Group Information Form

Group Information

Group Name (as it is to appear on identification cards and contracts): **Effective Date**:

Street Address: City: State: FL Zip:

Mailing Address: City: State: FL Zip:

Sales Correspondence Address: City: State: FL Zip:

Decision Maker (name): Phone: Email Address:
Title: Fax:
Please check product: Health: ☐ Life: ☐ Dental: ☐

Contact Person (name): Phone: Email Address:
Title: Fax:
Please check product: Health: ☐ Life: ☐ Dental: ☐

Additional Contacts:

Nature of Business:
Number of years in business: **SIC Code**:

Prior Health Carrier:
Prior Dental Carrier:
Prior Life Carrier:
Workers Comp. Carrier:

Contribution %	**Employer Emp**	**Dep**
Health:		
Life:		
Dental:		
HRA/HAS:		
FSA:		

Tax ID #:

Eligibility

Eligible the ☐1st or ☐15th of the month after
☐0, ☐30, ☐60, ☐90, ☐120, ☐180, ☐365 days or ☐Date of Hire

Termination
☐ Date of Term ☐ End of Month

Other:

If you have additional classes, please indicate them here:

Where will initial ID cards be sent? ☐ **Employer** or ☐ **Subscriber** Subsequent ID Cards? ☐ **Employer** or ☐

Product(s) Sold

Health:
Life:
Dental:
HRA/HSA or FSA:

Rx Options:

Agent Information

Agent Name/ID#: Agency:
Address: **Phone**: Fax:
Tax ID #: Email Address:
Please indicate any additional comments or special instructions you may have:

Items needed prior to final rating:
underwriting:☐ Enrollment Summary
☐ Applications (signed originals, including enrolling and refusals)
☐ UCT-6 Form (if requested)
☐ Quoted Rates attached (BCBSF Rep.responsibility)
FCL

Items needed before the group can be processed by
☐ True Group Application
☐ HMO Signature Page or Addendum (as applicable)
☐ Ancillary Applications (as applicable)
☐ Single Case Agent Agreement
☐ Check payable to Blue Cross Blue Shield of Florida or
☐ Agent of Record Letter on company letterhead

Important: Please contact your representative if you have any questions.

BlueCross BlueShield of Florida Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

UNDERWRITING QUESTIONNAIRE

SUPPLEMENT TO GROUP APPLICATION FOR GROUPS WITH 51 OR MORE EMPLOYEES

I. GENERAL INFORMATION

Name of Business _____ Anniversary Date _____

Business Address: _____ City _____ State _____ Zip Code: _____

Nature of Business _____ S.I.C. Code _____

II. GROUP ABSTRACT

1. Number of Years in Business _____ (Attach your most recent financial statement if less than two years.)
2. Indicate Classes of Eligible Employees /Waiting Period _____
3. Rates for Group Medical:

	Current Rates	Renewal Rates	Number of Emp. Eligible	Number of Emp. Enrolled
Effective Date	_____	_____	_____	_____
Single	_____	_____	_____	_____
Employee & Spouse	_____	_____	_____	_____
Employee & Child	_____	_____	_____	_____
Family	_____	_____	_____	_____

4. Employer Contribution _____% of Employee Premium; _____% of Dependent Premium.
5. Current Group Medical Insurer & Effective Date _____

   Reason for Current Bid Request _____
6. Five Year Prior Group Medical History & Effective Date _____

   Reason for Cancellation _____
7. Number of Employees/Dependents on COBRA Continuation _____ (Provide details in section IV)
8. Has your group been declined for coverage during the last 12 months [ ] Yes [ ] No If yes, provide details:

   _____

   _____

III. GROUP MEDICAL HISTORY

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). This information will be used to evaluate medical risk, not eligibility for individual coverage. The Health Insurance Portability and Accountability Act ("HIPAA") prohibits group health insurance issuers from establishing rules for eligibility on the basis of health factors. Health factors are defined as: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, and disability.

☐ Yes ☐ No 1. Within the past 12 months have any employees or their dependents been diagnosed or treated for any of the conditions below? Please check the appropriate box(es).

