

**ND**

Blue Cross Blue Shield of North Dakota is an independent licensee of the  
Blue Cross Blue Shield Association

Blue Cross Blue Shield of North Dakota (BCBSND)  
Return form to: BCBSND Representative

## Group Master Application – for Group Size 2-50

Please submit a complete and accurate application to our office **by the 15th of the month prior to the requested effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate page.

Requested Effective Date \_\_\_\_\_

Group Number 

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

### SECTION A – GROUP NAME & ADDRESS

Group's Legal Name:  
(should match the full legal name used on state business registry)

Is the group Doing Business As (DBA) another name? ☐ No ☐ Yes – If yes, enter DBA name below:

Name to be used by BCBSND: ☐ Legal ☐ DBA

City of Business Headquarters

State of Business Headquarters

Federal Tax ID Number (EIN)

#### Address (physical address required)

Physical Address (no PO Box or Private Mailbox)

City

County

State

ZIP

Mailing Address (if different from physical)

City

County

State

ZIP

### SECTION B – CONTACT INFORMATION

#### 1. Executive Contact (President, Owner, etc.)

Name Phone (area code required)  
Ext.

Title Email

#### 2. Group Administrator

Name Phone (area code required)  
Ext.

Title Email

**3. Employer Center** – Access group information any time using the Employer Center online portal. Provide contact information for the primary Employer Center user account below. **If selecting BCBSND Online Enrollment, digital invoices, or to set up ACH Pull payment options, access to Employer Center is required.** An email will be sent to this user with registration instructions once the group setup is complete. Once the Primary user is set up, they can appoint secondary users directly through Employer Center.\*

\*The Primary Employer Center contact may not be a producer or employee of a producer.

Primary User Name Phone (area code required)  
Ext. Email



**SECTION C – BILLING INFORMATION**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      |                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------|------------------------------------------------------|--|
| <b>1. Billing Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |        |      |                                                      |  |
| Billing Address (if different from mailing)                                                                                                                                                                                                                                                                                                                                                                                                              |        |      | Contact Name (if different from group administrator) |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      | Title:                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      | Phone (area code required): Ext.                     |  |
| City:                                                                                                                                                                                                                                                                                                                                                                                                                                                    | State: | ZIP: | Email:                                               |  |
| Payment Method (for ACH Pull, you will be contacted once your group setup is complete):<br><input type="checkbox"/> ACH Pull <input type="checkbox"/> ACH Push                                                                                                                                                                                                                                                                                           |        |      |                                                      |  |
| <b>2. Additional Billing Information</b> – Complete only if there is more than one billing address. If you have more than two billing locations, submit that billing information on another page.                                                                                                                                                                                                                                                        |        |      |                                                      |  |
| Billing/Business Name:                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                                      |  |
| Billing Address                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      | Contact Name:                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      | Title:                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      | Phone (area code required): Ext.                     |  |
| City:                                                                                                                                                                                                                                                                                                                                                                                                                                                    | State: | ZIP: | Email:                                               |  |
| Payment Method (for ACH Pull, you will be contacted once your group setup is complete):<br><input type="checkbox"/> ACH Pull <input type="checkbox"/> ACH Push                                                                                                                                                                                                                                                                                           |        |      |                                                      |  |
| <b>3. Digital Invoices Only</b> – You will be able to access PDF and Excel versions of invoices via the Employer Center portal. We will send you an email each month notifying you that digital invoice(s) are available to download. Please provide contact information in Section B #3 for the person(s) you want to receive Employer Center digital invoice notices.<br><input type="checkbox"/> Check the box if you wish to receive paper invoices. |        |      |                                                      |  |
| <b>4. Third Party Administrator</b> – Complete only if a Third Party Administrator (TPA) is used.                                                                                                                                                                                                                                                                                                                                                        |        |      |                                                      |  |
| TPA Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |      |                                                      |  |
| Address                                                                                                                                                                                                                                                                                                                                                                                                                                                  |        |      | Contact Name:                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      | Title:                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |      | Phone (area code required): Ext.                     |  |
| City:                                                                                                                                                                                                                                                                                                                                                                                                                                                    | State: | ZIP: | Email:                                               |  |
| Does the group use this TPA for COBRA administration? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>If yes: Will the TPA submit COBRA enrollment/disenrollment directly to BCBSND? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Will invoices for COBRA participants go to the TPA address listed? <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                 |        |      |                                                      |  |

