Wellmark

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

Blue Dental℠

Effective Date_____/_____/_____

A. Employer Information

Employer Legal Name_____ Doing Business As_____

Headquarters Address Line 1_____

Address Line 2_____

City_____ State_____ ZIP_____

County_____ Federal Tax Identification Number (TIN) __ __ __ __ __ __ __ __ __

Phone Number (_____) _____ Ext_____

B. Employer Eligibility

Average Number of Employees Employed[1] on Business Days in the Preceding Calendar Year 20___ Number of Employees_____

[1]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. Contact your Wellmark authorized representative to get a large group employer application form.

Select the type of business entity. (**Please select only one**)

☐ Corporation or LLC treated as a corporation for federal tax purposes;

☐ Partnership or LLC treated as a partnership for federal tax purposes;

☐ Sole proprietorship, or business treated as a disregarded entity for federal tax purposes.

Required

☐ I certify and agree that I am applying for health insurance for an employer sponsored group health plan which includes at least one enrolled common law employee other than (a) the owner or spouse of the sole proprietorship; (b) a non-working partner or spouse in a partnership or LLC; or (c) a non-working shareholder or spouse of a corporation or LLC. I may be required to provide documentation of employee or working status to validate eligibility for this group health plan.

Note: A sole proprietor, non-employee partner, or non-employee shareholder applying for coverage for self/spouse only is not eligible for group health insurance and must seek coverage in the individual market. Sole proprietors, non-working partners, and non-working shareholders may enroll in group coverage if at least one other common law employee, working partner, or working shareholder is enrolled in the group health plan.

C. Administrative Contact *(Please identify the primary contact person for health insurance.)*

First and Last Name_____ Title_____

Email Address_____

Phone Number (_____) _____ Ext_____

D. Billing Information

Billing Contact if different than the administrative contact.

First and Last Name_____ Title_____

Email Address_____

Phone Number (_____) _____ Ext_____

Billing address (Required if different than the employer's address in the Employer Information section.)

Address Line 1 (Street Address or Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Will a third party such as a TPA or CPA be receiving your bill?[2]

[2]By checking yes, I authorize Wellmark, Inc. to deliver, by paper or electronic means, the periodic Wellmark group statement or premium invoice to the 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.

E. Employer Benefit Elections

Plan Year 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.

Medical Coverage (Employers may offer up to three medical plan options.)

Medical Plan Name and Network 1_____

Medical Plan Name and Network 2_____

Medical Plan Name and Network 3_____

Wellmark Value Health Plan products are only available in certain counties. When selecting a plan, be sure it is available in your area.

Ancillary Coverage

Dental Coverage

☐ Blue Dental Dental Plan Name_____

Avesis Vision Coverage

☐ Avesis Vision[3] Note: Vision can only be elected if medical is elected.

[3]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 of Iowa products or services.

F. Additional Services

Retiree Coverage

☐ Yes ☐ No Will coverage be offered to retirees? (If yes, complete and attach a retirement agreement.)

COBRA Services (Employer must have at least 20 or more employees during 50% of the previous calendar year)

If COBRA services are being offered, a COBRA Administrative Agreement (N-4102) must be completed and submitted with this application.

☐ Yes ☐ No Does the Employer want COBRA services? **(Billed as an annual administrative fee and a percentage of premium.)**

F. Additional Services, cont'd

Standard COBRA administration is a shared service provided for a fee as listed on the COBRA Administrative Services Agreement. For more information on the shared service please refer to Sections B and C of the COBRA Administrative Services Agreement. Standard COBRA administration is only available for Wellmark issued or Wellmark administered products. This includes Wellmark health and pharmacy plans and our Blue Dental product. A completed COBRA Administrative Services Agreement must be submitted to Wellmark for COBRA services to begin. Employer (Account) remains responsible for complying with all applicable laws and regulations relating to COBRA or State continuation of coverage laws. Wellmark does not assume any responsibility for the acts, omissions or breaches of duty of Account. Account agrees to indemnify Wellmark, to hold Wellmark fully protected, harmless for all damages and causes of action except for such duties as assumed by Wellmark. Wellmark shall not provide any administrative services with respect to Alternative Continuation (COBRA like) coverage or State continuation of coverage laws.