☐ ARC or AIDS	☐ Diabetes	☐ Immune System	☐ Neurological
☐ Alcohol Abuse	☐ Drug/Substance Abuse	☐ Infertility	☐ Pancreas
☐ Arthritis	☐ Enlarged Lymph Nodes	☐ Intestines	☐ Skin
☐ Back, Neck	☐ Epilepsy	☐ Kidney	☐ Stomach
☐ Blood	☐ Ears/Eyes	☐ Liver	☐ Stroke/Paralysis
☐ Bone/Joint	☐ Emphysema/Pulmonary	☐ Lungs	☐ Transplants
☐ Brain	☐ Growth Disorders	☐ Lupus	☐ Vascular Disease
☐ Cancer/Tumor	☐ Heart Disease	☐ Mental/Nervous	☐ Venereal
☐ Cardiovascular	☐ High Risk Pregnancies	☐ Migraines	☐ Other, Detail Below

☐ Yes ☐ No 2. Within the last 12 months has any employee or their eligible dependent been hospitalized or had any surgical consultation advice or treatment for any condition?

☐ Yes ☐ No 3. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?

☐ Yes ☐ No 4. Within the last 12 months, has any employee or their eligible dependent had medical claims in excess of $10,000?

If you answered "Yes" to any of the medical questions, please complete the following:

Question #	Illness and Medication	Year of Treatment	Age 18 or Younger

IV. ADDITIONAL INFORMATION

COBRA CONTINUANCE

Provide details on type of qualifying event and expiration date of each person entitled to COBRA continuance.

_____

_____

The undersigned Company Officer and Agent hereby acknowledges that: 1) the information set out in this Underwriting Questionnaire will be relied on by Blue Cross and Blue Shield of Florida, Inc./Health Options, Inc.; (2) this information is complete, truthful and correct; (3) to the best of my knowledge no information has been withheld or omitted concerning the past and present state of health of eligible employees and their dependents applying for this coverage and; (4) the summary health information set out in this Underwriting Questionnaire was not acquired, used, or disclosed other than as is permitted by applicable law, and specifically was not and will not be used for employment-related actions and/or decisions. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

_____ _____

Print Name of Authorized Company Officer | Signature of Authorized Company Officer

_____ _____

Date | Title of Officer

_____ _____

Print Name of Agent/Agent Number | Signature of Agent

_____ _____

Date | Name of Agency

BlueCross BlueShield of Florida
Health Options
Independent Licensees of the Blue Cross and Blue Shield Association

ENROLLMENT SUMMARY

MEDICARE SECONDARY PAYER COMPLIANCE (CHECK APPROPRIATE BOX)

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 preceding calendar year.

❑ Yes ❑ No Al 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.

COMMON OWNERSHIP / CONTROLLED GROUP COMPLIANCE (CHECK APPROPRIATE BOX)

❑ 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 ("HIPPA") which 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. If you answered yes, you are required to complete the Common Ownership form # 62891-0910 SR as part of your application.

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

I. General Information				**Tax ID #** _____
1. Group Name			2. Group Number	
3. Group Sales Rep/Agent			4. Effective Date	
5. Employer Contribution Toward Employees Premium (must be at least 100% for 1-3, 50% for 4-50 and 75% for 51+)				
II. Recap of Employee Participation (include all employees from Common Ownership if Boxed checked Yes above)				
1. TOTAL EMPLOYEES ON PAYROLL			⇨	
2. TOTAL COBRA CONTINUANTS			⇨	
3. TOTAL INELIGIBLE EMPLOYEES		Total of A + B + C	⇨	
	A. Total Part Time Employee(s) ⇨			
	B. Total New Employee(s) (in Waiting Period) ⇨			
	C. Other ⇨			
4. TOTAL ELIGIBLE EMPLOYEES (DETERMINES GROUP SIZE & PRODUCT)		1 + 2 Minus 3	⇨	
	D. Total Employees with Other Group Coverage ⇨			
	E. Other ⇨			
	F. Total from Common Ownership Groups that are not Covered by BCBSFL ⇨		⇨	
5. TOTAL ELIGIBLE FOR PARTICIPATION		4 Minus D minus E minus F	⇨	
	G. Total Refusals (eligible employees not taking the coverage or with individual coverage) ⇨			
6. TOTAL ENROLLED		5 Minus G	⇨	
7. EMPLOYEE PARTICIPATION (100% 1-3, 70% 4-50, 75% 51+ is REQUIRED)		6 Divided by 5	⇨	

Employers must have an application completed for all employees, even those who are not taking the health coverage, and submit those applications to Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. It is recommended that the employer also retain a copy of all applications.

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 and 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 and 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.

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.

_____ _____ _____

Group Officer's Signature **Title** **Date**