**SECTION D – PRODUCER INFORMATION**

|                                                                                           |                   |                       |
|-------------------------------------------------------------------------------------------|-------------------|-----------------------|
| <b>1. Primary Producer</b>                                                                |                   |                       |
| Producer's Name                                                                           | Producer's Agency | Producer's NPN Number |
| <b>2. Secondary Producer</b> (if no secondary producer, skip to next section)             |                   |                       |
| Producer's Name                                                                           | Producer's Agency | Producer's NPN Number |
| Commission Split – Medical:      Primary Producer: _____%      Secondary Producer: _____% |                   |                       |
| Commission Split – Dental:      Primary Producer: _____%      Secondary Producer: _____%  |                   |                       |

**SECTION E – GROUP INFORMATION**

|                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                      |                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|-----------------------|
| <b>1. General Information</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                      |                       |
| SIC Code                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Industry Description | Date Business Started |
| Type of Business (if LLC/LLP, choose the option that matches how the business files with the IRS):<br><input type="checkbox"/> S-Corp <input type="checkbox"/> C-Corp <input type="checkbox"/> Trust <input type="checkbox"/> Sole Proprietorship<br><input type="checkbox"/> Partnership <input type="checkbox"/> Nonprofit/Religious Org <input type="checkbox"/> Public/Govt Entity <input type="checkbox"/> Other _____ |  |                      |                       |



**SECTION E – GROUP INFORMATION**

Does the group have any affiliated businesses or is the group part of an affiliated service group as defined under section 414 of the Internal Revenue Code? Affiliated businesses may include parent-subsidiary, brother-sister, or the combination of such affiliations that constitute a control group under the Internal Revenue Code. ☐ No ☐ Yes – Enter name(s) of affiliated businesses:

Current Medical Carrier

Current Dental Carrier

Will the group offer other coverage to its eligible employees?

Medical: ☐ No ☐ Yes – If yes, then the group is not eligible for group medical coverage with BCBSND.Dental: ☐ No ☐ Yes – If yes, then the group is not eligible for group dental coverage with BCBSND.

**2. Deductible and Out of Pocket Accumulators** – To credit amounts accumulated from the prior carrier, confirm if amounts accumulated on the basis of a calendar year (January - December) or a plan year (matching your contract renewal period, e.g., renewal month is April, accumulation starts April 1 and ends March 31).

**Note:** BCBSND deductible and out of pocket amounts accumulate on the basis of a calendar year.

Under the prior carrier, deductible and out of pocket amounts accumulated on the basis of a:

☐ calendar year.☐ plan year. Enter dates for the plan year accumulators with prior carrier: \_\_\_\_\_☐ not applicable (no prior group policy)

**3. COBRA** – Applies if group employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (excluding church and federal government groups). You may count a part-time employee as a fraction of a full-time employee.

Is the group subject to COBRA? ☐ No ☐ Yes

**4. ERISA** – Applies to most groups other than church and government entities.

Is the group subject to ERISA? ☐ No ☐ YesIf yes, does ERISA plan year differ from your renewal date? ☐ No ☐ Yes, when does the plan year begin (MM/DD): \_\_\_\_\_

**5. OBRA** – Applies if group employed 100 or more employees (full-time and/or part-time) for at least 50% of the workdays of the preceding calendar year.

Is the group subject to OBRA? ☐ No ☐ Yes

**6. TEFRA/DEFRA** – Applies if group employed 20 or more employees (full-time and/or part-time) for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.

