

APPLICATION FOR BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA COVERAGE

GROUP SIZE: 1-50
(Eligible Employees)

1. Name of Group: _____
FULL LEGAL NAME AS IT SHOULD APPEAR IN THE GROUP CONTRACT
2. Physical Address: _____
STREET CITY STATE ZIP CODE COUNTY
- Billing Address:
(if different from above) _____
STREET CITY STATE ZIP CODE COUNTY
- Group Administrator: _____ Tax ID No. (EIN): _____
Telephone Number: _____ Fax Number: _____ Email Address: _____
3. Type of Organization: Sole Proprietorship Partnership Corporation Trust Other: _____
4. Divisions/Subsidiaries/Affiliates to be covered *(attach list if necessary)*:
Name: _____ Relationship: _____
Address: _____ Nature of Business: _____
5. **GROUPS OF 1-50:** The group 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.
6. Eligibility requirements to be applicable to newly hired employees *("0 day probationary period" is only available to groups of 6 or more eligible employees)*:
 1st of the month following 30 days Next day following 90 days
 Next day following 30 days 0 day probationary period, effective 1st of the month following the date of hire
 1st of the month following 60 days 0 day probationary period, effective on date of hire
 Next day following 60 days
7. Choose one of the following to be applicable to employees terminating coverage:
 End of the contract month following employment termination
 Last day of employment *(not available for groups of 1-5 eligible employees)*
8. Employer *(group)* contribution *(percentage)*: _____ Employee: _____ Dependents: _____
9. If your group has employed 20 or more employees *(including all full-time, part-time, and seasonal employees)* on at least 50% of the working days in a calendar year, and your group is not exempt from COBRA, your group must offer COBRA continuation coverage. This requirement applies to both private and public employers, although there are some specific exemptions under federal law, such as most church-sponsored plans.
Is your group health plan required to comply with federal COBRA continuation coverage requirements for this contract year? Yes No Exempt
10. 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 the Employee Retirement Income Security Act of 1974 (ERISA)? Yes No
If you checked "No", please indicate the reason: Government Plan Church Plan Other: _____
If you checked "Yes", please identify a contact person for ERISA plan information: _____
Name and Title: _____
Address: _____ Phone: _____
11. Is this coverage in addition to or replacing a group health program? Adding to Replacing Renewing a BCBSNC health plan No Prior Carrier
If adding to or replacing, please complete the following *(use additional sheets if necessary)*:
Name of Current Insurer(s): _____
Type(s) of Coverage: _____ Date other coverage(s) will be terminated: _____

An independent licensee of the Blue Cross and Blue Shield Association. ©,SM Marks of the Blue Cross and Blue Shield Association. SM1 Mark of Blue Cross and Blue Shield of North Carolina.

Your plan for better health.™ | bcbsnc.com



BlueCross BlueShield
of North Carolina

12. 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.

Do 25% or more of the persons covered by your plan meet the following criteria?

Non-English speaking? Yes No Literate only in a foreign (*non-English*) language? Yes No

If Yes, what is their primary language (e.g., *Spanish*)? _____

If more than one language is listed, state percentages of members literate in each language _____

13. 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 during the benefit period, please verify benefit plans, annual contribution amounts, and the HSA administrator you will be contributing through below:

Blue OptionsSM PPO/Blue Care[®] HMO/Classic Blue[®] CMM Plans

Blue Options HSASM Plans

		ANNUAL FUND CONTRIBUTION AMOUNT (in dollars)						HSA Administrator
Combo Number	LOB	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family	Employee + 1 Other	
<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.

14. 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.

15. **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.

16. 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 administrator, if HSA services are being purchased), in no way binds BCBSNC and the HSA 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 administrator as signified by the earlier of the following events: BCBSNC's issuance of the Group Contract and the HSA 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 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 administrator's group contract shall be binding upon the parties as issued, without necessity of signature by the Group. References to the HSA administrator in this document shall apply only if HSA services are being purchased by Group.

17. 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 which shall constitute a binding contract upon acceptance by BCBSNC (and by the HSA administrator, if HSA 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 administrator, if applicable).

Authorized Signature (*for the Group*): _____ Date: _____

Print Name: _____ Title: _____