

# Group Application for Blue Cross and Blue Shield of North Carolina Coverage

<input type="checkbox"/> New Group	Prospect Number: _____	<input type="checkbox"/> Renewal Group	<input type="checkbox"/> Change <input type="checkbox"/> No Change	Group Number: _____	Effective Date: _____
1. Name of Group: _____				Tax ID No (EIN): _____	
2. Type of Organization: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____					
3. Physical Address:					
ADDRESS 1			ADDRESS 2		
CITY		STATE	ZIP CODE	COUNTY	
Billing Address: (if different from above) ADDRESS 1					
CITY			STATE	ZIP CODE	
Group Administrator:		Telephone Number:	Fax Number:	Email Address:	
4. Divisions/Subsidiaries/Affiliates to be covered (attach list if necessary):					
Name: _____		Relationship: _____			
Address: _____		Nature of Business: _____			
5. Industry Type (NAICS Code):	6. Do any eligible employees reside outside the State of North Carolina? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, list states:</b> _____				
7. <b>GROUPS OF 1-50 EMPLOYEES:</b> The Group certifies that it meets the definition of Small Employer Group as follows: any individual or entity actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for the purpose of taxation by the State of North Carolina, shall be considered one employer. The Group further certifies that all individuals enrolling for coverage meet the following definition of eligible employee: An eligible employee is an individual working 30 hours or more per week on a full-time basis with the employer reporting the FICA withheld by W2 Form on an annual basis. Persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible. An individual who is a "statutory employee" as that term is defined under Internal Revenue Code Section 3121(d)(3) and works on a full-time basis for the Group may be considered eligible for coverage. Documentation of "statutory employee" status is required. <b>Elected Official Coverage:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
8. <b>GROUPS OF 51 OR MORE EMPLOYEES:</b> BCBSNC standard eligibility allows for persons to be covered who are active, full-time employees, working 30 hours or more per week and their eligible dependents. Underwriting approval is required for any additional eligibility requests.					
<b>Domestic Partner Coverage Options</b> (check all that apply):		<b>Retiree Coverage:</b> (New Groups Only)		<b>Elected Official Coverage:</b>	
<input type="checkbox"/> None <input type="checkbox"/> Same Sex <input type="checkbox"/> Opposite Sex		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Other Special Eligibility (please specify):</b> _____					
9. <b>Health and US Able Life Products:</b> Eligibility requirements to be applicable to future employees Note: "0 day probationary period" is only available for health coverage for groups of 6 or more eligible employees:					
<input type="checkbox"/> 1st of the month following 30 days		<input type="checkbox"/> Next day following 90 days			
<input type="checkbox"/> Next day following 30 days		<input type="checkbox"/> 0 day probationary period, effective 1st of the month following the date of hire			
<input type="checkbox"/> 1st of the month following 60 days		<input type="checkbox"/> 0 day probationary period, effective on date of hire			
<input type="checkbox"/> Next day following 60 days					
10. Choose one of the following to be applicable to employees terminating health coverage:					
<input type="checkbox"/> End of the contract month following employment termination					
<input type="checkbox"/> Last day of employment (only available to groups of 6 or more eligible employees)					
11. Pre-existing waiting period options:					
<input type="checkbox"/> Applies to all enrollees timely and late (applies to all group sizes)					
<input type="checkbox"/> Waived for original effective date enrollees; Applies to subsequent timely and late enrollees (applies only to group sizes 51+)					
<input type="checkbox"/> Waived for original effective date enrollees and subsequent timely enrollees; Applies to late enrollees (applies only to group sizes 51+)					
<input type="checkbox"/> Waive for all enrollees timely and late (applies only to group sizes 51+)					
<input type="checkbox"/> Waived for original effective date enrollees, late enrollees delayed to open enrollment (applies only to group sizes 51+)					

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**BlueCross BlueShield  
of North Carolina**

12. For Health Coverage (applicable only for group of 100+): Number of Eligible Employees: _____ Number of Enrolled Employees: _____	13. Group Health Contribution (percentage): Employees: _____ % Dependents: _____ %
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14. All employer-sponsored group health plans must offer COBRA continuation coverage unless the employer is exempt from COBRA. (An employer is exempt if the group (i) employed fewer than 20 employees (including all full-time, part-time, and seasonal employees) on at least 50% of its working days during the preceding calendar year; or (ii) is a church plan or governmental plan as defined under the Internal Revenue Code.)

**Is your group health plan exempt from COBRA?**  
 Yes  No

15. The Employee Retirement Income Security Act of 1974 (ERISA) regulates employee health benefit plans sponsored by most employers. Governmental Plans and church-sponsored plans (as defined by federal law) are exempt.

