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Employer Group Application
Attachment A to the Group Agreement
- This document has been classified as confidential -

BCBST-EGA 6-99A (Revised 01/10)

Employer hereby applies to BlueCross BlueShield of Tennessee, Inc. for group insurance benefits (Medical, Dental and VisionBlue products). If BlueCross BlueShield of Tennessee accepts this application, the Group Agreement issued will be materially as set forth in the specimen Group Agreement (including the Evidence of Coverage) ("Documents") which have been reviewed. A copy is available upon request.

Please answer all questions completely and accurately. **This completed application should be submitted along with a check equal to one month's estimated premium.**

When completing electronically, use tab key to move from field to field. When completing paper version, please type or print clearly with a ballpoint pen, using black or blue ink (no felt tip pens please).

Section A – General Information

1. Today's Date: ______________
2. Requested Effective Date of Coverage: ______________ Initial Renewal Date: ______________
   (To be completed by BlueCross BlueShield of Tennessee)
3. Federal Employer Identification Number (FEIN): ______________
4. Employer's Legal Name (as listed on your FEIN): ______________

   (4a) Health Benefit Plan Name (as listed on your Form 5500): ______________
5. Mailing Address: ______________
   City: ______________ County: ______________ State: ______________ Zip: ______________
6. Name of Employer's Executive Decision Maker: ______________ (6a) Title: ______________
7. Legal Entity: ☐ Corporation ☐ Partnership ☐ Proprietorship
   ☐ Limited Partnership ☐ Limited Liability Company ☐ Other ______________
8. Subsidiaries under this Group Agreement ☐ None ☐ Yes – List names and addresses below
   (**If** additional space is needed list name(s) and address(es) on separate page.)

   Name: ______________
   Mailing Address: ______________
   City: ______________ State: ______________ Zip: ______________
   Name: ______________
   Mailing Address: ______________
   City: ______________ State: ______________ Zip: ______________
   Name: ______________
   Mailing Address: ______________
   City: ______________ State: ______________ Zip: ______________
   Name: ______________
   Mailing Address: ______________
   City: ______________ State: ______________ Zip: ______________
9. Does this Employer's plan qualify as an ERISA plan? ☐ Yes ☐ No

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Section B – Optional Coverage and Services

Optional Coverages – Medical Only	**Option 1 of ___**		**Option ___ of ___**		**Option ___ of ___**	
	Accept	**Decline**	**Accept**	**Decline**	**Accept**	**Decline**
1. Behavioral Health (Required for groups with 26 or more employees)	☐	☐	☐	☐	☐	☐

Optional Services (applies to all options in a multi-option plan)	**Medical**		**Dental**		**VisionBlue**	
	Accept	**Decline**	**Accept**	**Decline**	**Accept**	**Decline**
1. COBRA Administration **without** initial notification letter option. Available for groups with 20 or more Employees (size is as defined in COBRA legislation)	☐	☐	☐	☐	☐	☐
2. COBRA Administration **with** initial notification letter option. Available for groups with 20 or more Employees (size is as defined in COBRA legislation)	☐	☐	☐	☐	☐	☐

3. Will BCBST handle COBRA Administration for non-BCBST product(s)? ☐ Yes ☐ No

Insert your Group Rate Proposal(s) page(s) at the end of this form. Clearly indicate the rate tier chosen.

Section C – Plan Eligibility (Medical and/or Dental and/or VisionBlue)

1. To comply with Federal regulations, list total number of employees (full-time, part-time, owners/partners, private contractors): ______________

2. Number of employees who work a minimum 30 hrs. per week (include owners/partners): ______________

3. Does the Employer elect the option to cover permanent Part-Time Employees (Employees who work at least 20 hours per week at least 39 consecutive weeks of the year and have done so for at least one year):
   Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No VisionBlue: ☐ Yes ☐ No

4. Are retirees covered? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No VisionBlue: ☐ Yes ☐ No
   (BlueCross BlueShield of Tennessee guidelines must be met to cover retirees)

5. Special Classes of Employees to be (based on work related criteria):
   (a) **Excluded** from Medical coverage: ☐ None ☐ As Follows
   Explain: ______________
   (b) **Excluded** from Dental coverage: ☐ None ☐ As Follows
   Explain: ______________
   (c) **Excluded** from VisionBlue coverage: ☐ None ☐ As Follows
   Explain: ______________

6. Special Classes of Employees to be (based on work related criteria):
   (a) **Included** for Medical coverage:
   ☐ Key employees (as defined by Employer) have no new employee eligibility period.
   ☐ As Follows (Non-Standard provisions require Risk Management approval and Attachment A-2):
   ____
   (b) **Included** for Dental coverage:
   ☐ Key employees (as defined by Employer) have no new employee eligibility period.
   ☐ As Follows (Non-Standard provisions require Risk Management approval and Attachment A-2):
   ____
   (c) **Included** for VisionBlue coverage:
   ☐ Key employees (as defined by Employer) have no new employee eligibility period.
   ☐ As Follows (Non-Standard provisions require Risk Management approval and Attachment A-2):
   ____

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7. Medical/Dental/VisionBlue Eligibility Waiting Period for Existing Employees.
   Waive at the initial effective date of this Group Agreement: ☐ Yes ☐ No
8. Medical/Dental/VisionBlue Eligibility for New Hires: ☐ Medical ☐ Dental ☐ VisionBlue

***Effective/Termination Date Option Definitions:**

First Billing (Standard):
Subscriber will be effective as of the first billing date following the new hire/rehire eligibility period; termination date is the last day of the billing period following subscriber termination.

Next Day (Referred to as Give and Take):
Subscriber will be effective as of the first day after completing the eligibility period (if employer wants employee effective on date of hire, "Day Of" must be selected); termination date is midnight on the last day of subscriber's employment.

