



## General Eligibility Requirements

**Please Note** – We have provided these requirements as a guide. It is only intended to help you understand some of the most common eligibility requirements for offering Excellus BlueCross BlueShield health plans. Please be aware that from time to time our policies and procedures may change. If you need to verify any information, please contact our account services department. They will be happy to answer any questions you may have.

A small group is one with between 1 and 50 eligible employees and meets the following criteria:

- Is physically located within our operating area
- Is engaged in a legal business with the authority necessary to contract for coverage
- Regularly employs at least one person on an active basis for salary or wages throughout the year. The business must be non-seasonal in nature, meaning the employer on at least 50% of its working days during the preceding year employed one or more eligible persons
- Has an employer-employee relationship with eligible personnel
- Files state and federal income taxes as an ongoing enterprise or files appropriately as a non-profit entity
- If the employer contributes 100% of the premium, 100% of the employees must participate
- Meets and maintains applicable minimum participation enrollment requirements (see below)
- Is financially sound and expected to be a viable ongoing concern.

### Maximum Number of Product Combinations

Small groups who select Excellus BlueCross BlueShield coverage are limited to the following number of product combinations:

<u>Group Size</u>	<u>Number of Products</u>
1-5 net eligible employees	1
6-20 net eligible employees	2
21-50 net eligible employees	3

For groups with 100% participation and more than 1 eligible employee, one additional product is allowed. This does not apply to groups of 1-5 net eligibles that are offering BluePPO HSA.

### Minimum Participation for Excellus Blue Cross BlueShield Health Plans

For employers offering Excellus BCBS non-HMO health plans, 75% of the net eligible employees must enroll. Products with different minimum participation requirements are noted below.

### Product Specific Minimum Participation Requirements

#### **BlueEPO Balance**

- For employers who only offer BlueEPO Balance, 75% of the net eligible employees must enroll
- For employers who offer BlueEPO Balance and one or more additional products, 50% of net eligible employees must enroll in BlueEPO Balance and 20% of net eligible employees must enroll in each additional product offering. Overall, 75% of net eligible employees must be enrolled in Excellus BCBS products.



### ***FourFront***

- For employers who only offer FourFront, 75% of the net eligible employees must enroll
- For employers who offer FourFront and one or more additional products, 20% of net eligible employees must enroll in FourFront and 20% of net eligible employees must enroll in each additional product offering. Overall, 75% of net eligible employees must be enrolled in Excellus BCBS products.

### ***BluePPO HSA***

- **For employers with 6 or more eligible employees** who only offer BluePPO HSA, 5% of net eligible employees must enroll in the first and second year of the product offering and 10% of net eligible employees must enroll in the third year of the product offering. In addition, at least 50% of eligible employees must be enrolled in a health insurance program through another carrier.
- **For employers with 6 or more eligible employees** who offer BluePPO HSA and one or more additional products, 5% of net eligible employees must enroll in the first and second year of the product offering and 20% of net eligible employees must be enrolled in each additional product offering. In year three of the product offering 10% of net eligible employees must enroll in BluePPO HSA and 20% of net eligible employees must be enrolled in each additional product offering. A total of 75% of net eligible employees must be enrolled in Excellus BCBS products.
- **For employers with 5 or fewer eligible employees**, 100% of net eligible employees must enroll in BluePPO HSA.

Please note: Employees who waive coverage under your plan because they have coverage through a spouse or as a dependent covered under their parent's policy are not counted as eligible employees for purposes of calculating minimum participation requirements.