Will this coverage insure an Employee Welfare Benefit Plan that is regulated by ERISA?  Yes  No

**If you checked yes, please identify a contact person for ERISA plan information.**

Name and Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

16. Under federal law, the Plan Administrator may be required to provide a notice to Plan Participants who do not read English but are literate in another language, advising them of where they can get information and assistance concerning their benefits and member rights. The notice must be in their primary language and appear in the summary plan description (member booklet). The following information is being requested to determine if such a notice will be necessary. It may also assist BCBSNC in meeting special customer service needs.

<p><b>For Groups 1-50:</b> Do 25% or more of the persons covered by your plan meet the following criteria:</p> <p>Literate only in a foreign (non-English) language? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, what is their primary language (e.g., Spanish)? _____</p> <p>If more than one language is listed, state percentages of members literate in each language: _____</p>	<p><b>For Groups 51+:</b> Do 10%, or 500 of the persons covered by your plan, whichever is less, meet the following criteria:</p> <p>Literate only in a foreign (non-English) language? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, what is their primary language (e.g., Spanish)? _____</p> <p>If more than one language is listed, state percentages of members literate in each language: _____</p>
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17. The Group acknowledges that it agrees to pay BCBSNC the following rates for the benefits below.

Please check the benefit plan(s) you have selected for your group. If you will be contributing to an HSA/HRA during the benefit period, please verify benefit plans, annual contribution amounts, and the HSA/HRA administrator you will be contributing through. If the BCBSNC chosen HSA/HRA administrator has been selected for the HSA/HRA, please also verify if fees should be included in the premium or deducted from the employee's HSA/HRA account.

**HRA product is not currently available to Groups 1 to 50**  
**Blue Options<sup>SM</sup> PPO/Blue Care<sup>®</sup> HMO/Classic Blue<sup>®</sup> CMM Plans**  
**Product and quote numbers will display here.**

**Blue Options HSA<sup>SM</sup>/HRA Plans**

	Quote Number	LOB	ANNUAL FUND CONTRIBUTION AMOUNT (in dollars)					HSA/HRA Administrator	Include in Premium	Deduct from Employee's HSA Account
			Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family			
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										

Please write in quote information, if existing quotes do not reflect the Group's final choices. Please note that any change in the amounts you listed above could result in a change to the rate you were quoted.

18. **Certification of Compliance with Federally Mandated Coverages:** Federal Social Security laws require employers to provide primary health care benefits under employer group health plans to certain individuals who are entitled to Medicare. The Group certifies and agrees that individuals eligible for Medicare, who are required to receive primary health care benefits under the Group's employee group health plan pursuant to federal Social Security laws, will be enrolled in a manner consistent with such laws. The Group hereby agrees to indemnify BCBSNC, hold it harmless against and reimburse it for any and all expenses paid or incurred by BCBSNC due to any act or omission of the Group or the employer inconsistent with the relevant Social Security laws, as amended.

19. In applying for this coverage, the Group further understands that the Group's tender of this application and fees as required by BCBSNC (or by BCBSNC's chosen HSA/HRA administrator, if HSA/HRA services are being purchased), in no way binds BCBSNC and the HSA/HRA administrator to contract with the Group. Submission of this application and requisite fees, constitutes an offer by the Group, which may be accepted by BCBSNC and the HSA/HRA administrator as signified by the earlier of the following events: BCBSNC's issuance of the Group Contract and the HSA/HRA administrator's issuance of its group contract, or issuance of identification cards to the Group's members. The Group Contract issued by BCBSNC (and the group contract issued by the HSA/HRA administrator) shall set out the terms of the agreement between the parties, and this application shall be incorporated therein by reference. Group agrees that BCBSNC's Group Contract and the HSA/HRA administrator's group contract shall be binding upon the parties as issued, without necessity of signature by the Group. References to the HSA/HRA administrator in this document shall apply only if HSA/HRA services are being purchased by Group.

**Life/AD&D/STD:**

Underwritten by USABLE Life, an independent life insurance company, that does not provide BCBSNC products or services and is solely responsible for the life and disability insurance coverage below.

<p>20a. Number of Employees:</p> <p>Eligible: _____ Enrolled: _____</p>	<p>20b. Employer Contribution:</p> <p>Life and AD&amp;D _____ %      Supplemental _____ %</p> <p>Dependent Life _____ %      STD _____ %</p>
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21. Class Descriptions	Life/AD&D* <input type="checkbox"/> Amount of Insurance	Supplemental <input type="checkbox"/> Life <input type="checkbox"/> AD&D Amount of Insurance		Short Term Disability <input type="checkbox"/> Salary Multiple <input type="checkbox"/> Flat Schedule Maximum Weekly Benefit	
		1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____	3. _____	3. _____
4. _____	4. _____	4. _____	4. _____	4. _____	4. _____

\* If Life and AD&D benefit is a multiple of salary, the amount will be rounded to the next higher \$1,000.

