probationary periods on the:
 original hire date (retroactive).
 date the employee transfers to full-time hours.

Will the group waive the probationary period on initial enrollment (new groups only)? No Yes

4. Premium Contribution – Employers must contribute at least 50% of the lowest monthly premium rate for employees. Only groups 51-100 may vary contribution amount by class.

Specify the contribution amount below.

Class	Medical/Vision		Dental	
	Employee	Dependent	Employee	Dependent
Class 1	%	%	%	%
Class 2	%	%	%	%
Class 3	%	%	%	%

5. Minimum Participation Requirements

Groups with 1 to 4 eligible employees: 100% of eligible employees must enroll (after consideration of valid waivers).[†]
 Groups with 5 or more eligible employees: 75% of eligible employees must enroll (after consideration of valid waivers).[†]
[†]If offering coverage to independent contractors (groups of 1-50 only), include them in the calculations below.

At the time of the application the group represents that:

A. Number of employees on payroll plus working owners (excluding COBRA participants ^{**})	_____	(A)
B. Minus individuals not eligible: working fewer than 30 hours	- _____	(B)
C. Minus individuals not eligible: still serving new-hire probationary period	- _____	(C)
D. Minus individuals not eligible: independent contractors (unless group of 1-50 offering coverage to independent contractors)	- _____	(D)
E. Equals the subtotal number of eligible employees	= _____	(E)

Use subtotal (E) to continue calculations for Medical and Dental.

	Medical	Dental
F. Minus employees waiving with other qualifying coverage	- _____ (F)	- _____ (F)
G. Equals number of employees eligible to enroll	= _____ (G)	= _____ (G)
H. Minus employees declining (no other qualifying coverage)	- _____ (H)	- _____ (H)
I. Equals number of employees enrolling	= _____ (I)	= _____ (I)
J. Participation percentage (I divided by G)	_____ % (J)	_____ % (J)

K. Number enrolling on COBRA ^{**}	_____ (K)	_____ (K)
L. Number of former and current employees and/or dependents presently eligible for COBRA ^{**} for whom election and payment is not yet received	_____ (L)	_____ (L)

^{**}Refers to both COBRA and non-COBRA continuation of coverage participants.



SECTION F – ADMINISTRATION (continued)

6. Groups 1-50 – Special Annual Enrollment Period – If required by law (and subject to the law’s required terms), small groups that do not meet minimum contribution and/or participation rules will be offered a special annual enrollment period for a January 1st effective date. Minimum contribution and participation rules must be met for renewing groups.

Groups 51-100 – New groups may enroll without meeting the minimum employer premium contribution or group participation percentages. However, groups may not be renewed if they fail to meet either or both minimum requirements at the time of renewal.

7. Enrollment Method

	Spreadsheet	Regence Online Enrollment*	Paper Enrollment Forms
Initial/Open Enrollment	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Ongoing Enrollment	N/A	<input type="checkbox"/>	<input type="checkbox"/>

*If choosing “**Regence Online Enrollment**,” will the group allow employees to enroll themselves? No Yes

8. Employer Center – Access group information any time using the Employer Center online portal. Provide contact information for the primary Employer Center user account below. **If selecting Regence Online Enrollment, or to set up ACH Pull or Debit/Credit payment options, access to Employer Center is required.** An email will be sent to this user with registration instructions once the group setup is complete.

Primary User Name	Phone (area code required) Ext.	Email
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9. Health Savings Account (HSA) – Complete only if a Regence HSA-eligible healthplan will be offered. Regence offers integration with HealthEquity, an HSA Administrator. This integration allows HealthEquity to automatically set up health savings accounts for each employee enrolled on a Regence HSA-eligible healthplan and offers employees the ability to pay providers directly from their HSA.

Will the group elect HealthEquity to administer its health savings accounts?
 No Yes – Who will pay the monthly fee? Employer Employee

SECTION G – ACKNOWLEDGMENTS AND CERTIFICATIONS

If you have any questions about the benefits and services that are covered, provided, limited, or excluded under the group coverage(s) for which you are making application, contact your Sales Representative before applying.