## EXCELLUS UNDERWRITING REQUIREMENT CHECKLIST

1. \_\_\_\_\_ **Group Information Worksheet** - Must be completed and signed by the employer group.
2. \_\_\_\_\_ **Tax Returns and Business Documentation** – A copy of the most recent quarterly NYS45-ATT. Please make notations indicating eligible employees (those working a minimum of 20 hrs/week) and ineligible employees (part-time employees working fewer than 20 hrs/week, seasonal employees and other persons not eligible for health insurance).
3. \_\_\_\_\_ If you are submitting enrollment applications for partners or business owners not listed on the NYS 45-ATT, then please submit one of the following:
  - **Partnerships:** a copy of the most recent **1065 K-1** form for all partners showing 100% ownership of the business.
  - **Sole Proprietors:** a copy of the most recent **Schedule C** form
  - **Corporations:** a copy of the most recent **1120C, 1120E or 1120S** form.
  - **Charitable organizations:** **IRS form 990** is required unless exempt from filing tax returns from the IRS, then a copy of the exemption is required.
- Note:** If a business with 2 or more employees has been in operation for less than one year, please provide a copy of the DBA certificate, partnership certificate, certificate of incorporation or other similar tax documentation verifying the business is authentic.
4. \_\_\_\_\_ **Attestation Form** – Must be signed for any newly hired employees, owners, partners or retirees **not** listed on the **NYS 45\_ATT** and all sole proprietors.
5. \_\_\_\_\_ **Subscriber Application Form** – Must be completed and signed by the subscriber.
6. \_\_\_\_\_ **Waiver of Group Coverage Form** – Must be completed by **all** employees **not** taking coverage.
7. \_\_\_\_\_ **Handicapped Dependent Form** (when applicable)
8. \_\_\_\_\_ **For New Groups**, your initial payment must be a check written on the business account and made **payable to Excellus Blue Cross Blue Shield**.
9. \_\_\_\_\_ **Signed Rate Sheet/Benefit Summary** - All pages must be returned. (Must be downloaded from RBA website).
10. \_\_\_\_\_ **Eligibility Policy Form** – Must be completed by all groups.
11. \_\_\_\_\_ **Broker's Letter of Record** – Must be signed and copied onto a piece of your company letterhead.
12. \_\_\_\_\_ **Client Profile** – Must be completed by all new groups.

**Upon completion of all required forms, please mail along with payment to:**

**Nina Shelton  
Rochester Business Alliance  
150 State Street  
Suite 400  
Rochester, NY 14614**

**Phone: 585/256-4644**

**Instructions for Member Firm Information Form**

1. Please fill in the name and address of the member firm. Provide the physical street address. P.O. boxes should be used for billing purposes only.
2. TIN# - the member firm's tax identification number.
3. Describe in general the type of business (i.e. computer software, independent contractor).
4. Indicate the effective date insurance coverage is to begin.
5. Please indicate when the member firm joined the Chamber, Trust or Association.
6. **a.** Enter the total number of all active employees working at the member firm. This number should include owners and employees working at all locations of the company.
- b.** Enter the total number of retirees eligible for coverage. The member firm must have a consistently applied business policy governing retirees and their dependents
- c.** Enter the number of people who have elected continuation of coverage through COBRA or New York State extension.
- d.** Enter the number of active employees not eligible for coverage.

New hires not meeting the member firm's new hire eligibility policy	
Employees working less than 20 hours per week	
Seasonal employees	
Employees covered through a union sponsored health plan	
Total ( <i>Enter this number in 6 d.</i> )	

- e.** Add lines **6a** through **6c**, subtract **6d** and enter total.
- f.** Valid waivers include:
  - Spousal coverage through a commercial carrier
  - Spousal coverage through Tricare
  - Coverage with a parent through a commercial carrier
  - Retiree coverage through a former employer through a commercial carrier
- g.** Subtract the number entered on line **f** from line **e**. (**g = e - f**)
- h.** Enter the total number of eligible employees enrolling in this product.
- i.** To determine member firm participation, divide line **6h** by line **6g**.
7. List the name of the Owner(s)/Partner(s) of the member firm.
8. If yes, please attach a list of the related companies, the locations and the number of eligible employees working at this location.

## Tax Documentation Needed:

- **For member firms with 2 or more employees:** This category also includes businesses with several employees, but only one is eligible for health insurance coverage.
  1. Each Employer with 2 or more employees must provide a copy of their most recent **NYS45-ATT-MN**, with notations indicating eligible employees (those working a minimum of 20 hours per week) and ineligible employees (part-time employees working fewer than 20 hours per week, seasonal employees and other persons not eligible for health insurance).