G. Medicare Secondary Payer

Wellmark is a Responsible Reporting Entity under federal law and must report employer and employee information to the Centers for Medicare and Medicaid services (CMS). The purpose of this reporting is to identify when CMS should pay secondary to an employer group health plan instead of primary. Failure to provide the information requested in this section can result in penalties being assessed to the group including but not limited to $1000 per day per member for not accurately reporting to CMS and/or an excise tax equivalent to 25% of the employer's group health plan expenses for the relevant year.

Medicare Secondary Payer (MSP) Contact

If the MSP contact is different from the administrative contact, please complete the following:

First and Last Name_____ Title_____

Email Address_____ Phone Number (_____) _____ Ext_____

Medicare Secondary Payer (MSP) Questions

☐ Yes ☐ No Will this coverage be for a collectively bargained health and welfare fund? (i.e., union)

☐ Yes ☐ No Did you employ 20 or more employees for 20 or more calendar weeks during the previous or current calendar year? If no, in the event you experience a change, you must notify Wellmark when this change occurs.

Note: *An employer is considered to employ 20 or more employees for a particular week if the employer has at least 20 full-time or part-time employees on its employment rolls each working day of that week. This condition is met as long as the total number of individuals on the employer's rolls add up to at least 20, regardless of the number of employees who work or who are expected to report for work on a particular day.*

☐ Yes ☐ No Did you employ 100 or more employees during 50% of your business days during the previous calendar year?

Note: *An employer will be considered to employ 100 or more employees on a particular day if the employer has at least 100 full-time or part-time employees on their employment rolls on that day. This condition is met as long as the total number of individuals on the employer's rolls add up to at least 100, regardless of the number of employees who work or who are expected to report for work on a particular day.*

☐ Yes ☐ No Did your organization participate in a multi or multiple employer group health plan (more than one employer in a group, i.e., Multiple Employer Welfare Association) during the previous calendar year?
If yes, complete the following:

Multi or Multiple Employer Plan Name_____

Address_____

City_____ State_____ ZIP_____

☐ Yes ☐ No Was your organization part of a commonly owned or commonly controlled group of organizations during the previous calendar year?
If yes, complete the following:

Name of Commonly Owned/Controlled Entity_____

Address_____

City_____ State_____ ZIP_____

Name of Commonly Owned/Controlled Entity_____

Address_____

City_____ State_____ ZIP_____

G. Medicare Secondary Payer, cont'd

Medicare Secondary Payer (MSP) Questions, cont'd

All information in the MSP section will be used to identify the Medicare secondary payer status of Medicare enrolled employees.

☐ Yes ☐ No Do you have any additional tax ID numbers used to report your employee earnings to the IRS?

If yes, please complete and attach a Medicare secondary payer (MSP) form (N-2305) for each tax ID number.

H. Document Checklist

☐ 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.

☐ Small Group Employer Eligibility Documents

- For an established business, the most recent Employer's Quarterly Contribution and Payroll Report (Iowa state tax form 65-5300) reconciled for each eligible employee **OR** a W-2 Summary Wage and a Tax Form for each eligible employee AND a W-3 Transmittal of Tax Statement for the most recent tax year.
- If business was established in the prior 12 months, a W-4 and Iowa Centralized Registry Form for each eligible employee and the confirmation of the group's federal tax identification number (TIN) from the U.S. Department of the Treasury.
- A K-1 form to provide documentation of non-wage earning owners (if a common law employee has been validated).
- A completed application or waiver for each eligible employee.

☐ WageWorks[4] 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 (if applicable).

[4]WageWorks is a separate independent company providing HSA account services compatible with Wellmark's high deductible health plans.

I. Required Signatures

By signing below, and/or by payment of the required premiums for the plans selected herein, Employer agrees and certifies:

