BlueCross BlueShield of New Mexico

Group Transmittal

To be submitted with the Group Application

Policyholder _____ **Group Number** _____

1. Contact Information

Administrative Contact (Daily Administration) _____ Fax Number _____

Phone Number - Administrative Contact _____ Email Address _____

Group Administrator (Plan changes, etc.) _____ Email Address _____

Billing Contact (Billing Issues) _____ Email Address _____

Billing Address _____

City _____ State _____ Zip _____

2. Benefits & Eligibility - As indicated in your proposal.

Waiting Periods *Subject to the actively at work provision contained in your proposal*

New Hires: _____ ☐ Days ☐ Months ☐ Years

Do you have any current employees that need to fulfill the waiting period: ☐ Yes ☐ No

Employees are effective*:

- ☐ 1st day of the insurance month following completion of the eligibility waiting period
- ☐ The day following completion of the eligibility waiting period
- ☐ Other _____

Does any class have a different waiting period: ☐ Yes ☐ No

If YES, Please describe in Special Request Section

Does the waiting period apply to all coverages: ☐ Yes ☐ No

If NO, Please describe in Special Request Section

** If medical underwriting is required, an individual's coverage will not take effect until the date the application is approved. The effective date will be delayed for an employee who is not actively at work for a dependent whose activities are limited due to sickness or injury on the date coverage would otherwise take effect.*

Minimum Hours _____ (standard is 30 hours per week)

Annual Enrollment

☐ Life / AD&D / Accident / Critical Illness / Disability and/or Vision From _____ To _____ ie: (9/1 to 9/30)

☐ Dental From _____ To _____ ie: (9/1 to 9/30)

☐ Not Applicable

Prior Credit For Rehires

Is there prior employment credit for rehired employees? ☐ Yes ☐ No

If YES, credit will be given for employees rehired within **6 months**, unless otherwise approved by The Company.

Does the credit for rehires apply to all coverages: ☐ Yes ☐ No

If NO, Please describe in Special Request Section

Other

Do you have any Canadian Employees that work in the United States: ☐ Yes ☐ No

Do you intend to cover any US Citizens working outside of the United States: ☐ Yes ☐ No

Do you intend to cover any non-US citizens who work within the United States: ☐ Yes ☐ No

Basic Dependent Life Policyholder will contribute: ☐ NA ☐ Other ☐ 0%; or _____ **%**

Spouse Premium If applicable, calculate spouse premium: ☐ Based on Employee Date of Birth ☐ Based on Spouse Date of Birth

Definition of Earnings

☐ As stated in the proposal

☐ *Other _____

**If "Other" is selected, underwriting approval is required and the proposed rates are subject to change.*

Policyholder _____ **Group Number** _____

3. Group Administration

Certificates Email policy documents and certificates to:

☐ Group Administrator ☐ Administrative Contact ☐ Billing Contact

☐ Broker _____ ☐ Other _____

☐ Other _____ ☐ Other _____

Disability/Accident Coverage If the employee pays all or a portion of the premium, how is it paid: ☐ Pre-Tax ☐ Post-Tax ☐ Not Applicable

For STD Coverage: ☐ Benefits begin after sick leave, vacation, salary, PTO end ☐ Benefits begin immediately after the STD elimination period

Do all eligible employees participate in Social Security: ☐ Yes ☐ No If No, Explain _____

Do all eligible employees participate in Medicare: ☐ Yes ☐ No If No, Explain _____

Mailing Address for Sick Pay Reports: _____

Form 5500, Schedule A Does this group have 100 or more eligible employees: ☐ Yes ☐ No

If YES, what is the benefit plan month, day, and year _____

Information will be sent to the Group Administrator as listed in Section1 above, unless otherwise state below.

4. Billing

Billing Options for groups with:

2-149 Lives	☐ List Billed Only	(We will provide an electronic bill with each employee's cost itemized with an option to pay on-line)
150-499 Lives	☐ List Billed	(We will provide an electronic bill with each employee's cost itemized with an option to pay on-line)
	☐ Self Administered, Paper	(You provide to us the number of lives, volume, and premium by coverage, on a monthly basis.)
500+ Lives	☐ Self Administered, Paper	(You provide to us the number of lives, volume, and premium by coverage, on a monthly basis.)

*Note: Dental coverage is always List Billed regardless of size.

Billing Set Up *For List Billing Only*

☐ **Alphabetically** You will receive **one bill,** with one total. Employees will be listed alphabetically.