Is the group subject to TEFRA/DEFRA? ☐ No ☐ Yes

If status has changed in the last year, date of change: \_\_\_\_\_

**7. Employee Counts for Affordable Care Act (ACA) Requirements** – ACA requires us to record the group's (including all affiliates') average number of employees for the preceding **completed** calendar year. This count includes the following local & worldwide employees: full-time, part-time, seasonal, union workers, as well as business owners, corporate officers, and partners if they are also employees. The count does **not** include contracted 1099 individuals or non-employees. If the employer did not exist for the entirety of the preceding calendar year, estimate the average number of employees in the current calendar year.

Average number of employees (for ACA) was \_\_\_\_\_ in the preceding **completed** calendar year 20 \_\_\_\_\_.

**8. Employee Count of Non-residents** – Count of eligible employees outside the state. Active employees residing in the state of Hawaii are not eligible for medical coverage.

|                     |  |  |  |  |  |
|---------------------|--|--|--|--|--|
| State               |  |  |  |  |  |
| Number of Employees |  |  |  |  |  |

**SECTION F – ADMINISTRATION**

**1. Eligibility** – Group level changes may only be made at renewal.

Provide the minimum number of hours employees are required to work per week to be eligible for coverage under this plan: \_\_\_\_\_ (must be at least 30 hours\*)

\*A minimum of 20 hours may be entered by agreement between the carrier and employer. Refer to Underwriting guidelines.

Will the group include coverage for domestic partners? ☐ No ☐ Yes

**SECTION F – ADMINISTRATION (continued)**

- 2. Employee Classes and Probationary Period** – A probationary period may not be waived or altered for a particular employee. Before adopting different probationary periods by employee class (hourly, salaried, etc.), consider seeking tax and/or legal advice. Premiums will be prorated for coverage effective dates other than the 1<sup>st</sup> of the month.
- Probationary period fulfillment is based on days, not months. For example, an employee hired on February 1st with a first of the month following 30 days probationary period would be eligible April 1st because February has less than 30 days.

List classes below (if one class, make selection on line 1), then select an option indicating when coverage is effective.

| Class Name(s) (account for all eligible employees) | 1 <sup>st</sup> of the month following: |                          |                          | On the actual:           |                          |
|----------------------------------------------------|-----------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                                    | Date of hire**                          | 30 days                  | 60 days                  | Date of hire             | 90 <sup>th</sup> day     |
| 1                                                  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2                                                  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3                                                  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

\*\*If choosing “1<sup>st</sup> of the month following the date of hire,” employees hired on the 1<sup>st</sup> of the month are effective on the:

- ☐ date of hire.  
☐ 1<sup>st</sup> of the next month.

Part-time employees transferring to full-time will start their probationary periods on the:

- ☐ original hire date (retroactive).  
☐ date the employee transfers to full-time hours.

Will the group waive the probationary period on initial enrollment (new groups only)? ☐ No ☐ Yes

**3. Premium Contribution**

**Medical:** The group must have a minimum employer contribution of 50 percent of the individual premium.

**Dental:** The group must have a minimum employer contribution of 50 percent of the individual premium.

Specify the contribution amount for each class below. Must be at least 50% of the individual premium.

|         | Medical/Vision |           | Dental   |           |
|---------|----------------|-----------|----------|-----------|
|         | Employee       | Dependent | Employee | Dependent |
| Class 1 | %              | %         | %        | %         |
| Class 2 | %              | %         | %        | %         |
| Class 3 | %              | %         | %        | %         |

**4. Minimum Participation Requirements (after consideration of valid waivers)**

**Medical:** At least 70% of eligible employees must enroll.

**Dental:** Groups with 3 to 10 eligible employees: 100% must enroll. Groups with 11+ eligible employees: At least 70% must enroll.

