



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association



An Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah and its non-insurer subsidiary, Regence ValueCare Regence HealthWise

Attn: Sales #28

P.O. Box 30270

Salt Lake City, Utah 84130-0270

C# _____ G# _____

Group Application Form

Official Company Name (As registered with the State of Utah) Tammy		Type of Business (Give Details)
Mailing Address (Include any Attention Line and Suite or Apt #), City, State, Zip		SIC Code
Billing Address (Include any Attention Line and Suite or Apt #), City, State, Zip		Telephone # Fax # E-mail address:
Chief Executive Officer	Health Benefits Decision Maker & Title	Health Benefits Group Leader

Network Option: <input type="checkbox"/> BCBS <input type="checkbox"/> ValueCare <input type="checkbox"/> HealthWise* <small>*(not available on HSA)</small>	Health Option: <input type="checkbox"/> BlueEssentials <input type="checkbox"/> BluePreferred <input type="checkbox"/> BlueClassic	HSA Qualified Plan: <input type="checkbox"/> Regence HSA Healthplan HSA Banking Partner: <input type="checkbox"/> US Bank <input type="checkbox"/> HSA Bank <input type="checkbox"/> Wells Fargo <input type="checkbox"/> Other _____	Life Options: Carrier: <input type="checkbox"/> Regence Life & Health - P.O. Box 1271 MS E3A, Portland, OR 97207 (domiciled in Oregon) BENEFIT Employee Life and AD&D _____ Supplementary Life <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Dependent Life _____ Voluntary Life <input type="checkbox"/> Yes <input type="checkbox"/> No _____ ST Disability <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Other <input type="checkbox"/> Yes <input type="checkbox"/> No _____ LT Disability <input type="checkbox"/> Yes <input type="checkbox"/> No _____
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Health Coverage Code	Drug Coverage Code	Dental Coverage Code	Vision Coverage Code	24 Hr. Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
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Eligibility Waiting Period: **Please indicate ONE CHOICE ONLY.**
 Effective 1st billing period following Date of hire or 1 2 3 4 6 months from date of hire.
 Other (explain) _____
NOTE: Date of hire Eligibility Waiting Periods must be approved by Underwriting.

Requested Effective Date: _____
 Requested Renewal Date: _____

Send COB Cards? <input type="checkbox"/> Yes <input type="checkbox"/> No	Including Data for Credit on? Deductible <input type="checkbox"/> Yes <input type="checkbox"/> No Stoploss <input type="checkbox"/> Yes <input type="checkbox"/> No	Send IDs to: <input type="checkbox"/> Subscriber <input type="checkbox"/> Other _____ <input type="checkbox"/> No IDs	Send Cert. of Creditable Coverage to: <input type="checkbox"/> Group <input type="checkbox"/> Both Group & Sub <input type="checkbox"/> Subscriber <input type="checkbox"/> Do not mail Certs	Type of Group: <input type="checkbox"/> Local <input type="checkbox"/> Self-Funded <input type="checkbox"/> Individual <input type="checkbox"/> National
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Agent/Agency Name _____ Commission % 0.00% Agent/Agency # _____
 Producer Name _____ Phone _____ Fax _____
 Agent/Agency Name _____ Commission % 0.00% Agent/Agency # _____
 Producer Name _____ Phone _____ Fax _____
 Onyx Customer ID # _____ Agent e-mail _____
 Sales Executive Name _____ SE# _____ Renewal Rep# _____ Account Exec# _____ Team _____
 Pooled with _____ Assoc Code _____ Initial Sales Received Date _____ Sales Complete Date _____
 Comments: _____

Application for Group Health Care Contract

(MUST BE COMPLETED BY AN AUTHORIZED COMPANY OFFICIAL)

Application is hereby made by (Company Name as registered with the State of Utah) _____, hereinafter called the Group, to Regence BlueCross BlueShield of Utah, its non-insurer subsidiary, Regence ValueCare, and/or Regence HealthWise, hereinafter called Regence BCBSU, for a new or renewal Health Care Contract. Official Company Mailing Address (Including Suite, if any) _____
 City _____ State _____ ZIP _____

COBRA:
 Group subject to COBRA? No Yes

ERISA:
 Group subject to ERISA? No Yes
 Is your plan year different than your renewal date? No Yes, list date _____

OBRA:
 Group subject to OBRA? No Yes

If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:
 Group subject to TEFRA/DEFRA? No Yes

If you employed 20 or more full-time and/or part-time employees during each of 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

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Application for Group Health Care Contract (Continued)

GROUP DEMOGRAPHICS: The following represents an accurate accounting of employees working for this Group as of the date of application.

