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## **Commercial Underwriting Package**

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Commercial health insurance coverage is available to employer, trust and association groups, subscribers and dependents that meet the qualifications specified in 4235 (c) (1) of the New York State Insurance Law and the Underwriting Guidelines of Excellus Health Plan, Inc, doing business as Excellus BlueCross Blue Shield ("Health Plan").

The attached documents must be completed by an Employer enrolling in the Health Plan's insurance.

Last Revised: September 9, 2011

**New Business Group Information Form**

**SECTION ONE: GENERAL GROUP INFORMATION**

1. Group name or DBA name, if applicable: \_\_\_\_\_
2. Legal entity name, if different than group name: \_\_\_\_\_
3. Name of owner/partners: \_\_\_\_\_
4. Physical location of employer: \_\_\_\_\_
5. Mailing address of employer (if different than physical address): \_\_\_\_\_
6. Information for contact person at employer group:

Name	Title	Phone #	Email Address
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7. Description of business: \_\_\_\_\_ SIC code: \_\_\_\_\_ EIN/TIN #: \_\_\_\_\_
8. Type of group sponsor: (check one)  
 Employer \_\_\_ Union \_\_\_ Trustees of Fund \_\_\_ Association \_\_\_ Other: \_\_\_\_\_
9. Organization type: (check one) State government \_\_\_ Local government \_\_\_ Church group \_\_\_  
 Nonprofit \_\_\_ Trust \_\_\_ Publicly traded organization \_\_\_ Privately held corporation \_\_\_  
 Privately held non-incorporated \_\_\_ Not-for-profit \_\_\_ Other: \_\_\_\_\_
10. Is coverage obtained through a Chamber Trust or Association, including a Professional Society?  
 Yes \_\_\_ No \_\_\_ (check one)  
 CTA Name \_\_\_\_\_ Professional Society Name \_\_\_\_\_
11. Are you a subsidiary company? Yes \_\_\_ No \_\_\_ (check one)  
 If yes, list parent company name & address \_\_\_\_\_
12. Are you a parent company with subsidiary companies? Yes \_\_\_ No \_\_\_ (check one)  
 If yes, please attach a list of the related companies, the locations and the number of eligible employees working at each location.
13. Are there any other health plans in place for your group? Yes \_\_\_ No \_\_\_ (check one)  
 If yes, type of plan(s) \_\_\_\_\_ Number of employees enrolled in this plan \_\_\_\_\_

**PLEASE SUBMIT ALL REQUIRED UNDERWRITING DOCUMENTATION WITH THIS FORM**

**REFER TO SMALL GROUP ENROLLMENT CHECKLIST FOR REQUIRED DOCUMENTATION**

**SECTION TWO: REGULATORY INFORMATION**

	Medical	Dental
14. Group Size		
a) Total number of employees at all locations	_____	_____
b) Total number of full-time & part-time eligible employees at all locations	_____	_____
c) Total number of eligible retirees at all locations	_____	_____
d) Total number of employees enrolled due to COBRA/NYS Continuation at all locations	_____	_____
e) Total eligible employees: (add lines b + c + d)	_____	_____
f) Employees working at other locations not eligible for the programs offered through our plan	_____	_____
g) Retirees who are offered a Medicare Advantage or Retiree Health Plan group product	_____	_____
h) Employees eligible for our health plan (subtract f and g from line e)	_____	_____
i) Eligible employees enrolling in the product offering(s) through our health plan	_____	_____
j) Group participation percentage (divide line i by line h)	_____	_____
15. Group size for federal Mental Health Parity and federal medical loss ratio reporting average number of total employees, at all locations, for the prior calendar year		_____
16. Do you employ any Vermont residents who work at employer locations in Vermont, including telecommuters working from their home in Vermont? Yes _____ No _____ (check one). If yes, please provide the number _____		_____
17. Do you employ any other out-of-state residents who work at out-of-state employer locations other than Vermont? Yes _____ No _____ (check one). If yes, please provide the number _____		
18. Employer contribution information for federal medical loss ratio rebating and underwriting requirements. Do you contribute the same percent for all products, classes, and tiers? Yes _____ No _____ (Check one) If yes, what percent do you contribute? _____ If no, please provide the detailed information on the attached spreadsheet.		