At the time of the application, the group represents that:

|                                                                                       |       |
|---------------------------------------------------------------------------------------|-------|
| A. Number of employees on payroll plus working owners (excluding COBRA participants*) | (A)   |
| B. Minus individuals not eligible: working fewer than the minimum hours               | – (B) |
| C. Minus individuals not eligible: still serving new-hire probationary period         | – (C) |
| D. Minus individuals not eligible: seasonal, substitute or temporary                  | – (D) |
| E. Minus individuals not eligible: contracted 1099 individuals                        | – (E) |
| F. Equals the subtotal number of eligible employees                                   | = (F) |

Use subtotal (F) to continue calculations for Medical and Dental.

|                                                                                                                                             | Medical | Dental |
|---------------------------------------------------------------------------------------------------------------------------------------------|---------|--------|
| G. Minus employees waiving with other qualifying coverage                                                                                   | – (G)   | – (G)  |
| H. Equals number of employees eligible to enroll                                                                                            | = (H)   | = (H)  |
| I. Minus employees declining (no other qualifying coverage)                                                                                 | – (I)   | – (I)  |
| J. Equals number of employees enrolling                                                                                                     | = (J)   | = (J)  |
| K. Participation percentage (J divided by H)                                                                                                | %(K)    | %(K)   |
| L. Number enrolling on COBRA*                                                                                                               | (L)     | (L)    |
| M. Number of former and current employees and/or dependents presently eligible for COBRA* for whom election and payment is not yet received | (M)     | (M)    |

\*Refers to both COBRA and non-COBRA continuation of coverage participants.

Does the group offer an Individual Coverage Health Reimbursement Arrangement (ICHRA) to a class or classes of employees?

- ☐ No ☐ Yes



**SECTION F – ADMINISTRATION (continued)**

**5. Special Annual Enrollment Period (not applicable to Dental)** – If required by law (and subject to the law's required terms), small groups that do not meet minimum contribution and/or participation rules will be offered a special annual enrollment period for a January 1st effective date.

**6. Enrollment Method**

☐ BCBSND Online Enrollment\*\*† ☐ BCBSND Paper Enrollment Forms

\*If choosing “**BCBSND Online Enrollment**,” will the group allow employees to enroll themselves? ☐ No ☐ Yes

†By selecting “**BCBSND Online Enrollment**,” you will be processing your own eligibility, (enrollments, maintenance updates, changes and disenrollment) directly into the BCBSND Online Enrollment System.

**7. Health Savings Account (HSA)** – Complete only if a BCBSND HSA-eligible healthplan will be offered.

BCBSND offers integration with HealthEquity, an HSA Administrator. This integration allows HealthEquity to automatically set up health savings accounts for each employee enrolled on a BCBSND HSA-eligible healthplan who has chosen to participate.

Will the group elect HealthEquity to administer its health savings accounts?

☐ No ☐ Yes – Who will pay the monthly fee? ☐ Employer ☐ Employee

**SECTION G – ACKNOWLEDGMENTS AND CERTIFICATIONS**

If you have any questions about the benefits and services that are covered, provided, limited, or excluded under the group coverage(s) to which this application applies, please contact your Sales Representative before signing this application.

**Note:** “The Company” as used here means the group applying for coverage as indicated in Section A – Group Name & Address of this application.

I certify that I am duly authorized to execute this application on behalf of the Company, and that the Company:

- a) Applies for the group coverage(s) selected in the signed rate and benefits page(s).
- b) Authorizes any person or other entity to release to Blue Cross Blue Shield of North Dakota (BCBSND) any information requested by BCBSND in connection with this application's processing.
- c) Acknowledges that, where permitted by law, BCBSND may choose not to approve this application and any premium deposit will be returned if the application for group coverage(s) is not approved.
- d) Acknowledges that coverage is not in effect until BCBSND accepts this application, establishes an effective date of coverage, and issues the group contract(s) to the Company.
- e) Acknowledges that, if it is approved by BCBSND, this application will form a part of the group contract(s) issued by BCBSND and agrees that the Company will be bound by the terms and conditions of the entire group contract(s).
- f) Acknowledges that eligibility standards (e.g., waiting period, dependent eligibility, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.
- g) Acknowledges that it has selected the group coverage(s) to be offered to its employees, that its selection of this group coverage(s) was based upon written information provided by BCBSND, and that no broker, producer, or consultant was or is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.
- h) Agrees to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to BCBSND for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide BCBSND, upon its request, verifications of employee participation levels.
- i) Agrees that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of BCBSND, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.
- j) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.
- k) Agrees to deliver, or otherwise make available to enrollees, all BCBSND paper or online member documents and other coverage-related materials upon request by BCBSND.
- l) Certifies that all forms and processes, electronic or otherwise, used by the group for enrollment purposes, other than those provided directly by BCBSND, are in compliance with all applicable state guidelines and regulations and/or have been provided to the state insurance regulator for approval prior to use.
- m) Agrees to make all coverage options available to all eligible employees and dependents who satisfy eligibility requirements.
- n) Acknowledges that benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and BCBSND in accordance with the group contract(s).



