Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

ENROLLMENT SUMMARY

For Groups with 51+ Eligible Employees

Medicare Secondary Payor Compliance

Multiple Employer Plan: a plan sponsored by more than one employer. **Multi-employer plan:** a plan jointly sponsored by employers and unions.

If you are a single employer plan:

☑ Yes ☐ No Our Company employed 20 or more employees** each working day in 20 or more calendar weeks during the current or preceding calendar year.

If you are a single employer, multiple employer, or multi-employer plan:

☑ Yes ☐ No Our Company employed 100 or more employees** on 50 percent or more of the business days during the preceding calendar year.

If you are a multiple employer or a multi-employer plan:

☐ Yes ☑ No All employers in our Group Health Plan (GHP) employed 20 or more employees** for 20 or more weeks in either the current or proceding calendar year.

☐ Yes ☑ No At least one of the employers in our GHP employed 20 or more employees** for 20 or more weeks in either the current or preceding calendar year.

☐ Yes ☑ No All employers in our GHP employed fewer than 20 employees** for 20 or more weeks in either the current or preceding calendar year.

**"Employees" includes all full and/or part time employees

Common Ownership/Controlled Group Compliance

☐ Yes ☑ No Our Company is part of a common ownership or Controlled Group as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

General Information

Group Name	City of Pompano			**Tax ID #**	59-6000411
Group Number	98854	**Group Sales Rep/Agent**	N/A	**Effective Date**	Oct 1, 2016

Employer Contribution Toward Employees Premium
a. Small Group (required) 100% 1-3 employees, 50% 4-50 employees 100
b. Large Group (recommended) 50% 51+ employees

What was the average total number of all employees (full-time, part-time, and seasonal) in the previous calendar year? 850

II. Recap of Employee Participation

Participation must be collected in certain scenarios. Please use the drop down and select the option that most fits your company.

Renewal w/76 or more Enrolled without Benefit Changes

Please read the information below and provide electronic signatures when the document is completed.

I certify that the above information is correct to the best of my knowledge. I understand that this information will be used to determine my company's compliance with Blue Cross Blue Shield of Florida, INC. and/or Health Options, INC. eligibility and Underwriting Guidelines, as well as the applicability of State and Federal laws relating to my company and plan. Blue Cross Blue Shield of Florida INC. and/or Health Options, INC. reserves the right to request a UCT-6 or other documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and Underwriting Guidelines, as well as validate the applicability of State and Federal laws.

I certify that the applicant is a single employer under section 414 of Internal Revenue Code of 1986 (26 U.S.C. 414 (b), (c), (m), or (o)), and under any applicable state law.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Officer of the Company's Signature _____ Date/Time Field _____

Florida Blue

4800 Deerwood Campus Parkway
Jacksonville, FL 32246
www.floridablue.com

Grandfathered Plan(s) Certification

[Please type or write legibly in black ink.]

Group Name City of Pompano Group Number 98854 Renewal Date 10/1/16

Our records indicate you have one or more "grandfathered" health plans as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA.) PPACA considers a group health plan that existed on the date of enactment, March 23, 2010, to be a "grandfathered" plan. Grandfathered plans are exempt from complying with certain provisions of the PPACA insurance reform (e.g., preventive cost share, emergency service benefit levels, appeals processes, etc.).

You have provided your employer contribution amount as of March 23, 2010 for the following grandfathered plan(s). Please review the plan(s) and the questions below to certify if the plan(s) listed will remain grandfathered upon this renewal.

Please respond to the following questions and return the form with your renewal paperwork:

Grandfathered Health Plan Product Name (For example: BlueOptions 1152)	Since March 23, 2010, have any of your employer contribution percentages been reduced by more than 5% for any coverage tier?
BlueCare Plan 4	☐ Yes or ☑ No
	☐ Yes or ☐ No
	☐ Yes or ☐ No
	☐ Yes or ☐ No
	☐ Yes or ☐ No
	☐ Yes or ☐ No

Please answer the following two questions:

1. Have you acquired or merged another corporation into your health plan solely to add enrollees to your grandfathered health plan(s)? ☐ Yes ☑ No
2. Have you transferred employees from one health plan to a grandfathered plan without a bonafide employment based reason for the transfer? ☐ Yes ☑ No

If you have answered Yes to any of the questions above for one or more of your health plan(s), those plan(s) can no longer be considered grandfathered and you will need to have a non-grandfathered health plan. Please contact your agent or Sales Rep for alternative plan options.

You certify to the best of your knowledge and belief that the information provided above is accurate.

You agree to indemnify Florida Blue for any and all penalties and/or fines and costs associated therewith for unilateral actions taken by you that cause a loss in grandfathered health plan status. We encourage you to read the grandfathering health plan rules and work with your attorney to ensure compliance with such rules.

Signature of Authorized Official Name and Title Date

"CITY":

Witnesses:

CITY OF POMPANO BEACH

_____

By:_____
LAMAR FISHER, MAYOR

_____

By:_____
DENNIS W. BEACH, CITY MANAGER

Attest:

_____ (SEAL)
ASCELETA HAMMOND, CITY CLERK

Approved As To Form:

_____
MARK E. BERMAN, CITY ATTORNEY

STATE OF FLORIDA
COUNTY OF BROWARD

The foregoing instrument was acknowledged before me this _____ day of _____, 2016 by **LAMAR FISHER** as Mayor, **DENNIS W. BEACH** as City Manager and **ASCELETA HAMMOND** as City Clerk of the City of Pompano Beach, Florida, a municipal corporation, on behalf of the municipal corporation, who are personally known to me.

NOTARY'S SEAL:

_____
NOTARY PUBLIC, STATE OF FLORIDA

_____
(Name of Acknowledger Typed, Printed or Stamped)

_____
Commission Number