Note: “The Company” as used here means the group applying for coverage.

I certify that I am an officer or employee of the Company, duly authorized to execute this application on behalf of the Company, and that the Company:

- a) Applies for the group coverage(s) selected in the signed rate and benefits page(s).
- b) Authorizes any person or other entity to release to Regence any information requested by Regence in connection with this application’s processing.
- c) Acknowledges that coverage is not in effect until Regence accepts this application, establishes an effective date of coverage, and issues the group contract(s) to the Company. If it is approved by Regence, this application will form a part of the group contract(s) and the Company will be bound by the terms and conditions of the entire group contract(s). Where permitted by law, Regence may choose not to approve this application and any premium deposit will be returned if the application for group coverage(s) is not approved.
- d) Acknowledges that eligibility standards (e.g., waiting period, dependent eligibility, minimum hours, etc.) established at initial application may be changed only at contract renewal and must be adhered to for all employees, independent contractors, and dependents. Benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and Regence.
- e) Acknowledges that it has selected the group coverage(s) to be offered to its employees and (if applicable) its independent contractors based upon written information provided by Regence and that no broker, producer, or consultant was or is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.
- f) Agrees, upon Regence’s request, to make payroll and other records directly related to employee or contractor participation levels or to employees’ or contractors’ coverage, premiums, or contributions under the group contract(s) available to Regence for inspection. This provision shall survive the termination of the group contract(s). Except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence, at no time shall any employee or independent contractor be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein. Further, all coverage options will be made available to all eligible employees, dependents, and (if applicable) independent contractors who satisfy eligibility requirements.



SECTION G – ACKNOWLEDGMENTS AND CERTIFICATIONS (continued)

- g) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.
- h) Agrees to deliver, or otherwise make available to enrollees, all Regence paper or online member documents and other coverage related materials upon request by Regence.
- i) Acknowledges that Regence must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc.).
- j) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Regence, that Regence does not provide health care services and cannot guarantee any results or outcomes of care, and that Regence is responsible for the quality of health care received only as provided by law.
- k) Certifies under penalty of perjury that all information provided and statements made in this application are accurate and complete to the best of its knowledge and belief and acknowledges that Regence will rely in part on the information in this application as the basis for Regence’s decision on whether to approve this application and issue any group contract(s). It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. In addition, Regence will have the right to collect any claims payments or other damages. If Regence continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that Regence will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by Regence.
- l) Acknowledges that, in those circumstances permitted by Utah law, Regence may impose a surcharge of up to twenty-five (25%) of annualized premium upon a small group that changes to Regence coverage from another carrier’s coverage as of a date other than the anniversary of the small group’s plan year with that other carrier.
- m) Acknowledges that if the Company has a producer, that producer may receive bonuses, commissions, administrative services fees, or other compensation, including non-cash compensation from Regence. Incentives may be based on any of several factors, including the size of the Company’s business, the products the Company purchases, the producer’s volume of business with Regence, and other services the producer provides to the Company. These incentives may have an indirect impact on the Company’s rates. For more information, please contact the producer for the Company.
- n) Acknowledges that Regence’s statements in this application, including the descriptions of laws in Section E, 3 through 7, are not legal advice and that the Company should look solely to its legal advisor with legal questions or concerns.

Any accompanying foreign language version of this form is provided only as an accommodation or courtesy to the customer and this English language version shall control the resolution of any dispute or complaint.

For assistance in administering your group’s benefit plan, see the Group Administrator Guide on regence.com. The guide provides information about benefits, eligibility, enrollment, monthly billing statements, and claims submission to help you answer your employees’ questions.

SECTION H – SIGNATURE

I certify that the information provided is accurate to the best of my knowledge.

If you type your name below, you understand that you are electronically signing this document and agree your electronic signature is the legal equivalent of your manual signature on this application.

Group Authorized Representative Signature

Signature Date

Group Authorized Representative (print name)

Official Title

Regence BlueCross BlueShield of Utah: 2890 E Cottonwood Parkway, Salt Lake City, UT 84121

