BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

RENEWAL CERTIFICATION

To help expedite the renewal process and ensure continued coverage, please complete this form in its entirety and return it with all required attachments in the return envelope provided. This form and any additional materials submitted are considered confidential and proprietary.

Section I – General Information

Company Name: _____

Company Federal Tax Identification Number(s): _____

Street Address of Primary Business Location: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Extension: _____ Fax: _____ E-Mail: _____

Name of Contact Person: _____

BCBSRI Group Number(s) _____ Renewal Date: _____

(*Found on your monthly bill*)

Section II – Coverage Renewal

- 0 I **do want** to renew my coverage directly with BCBSRI
- 0 I **do not want** to renew my coverage directly with BCBSRI _____

Signature Required

Reason for Cancellation (please check one that applies):

- 0 Buying coverage from another insurer (please specify): _____
- 0 Buying BCBSRI coverage through HealthSource RI
- 0 No longer offering coverage to employees
- 0 Other: _____

Section III – Employee Information

Total Number of Employees on Payroll Regardless of Employment Status: _____

(The total number should include owners, full-time, part-time, seasonal, and temporary employees for your primary business and any affiliated businesses.)

This information is required by the Centers for Medicare & Medicaid Services (CMS) in determining eligibility for a Medicare as Secondary Payer rate credit. Please refer to Appendix One for further information. **Please note:** In most cases, "total number of employees" *will be equal to or greater than the number of* "eligible employees."

Before mailing this form, please ensure that you have included the documentation requested in Section III.

Blue Cross Blue Shield of Rhode Island

Section IV – Employer Information (If more space is needed please attach a separate sheet of paper.)

A. Does this business have offices/locations at other addresses or in states other than your primary location listed above? Yes _____ No _____ If yes, please provide the location(s):

_____ _____ _____

City/State City/State City/State

B. If the group owns any other business; is jointly or cooperatively managed or operated with another business; or if this group also has full/partial ownership of any other business, please check "yes." Yes _____ No _____ If yes, please provide the following:

Name of Business **Name of Owners** **Percentage of Ownership (for each owner)**

Section V – Proof of Employee Eligible for Health Insurance

Your certification cannot be completed if you do not submit the following supporting documentation with the renewal certification form. If you have any questions on the required documentation please call your broker.

Please visit www.OHIC.RI.gov to review Regulation 11 for an explanation of the necessity of this documentation. Use the available "quick links" option and select "Regulations" to access Regulation 11.

A. Supporting documentation*

You must document that every individual meets the requirements of an "eligible employee," including owners of the group. (The definition of an "eligible employee" can be found in Appendix One.)

Wage Information may be blacked out for confidentiality purposes.

*Listed below are acceptable forms of supporting documentation. Please provide a copy of all forms that apply to your specific business:

1. Most recent Schedule C, Schedule K1, or 1120S Schedule K for all owners of each business,

2. Most recent payroll report showing withholding or most recent State Quarterly Tax and Wage Report,

3. 1099s for any employee who fits the definition of an eligible employee, but does not appear on any document listed above,

4. In addition, you also need to supply a W-4 form for any new hire not appearing on the tax documentation (you must indicate their hire date on the form).

Please note: Any payroll documentation submitted should contain the eligibility status for each employee as follows:

E – Enrolled W – Waiver PT – Part-time S – Seasonal T – Terminated Temp – Temporary

P – Fulfilling probationary period. Please note date of hire.

COBRA – For groups with 20 or more employees, please note start date of COBRA

B. Waivers

Please provide a waiver form for any eligible employee or his or her eligible dependent who is not currently enrolled on the group's plan (copy of waiver form attached).

Before mailing this form, please ensure that you have included the documentation requested in Section III.

Appendix One

1. Eligible Employee

"Eligible Employee" generally means an employee who works on a full-time basis with a normal workweek of thirty (30) or more hours. **At your sole discretion**, "eligible employee" can include all full-time employees who work a normal workweek anywhere between seventeen and a half (17.5) and thirty (30) hours, as long as you apply the same eligibility criteria to all employees and without regard to any health status related factors.

The term "eligible employee" **may include** a self-employed individual, a sole proprietor, a partner in a partnership, or an independent contractor if any of those individuals are included as employees under your health benefit plan.

The term "eligible employee" **does not** include temporary employees, substitute employees, or employees who work less than seventeen and one-half (17.5) hours per week. Any retiree under contract with any independently incorporated file district is also included in the definition of "eligible employee."

2. Small Employer

"Small Employer" means any person, firm, corporation, partnership, association, political subdivision, or self-employed individual who is actively engaged in business, including, but not limited to, a business or a corporation organized under the Rhode Island Non-Profit Corporation Act, Chapter 6 of Title 7, or a similar act of another state that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty(50) eligible employees, with a normal workweek of thirty (30) or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employee-employer relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file combined tax return for purposes of taxation by this state, shall be considered one employer.

3. Medicare as Secondary Payer (MSP)

Medicare is a secondary payer to Group Health Plans (GHP) for the "working aged" where either:

a) A single employer of twenty (20) or more employees is the sponsor of the GHP or is a contributor to the GHP,

or

b) Two or more employers are sponsors or contributors, and at least one of them has twenty (20) or more employees. The "20 or more employees" threshold is met whenever an employer has twenty (20) or more full- and/or part-time employees for twenty (20) or more calendar weeks in the current calendar year or in the preceding calendar year. The "20 or more employees" threshold is not limited to employees who enroll in the plan. "Employee" means an individual who is working for the employer. It also includes an individual who is not working for the employer, but is receiving payments from the employer that are subject to FICA, or would be if the employer were not exempt from those taxes. Leased employees are treated as "employees" of the person who leases them for purposes of the 20-employee threshold if; (a) the services are provided pursuant to an agreement between the recipient and any other person; (b) the leases employee has performed such services for the employer (or for the employer and related persons) on a substantially full-time basis for a period of at least 1 year; and (c) such services are performed under primary direction or control of the employer.

Before mailing this form, please ensure that you have included the documentation requested in Section III.