Wellmark

Group Employer Application for ACA Small Business Plans (1-50)

Blue Dental℠
Blue Dental PPO℠

A. EMPLOYER INFORMATION

Employer Legal Name:

Doing Business As:

Average number of employees employed on business days in the preceding calendar year[1]:

Average employee count year 20___ (yy):

Number of employees eligible for health:

Number of eligible employees enrolling in your health plan(s):

Is this employer purchasing coverage for at least one common law employee who is not:
1. The sole proprietor/owner (or spouse) of a sole proprietorship, or an LLC treated as a disregarded entity under federal law;
2. A non bona-fide partner (or spouse) of a partnership or LLC treated as a partnership under federal law; or
3. A non-employee shareholder of a corporation or LLC which has elected to be treated as a corporation under federal law.[2]

☐ Yes ☐ No

[1]Please include full-time, part-time, and seasonal employees regardless of hours worked or eligibility for the plan to arrive at the average number of employees. If the average number of employees is greater than 50, your business is not eligible for small group coverage. Please contact your Wellmark authorized representative to get a large employer application form.

[2]To be eligible for group insurance coverage, at least one common law employee must actually be enrolled in coverage. If no common law employees enroll in coverage, you are not eligible for small group insurance. Instead, you must purchase coverage in the individual/family market.

Federal Tax ID Number

__ __ __ __ __ __ __ __ __

Effective Date _____/_____/_____

I understand and confirm that the requested effective date is considered a designation of the date as my employer group's plan year and annual renewal date. I understand and agree that the plan year and renewal date will align with the requested effective date.

SIC Code (Industry code)

Sole Proprietor (Type of ownership) ☐ Yes ☐ No

Employer Address

Address Line 1 (Street Address or Apt/Suite#) *(Required)*:

Address Line 2 (PO Box, Street Address):

City: State: ZIP: County:

Administrative Contact

Full Name: Title:

Email: Work Phone: Mobile Phone (Optional):

B. BILLING INFORMATION

Billing Contact *(Required)*

Full Name: Title:

Email: Work Phone: Mobile Phone (Optional):

Billing Address (Required if different than the employer address in Section A.)

Is the Billing Address: ☐ An address of a third-party service provider?[3] ☐ An address of the account itself?

Address Line 1 (Street Address or Apt/Suite#) *(Required)*:

Address Line 2 (PO Box, Street Address):

City: State: ZIP:

[3]*I authorize Wellmark, Inc. to deliver, by paper or electronic means, the periodic Wellmark group statement or premium invoice to the alternate billing address described above. I acknowledge the above named Account is responsible for payment of the amount stated in the periodic Wellmark group statement or premium invoices, in accordance with the terms of the Group Insurance Policy or Administrative Services Agreement between Account and Wellmark. The Wellmark group statement or premium invoice delivered periodically to any third party service provider can be viewed by the Account by registering for electronic billing at Wellmark.com. For complete instructions, contact your Wellmark representative. Account may elect to receive an email notification providing Account notice that a Wellmark group statement or premium invoice is available for viewing.*

B. BILLING INFORMATION, cont'd

Class/Department Designation

Specify if you would like your benefits split by class/department of employees. *(Please note, if "Other" is selected, any free form text descriptions cannot be longer than eight (*) characters in length, including spaces. Example: IND CONT = Independent Contractor).*

Class/Department of employees (Select from the options below):

☐ Full time ☐ Part time ☐ Hourly ☐ Salaried ☐ Union ☐ Non-union

☐ Management ☐ Non-management ☐ Executives ☐ Other:_____

C1. DEFINED BENEFIT PLAN (You must select between Defined Benefit OR Defined Contribution.) Please complete section C1 for a Defined Benefit arrangement

1. Enter health plan name below

Health Plan Name	Plan 1	Plan 2	Plan 3

If the group chooses an HMO (Wellmark Health Plan of Iowa, Inc., and/or Wellmark Synergy Health, Inc., and/or Wellmark Value Health Plan, Inc.), the group's legal address must be located in that entity's service area. For detailed information, ask your authorized Wellmark representative or refer to the Small Business Enrollment and Administrative Guide.