☐ **By Account*** You receive **multiple bills.** Employees are separated by accounts. You can pay with multiple checks.

☐ **By Location*** You receive **one bill**, with subtotals and a grand total. Employees are separated by locations.

*Please indicate billing divisions on the enrollment census. Also include additional billing addresses in the special requests section of this form

Billing Method ☐ **Monthly** ☐ **Quarterly**

Premium is payable on the first of the month unless mutually agreed upon otherwise and explained in the special requests section of this form

☐ **Third Party Benefits Administration**

Third Party Benefits Administration means the Policyholder chooses or contracts with a vendor to provide services which may include enrollment administration, billing and/or premium collection of the products requested in the Group Application.

If you use a third party benefits administrator, please complete a Policyholder Vendor Authorization and Change Form and submit the signed form along with the completed Group Transmittal and Group Application.

5. Special Requests - Attach additional pages if needed.

Policyholder _____ **Group Number** _____

6. ERISA (SPD)

Applicant is subject to ERISA?* ☐ Yes ☐ No

If this plan is an "employee welfare plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq*., as amended("ERISA"), it is subject to certain requirements including those relating to reporting and disclosure and fiduciary responsibility. The plan must be established and maintained pursuant to a written instrument that designates a plan administrator, as defined in Section 3(16)(A) of ERISA, who has authority to control and manage the operation and administration of the plan.

You, as the plan Administrator or authorized representative, have selected us as the claims administrator of your plan, and you consent to the delegation of such authority to us. You acknowledge that, in some instances, we may delegate some or all of this authority to a third party administrator serving as the claims administrator and you consent to the delegation of such authority to a third party administrator.

We cannot be named as the plan administrator and is not responsible for the compliance of your plan with respect to any legal or tax matters, and it cannot offer any legal or tax advice. You are responsible for compliance with all applicable laws, including benefits, employment, and tax laws, relating to the sponsorship and administration of your plan. Our obligations to you are governed solely by the terms of the applicable policy provisions, except as otherwise required by law.

ERISA requires the distribution of SPD's for the majority of employee benefit plans. If as plan administrator of your employee benefit plan, you would like us to provide you with the required documents to create your plan's SPD, including certain additional documents such as a Statement of ERISA Rights and Claims Procedure, please indicate "Yes" and provide the following information:

☐ Yes ☐ No If Yes, provide the following: Plan Year Ends Annually On (Month/Day)* _____

Plan Number assigned to each line of coverage: (will be 3 digits starting with "5")**

Life/AD&D _____ STD _____ LTD _____ Dental _____ AD&D _____ Vision _____

Vol STD _____ Vol LTD _____ Vol Dental _____ Vol Life _____ Accident _____

Critical Illness _____ Vol Vision _____ Vol AD&D _____ Vol Accident _____ Vol Critical Illness _____

Plan Administrator** (Address cannot be a P.O. Box)

☐ Same as Policyholder ☐ Other, complete below

Name/Title _____ Phone _____

Address _____ City _____ State _____ Zip _____

Agent for Service of Process if different from plan administrator** (Address cannot be a P.O. Box)

Name/Title _____ Phone _____

Address _____ City _____ State _____ Zip _____

Plan Trustees (if applicable)** (Address cannot be a P.O. Box)

Name/Title _____ Phone _____

Address _____ City _____ State _____ Zip _____

Union Contracts/Collective Bargaining Agreements (if applicable): _____

**If you are not certain whether your plan is governed by ERISA, please visit the Department of Labor website for more information at: http://www.dol.gov/dol/topic/health-plans/erisa.htm **Required Fields*

7. Broker Authorization for Group Changes

☐ I authorize the Broker of Record, including any subsequently named Broker of Record, to submit policy change requests on our behalf for the policy contracts identified under the Group Policy Number above. I also agree that the policy change requests will not become effective until approved. It is also agreed to implement or revoke this consent, the Policyholder must submit a request in writing to Blue Cross Blue Shield of New Mexico, Attn: Policy Administration, 701 East 22nd Street, Lombard, IL 60148. This consent will not become effective until it is received by us and shall remain in effect until we receive revocation of the authorization in accord with the above.

8. Signature - This section must be signed.

_____ _____

Group Administrator's Signature (or other employee authorized to make plan changes) Date

_____

Typed or Printed Name

Dearborn Life Insurance Company

Application for Group Insurance

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

☐ New Application ☐ Change Group #: _____ Federal Tax ID #: _____

Section 1. POLICYHOLDER INFORMATION: Please Type or Print All Information.