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.

Signature of person who completed this form	Date	Email Address	Title
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**New Business Group Information Form**

**Calendar Year Employer Contribution  
(for calendar year coverage is effective)**

Group Name \_\_\_\_\_

Coverage Effective Date \_\_\_\_\_

Contribution Effective Date \_\_\_\_\_

Contribution End Date \_\_\_\_\_

Please note: If your contribution amount/type changes you are required to notify the Health Plan of these changes.

Rate Tier:

- 2 - Tier
- 3 - Tier
- 4 - Tier

Premium Contribution Type:

- Fixed \$ amt.
- % of premium

Other-please explain:

If your group's number of plan options per class exceeds two, please complete an additional form(s) or attach a spreadsheet with the contribution details.

If your group's employer contribution differs by subgroup, please complete the form for each subgroup.

**Class Names:**

A001 - All Actives

A004 - Management

A007 - Non-Union

R001 - Retired Non-Medicare Eligible

A002 - Hourly

A005 - Non-Management

A008 - Full-Time

R002 - Retired Medicare Eligible

A003 - Salaried

A006 - Union

A009 - Part-Time

Class Name	Plan Offering	Monthly Tier Contribution				HSA/HRA Annual Contribution if applicable
		Single	Subscriber & Spouse	Subscriber & Child / Children	Family	

**Signature:** The undersigned certifies that, to the best of my knowledge and belief, the information provided above is true and complete.

\_\_\_\_\_  
Name / Signature of Group Contact Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address



### Eligibility Policy for New Employees

Group Name: \_\_\_\_\_

Group Number {If Assigned}: \_\_\_\_\_

Our Standard new hire waiting period for eligibility for health insurance is:

(Type of employee: salaried, hourly, etc.)

\_\_\_\_\_ Date of Hire \_\_\_\_\_

\_\_\_\_\_ First of the month following date of hire \_\_\_\_\_

\_\_\_\_\_ First of month following 30 days of employment \_\_\_\_\_

\_\_\_\_\_ First of month following 60 days of employment \_\_\_\_\_

\_\_\_\_\_ First of month following 90 days of employment \_\_\_\_\_

\_\_\_\_\_ First of month following 6 months of employment \_\_\_\_\_

\_\_\_\_\_ First of month following 1 year of employment \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_  
Must be approved by underwriting prior to submission

Our Standard rehire waiting period for eligibility for health insurance is:

\_\_\_\_\_ Same guidelines as new hire \_\_\_\_\_

\_\_\_\_\_ Date of rehire \_\_\_\_\_

\_\_\_\_\_ First of the month following rehire \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_  
Must be approved by underwriting prior to submission

Minimum hours per week that an employee must work to be eligible:

\_\_\_\_\_ 20 hours \_\_\_\_\_

\_\_\_\_\_ 25 hours \_\_\_\_\_

\_\_\_\_\_ 30 hours \_\_\_\_\_

\_\_\_\_\_ 40 hours \_\_\_\_\_

Note: Employer can determine full time status as stated above but may not be less than 20 hours.

The above policies have been submitted for business indicated above. I understand that these policies are accepted and must remain in effect for at least one full year before they are eligible to be changed.

Authorized Group Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Date Effective: \_\_\_\_\_

### ATTESTATION

I, \_\_\_\_\_, the \_\_\_\_\_  
(Name) (Title)

at \_\_\_\_\_  
(Name of Employer)

do hereby attest that: (Check one)

\_\_\_\_\_ For groups with 2 or more employees, including businesses with only one employee who is eligible for health insurance coverage. Please list the individuals eligible for coverage who are not listed on the NYS-45-ATT. Eligible individuals include partners or owners of the business if actively engaged in the business, COBRA/NYS continuants, new employees, and retirees when it is the consistent policy of the business to cover retirees.

The individual(s) listed below work at least 20 hours per week at the above-named Employer or are otherwise eligible for coverage under a group health insurance plan to be issued by us. Include a notation for each person indicating New Employee (E) with date of hire, Partner (P), Business Owner (B), Retiree (R), COBRA (C), or other (O) with explanation.