*Note:* If the Employer's rules require a minimum of more than 20 hours per week in order to be eligible for coverage (e.g., 30 hours), then the notations should be based on the employer's own eligibility rule.
  2. If there are any persons who are proposed for health insurance and ARE NOT listed on the **NYS45-ATT-MN**, the Employer must provide one of the following as documentation that the person works at least 20 hours per week or is otherwise eligible for coverage:
    - (i) for partnerships, a copy of the most recent **1065K-1 for each partner**; OR
    - (ii) for business owners, a copy of the most recent Schedule **K-1** to Form **1120S**, or Schedule **F** to Form **1120F**; OR
    - (iii) the Attestation is for individuals not listed on the **NYS45-ATT-MN**, or for individuals being proposed for coverage when the business is new and has not yet filed a **NYS45-ATT-MN**, work at least 20 hours per week or are otherwise eligible for coverage (e.g., retired, new hires-**W4's** ). The owner or partners of a business should always be listed on the attestation.
  3. If the Employer has been in existence for less than one year, it must provide a copy of its **DBA** certificate, certificate of incorporation, business certificate or receipt of tax ID form.
- **For persons in business alone (sole proprietor).**
  1. Each Employer must provide a copy of their most recent **NYS45-ATT-MN**. If the sole proprietorship does not file the **NYS45-ATT-MN**, it must provide a copy of a pay stub, estimated tax form or other documentation of active employment status.
  2. If the Employer has been in operation for MORE than one year, it must provide a copy of one of the following tax forms: Schedule **C**, Schedule **E**, or **W-2**
  3. If the Employer has been in operation **LESS** than one year, it must provide a business certificate, a **DBA** certificate, OR similar tax documentation that the business is authentic and in operation.
  4. Each Employer must provide a signed Attestation that the sole proprietor or employee works *at least* 20 hours per week in the business.

**Member Firm Information Form**  
**Member Firms with 50 or fewer eligible employees**

(Must be completed by an Employer enrolling in Excellus Health Plan, Inc. Health Insurance)

1. Name and Physical Location of Member Firm \_\_\_\_\_

2. Name, Title and Phone # of Contact Person at Member Employer Group      TIN# \_\_\_\_\_

	(    )	-
Name	Title	Telephone

3. Type of Business \_\_\_\_\_ SIC Code: \_\_\_\_\_

4. Desired effective date of insurance coverage. \_\_\_\_\_

5. The date you became a member of the Association \_\_\_\_\_

If the date in above is more than 30 days prior to the current date, the reason you did not apply for coverage when you initially became a member of the Chamber, Trust or Association \_\_\_\_\_

6. Enrollment Questions (*for detailed instructions see page 2*)
- \_\_\_\_\_ a) Individuals actively working at all locations of the member firm (See Instructions 6a)
  - \_\_\_\_\_ b) Total number of retirees eligible for coverage (if any)
  - \_\_\_\_\_ c) Total number of COBRA / New York State extension participants
  - \_\_\_\_\_ d) Number of active employees **NOT** eligible for coverage (See Instructions 6d)
  - \_\_\_\_\_ e) Total number of eligible employees and retirees (**e = a+b+c-d**)
  - \_\_\_\_\_ f) Number of eligible employees **NOT** taking coverage due to a valid waiver
  - \_\_\_\_\_ g) Total number of net eligibles (**g = e-f**)
  - \_\_\_\_\_ h) Net eligible employees enrolling in this product offering through Excellus BCBS
  - \_\_\_\_\_ i) Group participation percentage (**h÷g**)

7. Name of Owner(s)/Partner(s) \_\_\_\_\_

8. Are you a subsidiary company, or parent company with subsidiary companies? Yes/No

9. Employer Contribution: Medical: Single \_\_\_\_\_% Family \_\_\_\_\_% Other \_\_\_\_\_

Dental: Single \_\_\_\_\_% Family \_\_\_\_\_% Other \_\_\_\_\_

10. See page 3 for required tax documents and attach.

11. 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 20 hours per week.

Signature of Contact Person	Date	Fax Number or E-Mail Address
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Signature of CTA Plan Administrator	Date	<b><u>C</u>hamber, <u>T</u>rust, <u>A</u>ssociation Name</b>
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## ATTESTATION

I, \_\_\_\_\_, the \_\_\_\_\_  
(Name) (Title)  
 at \_\_\_\_\_  
(Name of Employer)

do hereby attest that:

Check which applies

\_\_\_\_\_ Member Firms with 2 or more employees, including businesses with only one employee who is eligible for health insurance coverage. With respect to member firms with 2 or more employees, the following individual(s) *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 Excellus Health Plan, Inc.

Other individuals eligible for coverage can include partners, owners of the business but not technically an employee, and retirees when the consistent policy of the business is to cover retirees.

Include a notation for each person indicating New Employee (**E**) with date of hire, Partner (**P**), Business owner (**O**), Retiree (**R**), or COBRA (**C**).

OR

\_\_\_\_\_ Sole proprietor. 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. \_\_\_\_\_

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 20 hours per week.

