

**Please complete this form in its entirety. This form is required by New York State and failure to complete could result in your policy being cancelled.**

*Note: Underwriting may require additional documentation during review of the form, such as the most recently filed NYS-45 (or state equivalent).*

### Section 1: General Group Information

1. Group Number: \_\_\_\_\_ 2. Legal Entity Name: \_\_\_\_\_
3. Tax Identification Number (EIN/TIN): \_\_\_\_\_ 4. ZIP Code for Business Physical Address: \_\_\_\_\_
5. Does your business have any employees that are currently employed by a Professional Employer Organization (PEO) or leasing company and are covered as subscribers under this policy? ☐ Yes ☐ No
6. List Owners/Partners/Shareholders and Percentage of Ownership: *(Note: If there are more than four, please attach a separate listing.)*  
 Name: \_\_\_\_\_ % of Ownership    Name: \_\_\_\_\_ % of Ownership  
 Name: \_\_\_\_\_ % of Ownership    Name: \_\_\_\_\_ % of Ownership
7. Commonly Owned or Related Businesses (if applicable): \_\_\_\_\_

### Section 2: Group Size Regulatory Information

*(Note: The value of questions 1&2 must be greater than 0.)*

1. Total number of full-time employees and full-time equivalents at all locations, including subsidiaries and businesses under common control within the United States, in the prior calendar year: \_\_\_\_\_
2. Average number of employees and owners (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: \_\_\_\_\_
3. If your organization offers Excellus BCBS dental, enter total number of Dental eligible employees (including active employees and owners, retirees and individuals enrolled in COBRA): \_\_\_\_\_

### Section 3: Contribution

1. Annual Employer Contribution to a single tier: Health Savings Account \$ \_\_\_\_\_  
 Health Reimbursement Account \$ \_\_\_\_\_
2. If your organization offers Excellus BCBS dental, what is the monthly Employer Contribution to single tier dental? % \_\_\_\_\_
3. If your organization offers Excellus BCBS vision, what is the monthly Employer Contribution to single tier vision? % \_\_\_\_\_

*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 the minimum required hours per week.*

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

Print Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Excellus BlueCross BlueShield will submit reports with respect to the benefit plan, in the time and manner required under Section 204 of the Transparency Provisions of the CAA and/or related regulations and/or other authoritative guidance issued under the CAA, on behalf of the group relating to pharmacy benefits and drug costs. In addition to the above, unless you notify Excellus BlueCross BlueShield otherwise, you are authorizing Excellus BlueCross BlueShield to complete and file with CMS a gag clause attestation on your behalf annually up until the date services are terminated as long as all of your benefits are entirely insured by Excellus BlueCross BlueShield. You agree to provide Excellus BlueCross BlueShield with any information that may be necessary in this respect.