OR

\_\_\_\_\_ Sole proprietors. With respect to an applicant for coverage as a sole proprietor, the following individual works at least 20 hours per week at the above-named Employer. If you are applying for coverage as a sole proprietor, only one (1) name will be listed.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

I certify that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including that the persons proposed for coverage work at least 20 hours per week or are otherwise eligible for coverage.

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 \$5000 and the stated value of the claim for each such violation.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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Date \_\_\_\_\_

Ms. Caitlin Hryzak  
Broker Program Administrator  
Excellus BlueCross BlueShield  
165 Court Street, 2N  
Rochester, NY 14647

Re: Broker Letter of Record –

To Whom It May Concern:

This is to notify you that our company has appointed Bond Financial Network, Inc., whose business address is 71A Monroe Avenue, Pittsford, NY 14534 as our sole insurance representative, with respect to coverage provided to this organization by Excellus effective date \_\_\_\_\_ we have authorized Bond Financial Network, Inc. to act on behalf in place of our former agent.

I understand that if our company elects to purchase coverage from your company that Bond Financial Network, Inc. may be entitled to base and/or bonus compensation for our business.

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

Sincerely,

\_\_\_\_\_  
Signature of Company Officer

\_\_\_\_\_  
Please print (Officer Name)

\_\_\_\_\_  
Title of Company Officer



165 Court Street, Rochester, New York 14647

An Independent Licensee of the BlueCross BlueShield Association

Dear Administrator:

Please complete the following and return it to:

Excellus BlueCross BlueShield, Rochester Region
Membership and Billing Department
165 Court Street
Rochester, New York 14647

1. Billing Election - Please select the option you prefer.

[ ] We would like Excellus BlueCross BlueShield, Rochester Region to administer the billing for our COBRA or New York State continuation of coverage provisions subscribers. (If you select this option, you must sign the Administrative Agreement on the back of this form.)

[ ] We would prefer to collect premiums and remit the payments on our COBRA or New York State continuation of coverage provisions group bill for our subscribers.

2. COBRA and New York State continuation of coverage providers do not apply to us because:

[ ] We are considered a church plan.

3. Group Name: \_\_\_\_\_

4. Signature: \_\_\_\_\_ Title: \_\_\_\_\_

5. Group Number: \_\_\_\_\_ Telephone: \_\_\_\_\_

PLEASE SEE REVERSE SIDE FOR ADMINISTRATIVE AGREEMENT

**Administrative Agreement for Health Insurance Continuation Coverage**

Excellus BlueCross BlueShield, Rochester Region and \_\_\_\_\_ the  
("Employer") agree as follows:

1. As agent for the Employer, Excellus BlueCross BlueShield, Rochester Region will, on a monthly basis, bill and collect premiums from those employees and other beneficiaries of the Employer's group health insurance plan who qualify for and elect to purchase continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or New York State continuation of coverage provisions. Benefits and premiums will correspond to those otherwise applicable under the plan, provided that Excellus BlueCross BlueShield, Rochester Region will add to each bill a charge for its administrative service equal to two percent (2%) of the applicable premium, which service charge the Employer is assigning to Excellus BlueCross BlueShield, Rochester Region as its agent.
2. The employer will have sole responsibility for complying with all notice requirements and election procedures under COBRA or New York State continuation of coverage provisions and for determining who is eligible for continuation coverage under its group health insurance plan. The Employer will notify Excellus BlueCross BlueShield, Rochester Region in writing with respect to the commencement, termination and other terms and conditions of continuation coverage for each eligible individual, and Excellus BlueCross BlueShield, Rochester Region will be entitled to rely upon those instructions.
3. The Employer will indemnify Excellus BlueCross BlueShield, Rochester Region from and against any and all claims, liabilities, costs or damages that arise as a result of Employer's failure to comply with the requirements of COBRA or New York State continuation of coverage provisions. The Employer's duty to indemnify will survive the termination of the Agreement."
4. Any party may terminate the Agreement by giving sixty days written notice to the other parties.

Dated: \_\_\_\_\_

Excellus BlueCross BlueShield, Rochester Region,



By: \_\_\_\_\_

Scott Ellsworth  
President

\_\_\_\_\_  
Employer

By: \_\_\_\_\_