## SECTION G – ACKNOWLEDGMENTS AND CERTIFICATIONS (continued)

- o) Acknowledges that BCBSND must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc.).
- p) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of BCBSND, that BCBSND does not provide health care services, that BCBSND cannot guarantee any results or outcomes of care, and that BCBSND is responsible for the quality of health care received only as provided by law.
- q) Certifies under penalty of perjury that all information provided and statements made in this application are accurate and complete to the best of its knowledge and belief and acknowledges that BCBSND will rely in part on the information in this application as the basis for BCBSND's decision on whether to approve this application and issue any group contract(s). For the protection of all of BCBSND's members, fraud or misrepresentation of material fact by the Company for the purposes of defrauding BCBSND may result in BCBSND taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, BCBSND will have the right to collect any claims payments or other damages. If BCBSND continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that BCBSND will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by BCBSND.
- r) Appoints the producer of record indicated in Section D – Producer Information (if any) to represent it in matters of group coverage benefits provided by BCBSND. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.
- s) Agrees that any controversy or claim between the Company and BCBSND arising out of or relating to the group contract(s), or the breach thereof, whether involving a claim in tort, contract, or otherwise, shall be subject to final resolution through binding arbitration. The Company and BCBSND agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs, and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in Cass County, North Dakota (ND), unless mutually agreed otherwise by the parties. If any enrollee or former enrollee (or person claiming to be an enrollee or former enrollee) makes any claim or brings any action or proceeding arising out of or relating to the group contract(s) and to which BCBSND or the Company becomes a party, BCBSND and the Company agree to cooperate in the defense of such claim, action, or proceeding and to resolve any controversy or claim between BCBSND and the Company through arbitration under this paragraph only after the resolution of the enrollee's (or alleged enrollee's) claim.
- t) Acknowledges that if the Company has a producer, that producer may receive bonuses, commissions, administrative services fees, or other compensation, including non-cash compensation from BCBSND. Incentives may be based on any of several factors, including the size of the Company's business, the products the Company purchases, the producer's volume of business with BCBSND, and other services the producer provides to the Company. Any producer compensation is part of BCBSND's overall expense structure and does not change the rate factors applied under BCBSND's filed rating practices. For more information, please contact the producer for the Company.
- u) Acknowledges that BCBSND's statements in this application, including the descriptions of laws in Section E, are not legal advice and that the Company should look solely to its legal advisor with legal questions or concerns.
- v) Agrees to provide workers' compensation insurance to its employees as required by applicable law.

For assistance in administering your group's benefit plan, see the Group Administrator Guide on [bcbsnd.com](http://bcbsnd.com). The guide provides information about benefits, eligibility, enrollment, monthly billing statements, and claims submission to help you answer your employees' questions.

## SECTION H – SIGNATURE

I certify that the information provided is accurate to the best of my knowledge.

If you type your name below, you understand that you are electronically signing this document and agree your electronic signature is the legal equivalent of your manual signature on this application.

\_\_\_\_\_  
Group Authorized Representative Signature (No producer signatures)

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

\_\_\_\_\_  
Group Authorized Representative (print name)

\_\_\_\_\_  
Official Title

Blue Cross Blue Shield of North Dakota: 4510 13th Avenue South, Fargo, ND 58121