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

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



HealthyBlue GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on Back. All Dates = mm/dd/yy [ ] Check if name change [ ] Check if new address

PLEASE PRINT CLEARLY

Form section containing 'CHECK DESIRED ACTION' (Add Subscriber, Add Dependent, Change Coverage, Transfer to COBRA, Cancel Subscriber/Dependent) and 'CHECK PERSON(S) COVERED' (Self, Spouse & Child, Self & Child, Self & Spouse, Self). Includes plan selection options like Copay Option, Copay & Deductible Option, and HDHP Option.

SUBSCRIBER INFORMATION - Must be completed

Form section for subscriber information including Social Security #, Sex, Date of Birth, Last Name, First Name, Street, City, State, Zip, Day Phone, and Email Address.

FAMILY MEMBER INFORMATION - Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.

Form section for family member information with columns for Last Name, First Name, Social Security #, Sex, and Date of Birth for multiple family members.

OTHER COVERAGE INFORMATION

Form section for other coverage information including questions about previous insurance, Medicare status, and other plan details.

RELEASE - You must sign and date this form to be eligible for insurance.

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 \$5,000 and the stated value of the claim for each such violation.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

EMPLOYER INFORMATION (Must be completed by Group Administrator/Representative) \* Dept. # and Employee # is optional.

Was the employee subject to a waiting period before enrolling in your employer health plan? [ ] Yes [ ] No
If yes, what was the start date \_\_\_/\_\_\_/\_\_\_ and end date \_\_\_/\_\_\_/\_\_\_

Table with columns: Coverage (Medical, Dental), Group/Sub Group #, Check digit, Pkg #, Employer Name, Employee Status, Department #, Employee #.

Group Rep Signature/Date: \_\_\_\_\_

## Instructions for completing the Group Enrollment Form

**DESIRED ACTION** Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the Event Date. Please see your Group Administrator for events that fall outside the 30-day period. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

### Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

#### To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

#### Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible	CE - Cobra End Date
PC - Preferred Care	SR - Subscriber Request
CP - Commercial	SD - Subscriber Deceased
CB - Cobra Begin Date	SB - Spouse's BCBSRA
CD - Cobra Disabled Date	MC - Medicaid

#### To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

#### Cancel Dependent Reasons

MA - Marriage	MB - COBRA Begin Date
OA - Dependent Over Age	MR - Subscriber Request
DM - Deceased	DV - Divorce

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.

- |           |             |       |          |                  |
|-----------|-------------|-------|----------|------------------|
| ➤ Address | ➤ Birthdate | ➤ PCP | ➤ OB/GYN | ➤ Medical Center |
|-----------|-------------|-------|----------|------------------|

**DESIRED COVERAGE** All products may not be applicable to your employer group. Please check with your Group Administrator.

#### PCP Information

Blue Choice members must select a **Medical Center OR Primary Care Physician (PCP)**. Females may select an OB/GYN.

#### FAMILY MEMBER AND DOCTOR INFORMATION

Use an additional form, if more than four persons.

##### QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group
  - Unmarried child, natural, adopted or stepchild
  - A full time student (indicate under Relationship)
  - Chiefly dependent on you for support
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.** Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your employer group.

#### RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents).
- I hereby accept responsibility for payment of any portion of the premium.
- I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.
- I understand that this contract is subject to a twelve (12) month waiting period for pre-existing conditions that have existed for a six (6) month period prior to my applying for this benefit, unless prior coverage affords credits for some or all of this time period.
- **BLUE CHOICE**  
I understand that if I have elected a managed care product that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**  
I understand that the Preferred Provider Organization (PPO) coverage is comprised of and in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- **EXCLUSIVE PROVIDER ORGANIZATION (EPO)**  
I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

#### EMPLOYER INFORMATION

This section to be completed and signed by the Employer Group Administrator.  
Complete only the coverage section (Medical/Dental/Vision) that is applicable to the employee's request.

If you have any questions, please contact Customer Service at:  
 Excellus BlueCross BlueShield, Rochester Region (585) 325-3630 or 1-800-847-1200  
 Blue Choice Member Services (585) 454-4810 or 1-800-462-0108

**WAIVER OF GROUP COVERAGE**

Company Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please Check Applicable:**

- I waive my employer's group **health** insurance coverage for myself and my dependents (if any).
- I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).
- I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents.

**Reason for Waiving Coverage - Please Check One:**

- Covered through spouse's employer
- Covered through a parent's employer

Employer Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

- Other reason (explain): \_\_\_\_\_

As a result, I waive my and/or my dependents (if any) eligibility to enroll in my employer's group plan at this time.