Policyholder (full legal name): _____

Address (not PO box): _____

City: _____ State: _____ Zip: _____

Subsidiaries or Affiliates to be covered: ☐ Yes; or ☐ No (If more than one, indicate on separate sheet and attach to this application)

If Yes: Company Name: _____

Address (not PO box): _____

City: _____ State: _____ Zip: _____

Premium is payable on the first of the insurance month unless mutually agreed upon by the Policyholder and the insurance company.

Section 2. GENERAL INFORMATION:

Product Choice (Check all that apply)	**Policyholder will contribute:**	**Requested Effective:**	***Replacing Coverage Yes/No:**
☐ Group Term Life ☐ AD&D:	☐ 100%; or ☐ Other: _____ %		
☐ Supplemental Life ☐ AD&D:	☐ 0%; or ☐ Other: _____ %		
☐ Group Dental:	☐ 100%; or ☐ Other: _____ %		
☐ Group Short-Term Disability (STD):	☐ 100%; or ☐ Other: _____ %		
☐ Group Long-Term Disability (LTD):	☐ 100%; or ☐ Other: _____ %		
☐ Group Stand Alone AD&D:	☐ 100%; or ☐ Other: _____ %		
☐ Group Critical Illness:	☐ 100%; or ☐ Other: _____ %		
☐ Group Accident:	☐ 100%; or ☐ Other: _____ %		
☐ Group Vision:	☐ 100%; or ☐ Other: _____ %		
☐ Voluntary Term Life ☐ AD&D:	☐ 0%; or ☐ Other: _____ %		
☐ Voluntary Group Dental:	☐ 0%; or ☐ Other: _____ %		
☐ Voluntary Short-Term Disability (VSTD):	☐ 0%; or ☐ Other: _____ %		
☐ Voluntary Long-Term Disability (VLTD):	☐ 0%; or ☐ Other: _____ %		
☐ Voluntary Stand Alone AD&D:	☐ 0%; or ☐ Other: _____ %		
☐ Voluntary Group Critical Illness:	☐ 0%; or ☐ Other: _____ %		
☐ Voluntary Group Accident:	☐ 0%; or ☐ Other: _____ %		
☐ Voluntary Group Vision:	☐ 0%; or ☐ Other: _____ %		

***Enclose a copy of each in force policy to be replaced.**

Section 3. POLICYHOLDER STATEMENT:

The Policyholder or authorized representative (Policyholder) applies for a group insurance policy(s) through Dearborn Life Insurance Company.

The Policyholder represents and certifies that:

1. This application must be approved in writing by Dearborn Life Insurance Company. Issuing the insurance policy is evidence of approval. Coverage for insureds under the group policy is effective when the insured applies and is approved for coverage by Dearborn Life Insurance Company. The Policyholder will not collect premium from an insured who requires medical underwriting until Dearborn Life Insurance Company approves the insured's application for coverage; and
2. Dearborn Life Insurance Company will issue a policy only if Dearborn Life Insurance Company decides that the group is an acceptable risk based on Dearborn Life Insurance Company's underwriting practices and procedures; otherwise Dearborn Life Insurance Company has no liability except to refund premium. The Policyholder must return to individual insureds any part of the premium paid by those insureds; and
3. The premium rates are contingent, based on the accuracy of insured eligibility data given to Dearborn Life Insurance Company by the Policyholder. Misstatements on an insured's application or failure by the Policyholder or insured to report new medical information before an insured's effective date of coverage may cause a change to the coverage or premium rate as of the policy effective date; and
4. The Policyholder and insureds are subject to all the policy terms and provisions and trust agreements, if applicable. They may be amended from time to time; and
5. If the Policyholder does not collect or pay premiums by the premium due date, the policy will terminate at the end of the policy's grace period; and
6. Even with the purchase of a disability policy, the Policyholder may be required to buy disability coverage under a state disability benefit act or law; and
7. The Policyholder will: a) send Dearborn Life Insurance Company applications of individual insureds prior to the eligibility date; b) give certificates to all insureds; c) report changes in the insured group to Dearborn Life Insurance Company; and d) keep records of insured eligibility.
8. The information given and statements made on this application are complete and correct. Misstatements or omissions of information may affect the validity of any insurance policy issued and cause the denial of an otherwise valid claim.
9. Statements made by the Policyholder are representations and not warranties. No statement made by any insured will be used in any contest unless a copy of the instrument containing the statement is or has been given to the insured or, in case of death or incapacity of the insured, to his beneficiary or personal representative.