Employers may offer up to three plan options but may not offer a bronze option AND platinum option.

C2. DEFINED CONTRIBUTION PLANS (You must select between Defined Benefit OR Defined Contribution.) Please complete section C2 for a Defined Contribution arrangement.

1. Package offered: ☐ A

Employer is solely responsible to ensure that the employer's premium contribution strategy complies with all applicable laws and regulations relating to non-discrimination in employee benefits, including but not limited to the Age Discrimination in Employment Act, the Americans with Disabilities Act, Health Insurance Portability and Accountability Act, and Internal Revenue Code Section 105(h). Wellmark will not be held liable for any penalties or losses resulting from employer's violation of these laws and regulations.

D. OTHER COVERAGE

Check other products being selected:

☐ Blue Dental ☐ Blue Dental PPO Plan name: _____

☐ Vision[4] Note: Vision can only be elected if health is being offered.

[4]The vision plan is provided by Avesis Vision, an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services. Avesis Vision is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Vision coverage includes a Hearing Discount Savings Plan provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services.

E. ELIGIBILITY REQUIREMENTS

Please Check All That Apply:

☐ Employer is a public body
☐ Employer will offer coverage to part-time employees
☐ Employer will offer coverage to retirees (If checked, please provide a copy of the group's retiree agreement)
☐ Employer will apply a layoff provision (If checked, please provide supporting documentation)

COBRA Services (please check one if there are 20 or more employees):

If COBRA services are being offered, a COBRA Administrative Agreement must be completed and attached

☐ Wellmark to provide no COBRA services
☐ Wellmark to provide COBRA Administration and Billing Service (Billed as an annual administrative fee and a percentage of premium)

Confirmation of Medicare secondary payer (MSP) status (please complete the Confirmation of MSP Addendum and attach):

☐ The employer understands and acknowledges the information on the MSP form has been completed to the best of his or her knowledge.
☐ The employer confirms he or she did receive, read, and understand the "Information Regarding the Medicare Secondary Payer Statute" and any questions regarding this information have been answered.

F. ADDITIONAL HEALTH PLAN INFORMATION

Prior Medical Carrier Name:_____

G. REQUIRED DOCUMENT CHECKLIST

Please upload the following documentation upon completion of Enrollment:

- ☐ Quarterly wage & tax statement employer quarterly contribution and payroll report (JSR)
  (Other forms may be acceptable, see "Group Eligibility" in the Small Business Enrollment and Administrative Guide.)
- ☐ Medicare secondary payer (MSP) addendum
- ☐ Common ownership documentation (i.e. Schedule K-1) (if applicable)
- ☐ COBRA addendum (if applicable)
- ☐ Retiree agreement (if applicable)
- ☐ Layoff provision (if applicable)
- ☐ WageWorks[6] Proposal Request Form. Complete this form if the group has selected a high deductible health plan option and would like a quote on setting up an HSA (health savings account) for their employees.

[6]WageWorks is a separate company offering HSA account services. WageWorks does not provide Wellmark Blue Cross and Blue Shield products or services, and is solely responsible for any services it provides.

H. REQUIRED SIGNATURES

Employer is responsible for providing complete and accurate information on this application. Employer is responsible for compliance with all applicable laws regarding employer sponsored group health plans, including but not limited to ERISA, COBRA or state continuation laws, non-discrimination laws, eligibility criteria and eligibility waiting period requirements, and medicare secondary payer requirements. I understand that if this application contains any false statements, misrepresentations, or failures to disclose material facts, Wellmark may be entitled to terminate coverage or re-rate and adjust premium accordingly.

☐ I authorize the Wellmark Agent or Agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically, the information entered electronically may be considered the source of record, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 10 + 1 years.

I understand my account enrollment will not be completed until all required information is received by Wellmark.

Employer Representative Signature:_____ Date: _____/_____/_____

Selling Agent or Rep Name:_____ Date: _____/_____/_____

Selling Agent or Rep Number: __ __ __ __ __ __ __ __

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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