I understand that I and/or my dependents may enroll under this plan in the future only; within 30 days of involuntarily loss of other group coverage; or, at the time of my employer's open enrollment.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SMALL GROUP ENROLLMENT UNIT ELIGIBILITY WAITING PERIOD POLICY

Please complete **Section I** if policy is different from the Chamber, Trust or Association.

**OR**

Complete **Section II** if following the Chamber, Trust or Association policy.

### **Section I**

Member Firm Name: \_\_\_\_\_

Member Firm's waiting period for eligibility for health insurance is:

- Date of Hire
- First of the month following date of hire
- First of the month following 30 days of employment
- First of the month following 60 days of employment
- First of the month following 90 days of employment
- First of the month following 6 months of employment
- Other (must select between 0 days and 365 days) \_\_\_\_\_

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: \_\_\_\_\_

Minimum hours worked per week to be eligible for coverage is:

- 20
- 30
- 40
- Other: \_\_\_\_\_

(Minimum of 20 hours / Maximum of 40 hours)

### **Section II**

To be completed by the Chamber, Trust, Association:

Chamber, Trust, Association Name: \_\_\_\_\_

Eligibility Waiting Period: \_\_\_\_\_

Minimum hours worked per week to be eligible for coverage: \_\_\_\_\_

Date

Caitlin Hryzak  
Broker Program Manager  
Excellus Blue Cross Blue Shield  
165 Court Street, 2N  
Rochester, NY 14647

**Re: Broker of Record Letter**

Dear Caitlin:

This is to notify you that our company has appointed Nina Shelton, whose business address is 150 State Street, Rochester, NY 14614 as our sole insurance representative, with respect to coverage provided to this organization by Rochester Business Alliance effective \_\_\_\_\_.

I understand that if our company elects to purchase coverage from your company that Rochester Business Alliance may be entitled to base and/or bonus compensation for our business.

The designation will remain in effect until we notify Rochester Business Alliance in writing to the contrary.

Sincerely,

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

\_\_\_\_\_  
Print Officer Name

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



**Client Profile**

Please fill in all areas. If a question does not apply, write in N/A. Thank you for taking the time to fill out this questionnaire.

**GENERAL INFORMATION**

Name of Business \_\_\_\_\_

Mailing Address \_\_\_\_\_

BlueCross BlueShield Group No. \_\_\_\_\_

Type of Business \_\_\_\_\_ Owner/CEO \_\_\_\_\_

Website Address \_\_\_\_\_

Group Representative \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

Email Address \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

Benefit Decision Maker \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

**UNION INFORMATION**

Total Number of Union Employees \_\_\_\_\_ Name of Union \_\_\_\_\_

Union Contact Person \_\_\_\_\_ Telephone Number \_\_\_\_\_

**CONTRIBUTION STRATEGY**

Do you contribute to the medical coverage?  Yes  No

Medical Contribution Single \_\_\_\_\_ Family \_\_\_\_\_

Do you contribute to dental coverage?  Yes  No

Dental Contribution Single \_\_\_\_\_ Family \_\_\_\_\_

If contribution is based on a specific product or is unique, please explain briefly  
\_\_\_\_\_



**Client Profile (cont.)**

**OTHER PLAN OFFERINGS**

Do you have a Flexible Benefit/Cafeteria Plan     Yes                       No

If yes, type of plan:

Pre-Tax Premium (POP)     Flexible Spending Account (FSA)                       Full Cafeteria Plan

Administrator of Plan \_\_\_\_\_

Do you offer medical, dental, vision or Rx coverage through another Insurance Carrier?

Yes                       No

If you answered yes, please provide the following information.

Name of Carrier \_\_\_\_\_

Name of Plan \_\_\_\_\_

Plan deductible    Single \_\_\_\_\_ Family \_\_\_\_\_

Plan coinsurance \_\_\_\_\_

Office Visit copay \_\_\_\_\_

Inpatient hospitalization copay or coinsurance \_\_\_\_\_

Student/Dependent coverage ages \_\_\_\_\_

Domestic Partner Benefits                       Covered                       Not Covered

Prescription Drug Plan \_\_\_\_\_

Rating Tier                       2 Tier                       3 Tier                       4 Tier                       5 Tier

**The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed about is true and complete.**

Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return questionnaire to:  
Excellus BlueCross BlueShield, Rochester Region  
165 Court St  
Rochester, New York 14647  
Ph: 1-877-872-9308  
Fax: (585) 327-7512