

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

SECTION TWO REGULATORY EMPLOYER GROUP INFO	1. Average number of owners and employees at all locations (all FT and PT employees) for prior year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	2. Did you employ 20 or more employees who worked at least 20 weeks in the current year or prior year? Yes <input type="checkbox"/> No <input type="checkbox"/>
	3. Did you employ 100 or more employees on 50% or more of your business days in the current year or prior year? Yes <input type="checkbox"/> No <input type="checkbox"/>
	4. Do you employ any Vermont residents who work at employer locations in Vermont, or are telecommuting from their home? Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, please provide the number of such employees: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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**:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	2. Number of retirees (not on Medicare) eligible for the employer group plan:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	3. Number of individuals enrolled in COBRA/New York continuation of coverage and/or the young adult option:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	4. Total number of eligible individuals for group health insurance coverage (Question 1 + Question 2 + Question 3): Existing Policies - If the total number of eligible individuals is three or fewer, a copy of your most recent NYS-45 is required.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	5. Total number enrolled in the health plan:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	N/A	
	6. Participation percentage (Question 5 ÷ Question 4):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	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?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	8. How many part-time employees (fewer than 30 hours per week) did you employ during the previous calendar year?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	9. Total number of full and part-time employees (Question 7 + Question 8):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	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:	<input type="text"/>	<input type="text"/>	<input type="text"/>
11. Total number of full-time equivalents (Question 10 ÷ 1,440):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
12. Total number of full-time employees and full-time equivalents (Question 7 + Question 11):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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.

*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.



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 A003 - Salaried	A004 - Management A005 - Non-Management	A006 - Union A007 - Non-Union	A008 - Full-Time A009 - Part-Time	R001 - Retired Non-Medicare Eligible	Z001 - Custom Class/Other
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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	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 <input type="checkbox"/>	HRA <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HSA <input type="checkbox"/>	HRA <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