This application and the payment of premium are consideration for any master policy and certificates issued. This application is part of any insurance policy issued. The authorized signature on this application is acceptance of the policy terms.

Authorized Signature	Date (Must be signed prior to Effective Date)
Print Name and Provide Title	Licensed Resident Agent (if required)

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss, or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

BlueCross BlueShield of New Mexico

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Maryland: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR APPLICATIONS ONLY:

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

BlueCross BlueShield of New Mexico

FICA Tax/W-2 Agreement

Administrative Office: Lombard, Illinois
Fax (312) 946-3564

Request Effective with Tax Year: W-2: _____ (current or future tax year)

FICA Match: _____ (New group - current or future tax year) (Existing group - future tax year only)

Employer Name: _____ Telephone Number: _____

Contact Person: _____ Fax Number: _____

Employer Tax ID Number (EIN): _____ E-mail address: _____

Group Policy Number(s): _____

This Agreement Applies to:

☐ **Both STD and LTD** ☐ **Long Term Disability Only** ☐ **Short Term Disability Only**

A. W-2 Options for disability income benefits ("sick pay") - Choose Option 1 or Option 2:
W-2 Option may be selected up to November 15th of the current tax year.

☐ **OPTION 1. Insurer prepares W-2 statements for payees and files Federal and State information returns reporting sick pay.**

Employer hereby designates Insurer as its agent for the sole purpose of providing W-2 statements with sick pay information to payees by January 31st of each year, or such other date required by the Internal Revenue Service, and for making information return filings in accordance with Federal and State requirements regarding income tax, social security and Medicare tax. Insurer will use its EIN number on each of these forms. Employer is responsible for providing Insurer with all information necessary for Insurer to file timely and correct statements and returns, including the information necessary to determine the taxable portion of sick pay. The employee contributions made with after tax dollars will determine what portion of sick pay, if any, is excludable from employee's gross income. If Policy terminates, Insurer will continue to provide W-2 statements and make information return filings for sick pay payments on all claims incurred prior to termination of Policy.

NOTE: We will issue W-2's on a continuous basis, until notified differently by the Employer.

☐ **OPTION 2. Insurer DOES NOT prepare Form W-2 statements for payees and Federal and State information returns reporting sick pay.** If this option is chosen, Insurer will provide Employer by January 15th of each year with the information required by Federal law for Employer to prepare W-2s for its employees and file Federal and State information returns.

B. Employer FICA Options with respect to Employer's share of Social Security and Medicare taxes:
FICA Match Option can be selected as of your policy effective date for new groups. If you are an existing group, FICA Match Option can only be selected as of January 1st of the future tax year.

☐ **STANDARD. Employer retains responsibility for paying the Employer's share of Social Security and Medicare taxes.** Insurer will provide Employer with reports containing these amounts on a quarterly basis.

☐ **OPTION 1. Insurer pays the Employer's share of Social Security and Medicare taxes and deposits the taxes using the Insurer's EIN.** Employer will not be required to reimburse the Insurer for these amounts. Employer understands that the Employer FICA Match service will result in an increase of premium. If this Option is selected, the Insurer must prepare W-2 statements. Employer must select Option 1 in Section A.

C. General Sick Pay Reporting Requirements

Employer is responsible for providing Insurer with accurate information, including total wages paid employee during the calendar year, the last date the employee worked, and the employee contribution percentage of sick pay premium and whether these contributions were paid with BEFORE or AFTER tax dollars.

Insurer will notify Employer of the payments on which employee taxes were withheld. A weekly report will be sent to the Employer within the time required for Insurer's deposit of these amounts. Quarterly and Annual reports will also be sent to the Employer. Insurer will withhold and make timely deposits of employee Social Security and Medicare taxes.

Under no circumstances does Insurer assume any responsibility for Employer's portion of FUTA taxes or any other payroll or employment related tax, fee, premium or the like, including State disability insurance, State or local occupational tax or any Workers' Compensation tax which may be applicable to the sick pay.

Insurer agrees to withhold and deposit Federal income tax as required by the IRS or as requested by the employee on Federal W-4S form.

This Agreement will continue until replaced by a new Agreement, the Policy terminates and/or sick pay payments are discontinued. This Agreement replaces any prior dated Agreements.

COMPLETED BY - EMPLOYER:

Print Name: _____ Signature: _____

Title: _____ DATE _____

Email: _____