22. Short Term Disability (non-occupational):	Accident _____ Days/	Sickness _____ Days/	Duration _____ Weeks	The maximum weekly STD benefits is \$ _____ and the benefit may not exceed _____ % of an insured's weekly income (excluding bonuses, overtime or any form of extra pay).
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23. Dependent Life Insurance (Benefit amounts are limited in some states):     Yes     No

<b>Children:</b>	<input type="checkbox"/> from birth to 6 months	\$ _____	<b>Spouse:</b>	\$ _____
	<input type="checkbox"/> 6 months to 19 years* <small>*To age 26</small>	\$ _____		

24. Reductions and Termination (Benefit reduction due to age will be effective on the insured's birthday.)  
Employee Life and AD&D benefits reduce by the following percent or to the amount shown. Benefits terminate when an employee is no longer eligible as an active employee or at retirement.

At Age 65	At Age 70	Terminates	Other
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25. Guaranteed Issue Amount \$ \_\_\_\_\_ (Life and AD&D amounts over Guaranteed Issue are subject to evidence of insurability.)

**COMPLIANCE NOTICE:** USABLE Life does not provide legal or tax advice. Based upon information you have provided USABLE about your group, USABLE Life will notify you if USABLE Life perceives any obvious deficiency in your plan, but you must consult your own legal counsel for definitive advice and opinions regarding your plan's compliance.

**WARNING:** It is or may be a crime to knowingly provide false, incomplete or misleading information to USABLE Life for the purposes of defrauding USABLE Life or other person. Penalties may include imprisonment, fines or a denial of insurance benefits in accordance with applicable state law. It is further understood and agreed that this application shall be made a part of the USABLE Life policy or policies applied for and that no insurance shall be effective until approved by USABLE Life's home office.

# Complete for Life and Health

**26. GROUPS OF 100 OR MORE EMPLOYEES:**

In applying for this coverage, the Group understands that producer commissions are included in the monthly premium rates. The producer commission is calculated on either a flat per employee per month basis or on a percentage of the monthly premium per employee per month. The estimated total monthly commission amount for this group is \$ XXX.XX.

BCBSNC certifies that the correct aggregate commission dollars will be calculated and paid each month and that the commission payment will be issued directly to the agency associated to the group, as stipulated in the group's Agent of Record letter.

27. Subject to the acceptance of this application by BCBSNC at its home office, the effective date of coverage pursuant to this application shall be 12:01 AM Eastern Time on the \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year), provided that the initial monthly fees are paid, and coverage under the Group Contract will be for a period of 12 months, and that, unless terminated in accordance with the Group Contract, the Group Contract will be renewable each year.

By signing below, I understand that this application constitutes an offer that shall constitute a binding contract upon acceptance by BCBSNC (and by the HSA/HRA administrator, if HSA/HRA services are being purchased), and certify my authority to make such an offer on behalf of the Group. I further acknowledge my receipt and approval of a representative sample of BCBSNC's Group Contract (and the group contract issued by the HSA/HRA administrators, if applicable). If I am an employer with 1 to 9 employees, I understand the Life and Accidental Death and Dismemberment and Short Term Disability coverage is provided through a policy issued to the Trustee of the USABLE Life Group Insurance Trust, and I hereby apply for participation in said trust, which is insured by USABLE Life. A copy of the trust is maintained in USABLE Life's home office in Little Rock, Arkansas and is subject to examination by participating employers and USABLE Life.

By signing below, I understand that this application constitutes an offer that shall constitute a binding contract upon acceptance by BCBSNC (for both health insurance and Health Reimbursement Arrangement (HRA)/Flexible Spending Arrangement (FSA), if applicable), and certify my authority to make such an offer on behalf of the Group. I further acknowledge my receipt and approval of a representative sample of BCBSNC's Group Contract for health insurance and Administrative Services Agreement for HRA/FSA administrative services, if applicable. If I am an employer with 1 to 9 employees, I understand the Life and Accidental Death and Dismemberment and Short Term Disability coverage is provided through a policy issued to the Trustee of the USABLE Life Group Insurance Trust, and I hereby apply for participation in said trust, which is insured by USABLE Life. A copy of the trust is maintained in USABLE Life's home office in Little Rock, Arkansas and is subject to examination by participating employers and USABLE Life.

Authorized Signature (for the Group): \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Producer Name: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

Producer Number: \_\_\_\_\_