- | | |
|---|--|
| <p>A. Total Number of Owners & Employees _____</p> <p>B. Total Owners & Employees not eligible for coverage because:</p> <ul style="list-style-type: none"> • Part-time or working fewer than required hours per week _____ • Other (specify) _____ <p>C. Subtotal of Eligible Owners & Employees (A minus B) _____</p> <p>D. Eligible Owners & Employees not currently enrolling because:</p> <ul style="list-style-type: none"> • Waiving coverage because covered by another employer _____ • Waiving coverage because chooses no coverage _____ • New Hires within waiting period _____ | <p>E. Employees Enrolling at Group's Effective Date (C minus D) _____</p> <p>F. How many in 'E' have dependents? _____</p> <p>G. How many in 'F' enrolled their dependents? _____</p> <p>H. How many in 'E' are COBRA or State Extension enrollees? _____</p> |
|---|--|

COBRA ELIGIBILITY

- I. How many terminated employees and/or their dependents are currently eligible for COBRA or State Extension but have not applied? _____

CONTRIBUTION TO HEALTH PREMIUMS:

The Employer agrees to pay the following percentages of the total health premiums:

_____ 0.00% of the Single coverage rate

_____ 0.00% of the Two-party coverage rate

_____ 0.00% of the Family coverage rate

CONTRIBUTION TO HSA:

(if applicable)

\$_____ For Single Coverage

\$_____ For Family Coverage

CONTRIBUTION TO LIFE PREMIUMS:

The Employer agrees to pay the following percentages of the total life premiums:

_____ 0.00% of Employee Life and AD&D	_____ 0.00% of Long-term Disability
_____ 0.00% of Dependent Life	_____ 0.00% of Supplementary Life
_____ 0.00% of Short-term Disability	_____ 0.00% of Other _____

COMPANY STRUCTURE: LIST ALL PARENT, SUBSIDIARY OR OTHER COMPANIES AFFILIATED BY COMMON OWNERSHIP

In what state is the Company headquartered? _____

- Sole Proprietorship
- Partnership
- Corporation Parent
- LLC Subsidiary
- LLP Not Applicable

Company Name	Address	Owner(s)	Ownership %
_____	_____	_____	0.00%
_____	_____	_____	0.00%
_____	_____	_____	0.00%

Federal Tax ID (EIN) _____

EMPLOYEE/DEPENDENT ELIGIBILITY PROVISIONS:

To be eligible, an employee must: (a) be permanently employed working at least _____ hours per week for the Group; (b) be in an employer/employee relationship as defined by Federal Tax Laws; (c) have Federal and State (including FICA) taxes and any uncontributed portion of the health premium withheld on a payroll deduction basis; (d) be covered by employer-paid Workers Compensation; and (e) be accepted into one of the health programs sponsored by this Group in accordance with the provisions of this and any other written agreements between the Group and Regence BCBSU.

Eligible dependents include an eligible employee's legal spouse and dependent children, as defined in the Booklet. Exceptions to these Eligibility Provisions are specifically set forth as follows: _____

GENERAL:

Does this policy replace an existing policy? Yes No If yes, list prior insurance carrier(s): _____ Renewal Month _____

Groups with a maximum rate up, moving off anniversary, will be assessed a one-time 25% surcharge of their annual premium.

Has this Company ever been enrolled with Regence BCBSU? Currently Yes No If yes, please give cancel date: Month ____ Year ____

Is Regence BCBSU the only insurance carrier of Health Coverage in the group? Yes No If no, please list the other insurance carrier(s) to be offered: _____

Does your company carry Workers Compensation insurance? Yes No If yes, list carrier: _____

Please complete the following for those enrollees **not** covered by Workers Compensation. Please include an explanation.

Name	Job Title	Explanation
_____	_____	_____
_____	_____	_____

All enrollees not required by law to carry Workers Compensation coverage and who do not carry such coverage must be enrolled in 24-hour coverage. All enrollees required by law to carry Workers Compensation must do so.

The Group's completion and submission of this "Application for Group Health Care Contract" to Regence BCBSU shall be deemed an offer to contract and, if Regence BCBSU chooses to issue a health care contract to the Group, that issuance shall be Regence BCBSU's acceptance of the Group's offer.

This insurance will become effective when it is accepted by Regence BCBSU for Health and Regence Life and Health Insurance Company for Life and/or Disability as applicable.

I agree that the information as completed in this "Application for Group Health Care Contract" is true and recognize that Regence BCBSU, and Regence Life and Health Insurance Company, will rely upon this information in issuing coverage. I further understand and agree that other provisions (e.g., coverage, rates, etc.) may change throughout the contractual period with 30 days prior written notice by Regence BCBSU. Likewise, if any of the provisions contained herein change, I agree to notify Regence BCBSU in writing within 30 days of the change to obtain approval for such change. This Contract incorporates the Booklet and Application with the Group Contract and with such incorporation constitutes the entire agreement between Regence BCBSU and the Group. Regence BCBSU's agreement to provide certain administrative services for the Group should not be construed as, and the parties specifically agree does not, constitute Regence BCBSU's agreement to act as Benefit Administrator, as defined in the Employee Retirement Income Security Act of 1974 (ERISA), for the employer's group health plan or any portion of it.

If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Utah. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with Regence and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

Employer Signature _____ Employer Title _____ Date Signed _____

Agent/Producer Signature (if applicable) _____ Agent Title _____ Date Signed _____