1. Employer has read and understands the information contained in this document, including the plan summaries, the premium rates, the differences in issuers, networks, premium rates and employee cost share between plans shown and the plans selected.
2. Employer has been provided with access to (a) the Summary of Benefits and Coverage for each selected plan, (b) the provider network directory applicable to each selected plan, (c) the drug list or formulary applicable to each selected plan, and can access this information on Wellmark.com or by contacting an authorized Wellmark representative.
3. Employer agrees to pay the required premiums shown for the plans selected. Premiums shown in quoting material are subject to change based on employee demographic information and other factors.
4. Employer will comply with all terms and provisions of the Group Insurance Policy issued, the benefit documents or coverage manuals provided to each enrollee, the COBRA Administrative Services Agreement, if applicable.
5. Employer will make coverage available to all eligible employees and their eligible dependents and will distribute information and documents to enrolled employees as needed.
6. Employer will maintain records and furnish to Wellmark any information required in connection with administration of the coverage.
7. Employer will pay Wellmark by the premium due date, the premiums on behalf of each member covered under the contract unless otherwise stated in any other financial agreement between the parties; submit applications of employees prior to their date of eligibility; keep all necessary records regarding membership; and assume responsibility for handling the COBRA and state mandated continuation process, if applicable.
8. Claims filed by or on behalf of members may at Wellmark's option, be suspended, if premiums are not timely received.
9. Employer may receive on behalf of members; certain notices delivered by Wellmark and will immediately forward such notices to members at their last known address.
10. That in order for Wellmark to accept or decline this application for new or renewing group coverage, all the information requested must be completed. In the event the application or renewal package is not complete, Wellmark or its Agent is authorized to obtain the necessary information and to complete that information on this application or renewal package. The employer understands that the coverage issued by Wellmark may be different from the coverage selected herein. In that event, Wellmark shall notify the employer of such differences and by payment of the appropriate premiums, the employer will accept the coverage as issued.
11. The premium rates calculated for the employer are contingent, based on the accuracy of the eligibility data submitted on the employees and covered dependents to Wellmark by the employer. Wellmark reserves the right to review such rates upon receipt of all individual applications for employers, employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees application may result in a material change to the group's coverage or premium rates as of the effective date of coverage.

I. Required Signatures, cont'd

12. Employer is responsible to ensure that 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.
13. If Employer has selected a plan offered by Wellmark Value Health Plan, Inc., employer understands that the network associated with such plan is a limited local network and there are no benefits for services received by out of network providers.
14. All employees applying for coverage or renewing coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports, or self-employment wages documented on appropriate tax reporting forms. Each enrolled employee must be actively at work and satisfy any applicable eligibility-waiting period.
15. The requested coverage is not in effect unless and until this application is approved by Wellmark, that approval of coverage is evidenced by issuing Group Insurance Policy to the employer and an employee's coverage is not in effect until the employee applies and is approved for coverage by Wellmark.
16. This small group off-exchange product is not eligible for a premium tax credit.
17. Any Health Savings Account associated with a group sponsored health plan is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an eligible individual under IRS regulations to receive the HSA tax benefits.
18. The information contained in the Medicare secondary payer (MSP) section is complete and accurate as of the date of the employer's signature below.
19. The employer has reviewed the entire application or renewal package for group coverage and all information contained herein is true and complete to the best of the employer or authorized employer representative's knowledge and belief.
20. The employer authorizes the Wellmark independent agent or producer identified in this application or renewal package to make enrollment or eligibility changes on behalf of the employer's group health plan and employer will notify Wellmark if this authorization is revoked.
21. I authorize the Wellmark agent or agency who is identified with this application to enter the information on line 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 enrollment information. Wellmark authorized agents are required to retain records of this transaction for 11 years.
22. I understand my account enrollment will not be completed until Wellmark receives all required information.

Employer Representative Signature_____ Date_____/_____/_____

Agent/Producer Certification:

By signing or submitting this application or renewal submission package, the producer identified certifies that:

1. I am a licensed insurance producer and if applicable (for individual market and small group coverage) an appointed and authorized Wellmark representative.
2. Any information entered by my staff or me has been obtained directly from the employer and employees and I have their express permission to submit the information to Wellmark.
3. I have not signed any forms or applications as an employer representative or individual applicant.
4. I am maintaining a record of each employee's signed application, enrollment form, or waiver at my office and will provide a copy to Wellmark upon request.
5. I am maintaining records of this transaction in compliance with applicable laws.
6. I have disclosed that I am an authorized representative of Wellmark, I may receive compensation in the form of commission for assisting with the sale, enrollment, or renewal of Wellmark insurance and have complied with all applicable laws regarding any other forms of compensation related to my services.
7. No portion of any commissions received from Wellmark related to this transaction will be paid to an agent/producer or other individual not appointed or approved by Wellmark.

Selling Agent or Representative Signature_____ Date_____/_____/_____

Selling Agent or Representative 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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