Day Of (Referred to as Give and Take):
Subscriber will be effective on the last day of the eligibility period or the date of hire (if zero); termination date is midnight on the last day of subscriber's employment.

Complete the appropriate segments below for classes and eligibility periods of employees.

	Check Appropriate Boxes					
Employee Classes	**Eligibility Period** (Write # and check applicable period)			First Billing*	Next Day*	Day of*
Cover All Classes		☐ Days	☐ Months			
Only Complete Below if NOT Covering ALL CLASSES of Employees OR if Eligibility Varies by Class						
Hourly		☐ Days	☐ Months			
Salary		☐ Days	☐ Months			
Management		☐ Days	☐ Months			
Non-Management		☐ Days	☐ Months			
Other Classes – List specific classes:						
		☐ Days	☐ Months			
		☐ Days	☐ Months			
		☐ Days	☐ Months			
		☐ Days	☐ Months			

9. **Does the Termination Arrangement differ from selection in # 8 above?** ☐ **Yes** ☐ **No**
   (If "Yes," complete Attachment A-3 for each appropriate class)

10. Does the Employer elect a **Rehire Provision**? ☐ Yes ☐ No
    If "No," rehired employees must meet new employee eligibility requirements. **If "Yes," complete the following:**
    Coverage effective date for rehired employees and their eligible dependents will be determined by the billing arrangement.
    ☐ 30 ☐ 60 ☐ 90 ☐ 180 Other*- ________ ☐ days ☐ months from their last date of employment
    (*If selection is over 180 days, Risk Management approval is required.)

BlueCross BlueShield of Tennessee must receive an application for coverage within 31 days of date of rehire.

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Section D – Organization (Employer) Authorized Signature

This is to certify that all statements contained herein are true and exact to the best of my knowledge. I understand that this application is subject to final approval and acceptance by BlueCross BlueShield of Tennessee and I should not cancel my current coverage until such time BlueCross BlueShield of Tennessee has accepted it and has issued an effective date of coverage. I understand that, in evaluating this application, BlueCross BlueShield of Tennessee is relying on the truth of the statements herein. I also understand that BlueCross BlueShield of Tennessee Sales Representatives and Agents and/or Brokers are not authorized to approve this application. The payment included with this application will apply to the payment of premiums for the first month's billing.

I have either reviewed or had an opportunity to review a Specimen Group Agreement, including the Evidence of Coverage.

I understand that my Broker will be paid a commission and/or other fee by BlueCross BlueShield of Tennessee for placing/encouraging the Group's coverage. For more information, I will contact my Broker. Once this Employer Group Application has been accepted by BlueCross BlueShield of Tennessee, the Employer's payment of the premium for the group membership covered by BlueCross BlueShield of Tennessee (the "Aggregate Premium") shall constitute acceptance by the Employer of the Group Agreement.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. An electronic signature will have the same force and effect as a manual signature.

By signing below, I certify that I am authorized by Employer to execute this Employer Group Application.

Signature: ______________________ **Date**: ______________

Print Name of Signee: ______________________ **Title**: ______________

Section E – Broker's Certification

Primary Broker:

1. Broker's Name: ______________________
2. Address: ______________________

____

Co-Broker:

1. Co-Broker's Name: ______________________
2. Address: ______________________

____

I certify that I have met with the employer submitting this application and have fully explained its contents. I have discussed the Group Agreement, coverage, eligibility, pre-existing condition limitations, termination provisions, and effect of misrepresentation.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. An electronic signature will have the same force and effect as a manual signature.

Broker Signature: ______________________ **Date:** ______________

Co-Broker Signature: ______________________ **Date:** ______________

(If additional space is needed list the above information for each additional broker on a separate page.)

Section F – Company (BlueCross BlueShield of Tennessee) Acceptance

BlueCross BlueShield of Tennessee hereby accepts this application with the rates and benefits outlined in the attached.

By ______________ **Title:** President, Commercial Business & Established Markets **Date:** ______________

Joan C. Harp

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Administrative Form

This document has been classified as confidential

BCBST Admin Form (Revised 01/10)

To be completed by BlueCross BlueShield of Tennessee	
Group Number:	____________
Effective Date:	____________

Please answer all questions completely and accurately

Section A – General Information

When completing electronically, use tab key to move from field to field. When completing paper version, type or print clearly with a ballpoint pen, using black or blue ink (no felt tip pens please).

1. Group Name: ____________
2. Physical Location (**If** different than mailing address): ____________
   City: ____________ County: ____________ State: ______ Zip: ____________
3. Billing Address (**If** different than mailing address): ____________
   City: ____________ County: ____________ State: ______ Zip: ____________
4. Telephone Number: ____________ Extension: ________ (4a) Fax Number: ____________
5. Name of Group Administrator: ____________ (5a) Title: ____________
6. E-mail Address for Group Administrator: ____________
7. E-mail Address for Executive Decision Maker: ____________
8. Nature of Business (Please be detailed): ____________
9. Current Group Medical Carrier: ____________
   9a. Current Dental Carrier: ____________
   9b. Current Vision Carrier: ____________
10. Is this coverage part of a Union–negotiated contract? ☐ No ☐ Yes Date of Expiration: ____________
    10a. Is this a minority ownership? ☐ Yes ☐ No
    10b. Is this a government contractor? ☐ Yes ☐ No
11. What is the employer's fiscal year? ______ -- ______
12. ERISA plan year begins on (MM/DD): ______
13. In the past 36 months, has any creditor filed a petition requesting the Employer or any affiliated entity to be placed into bankruptcy? ☐ Yes ☐ No
14. In the past 36 months, has any Employer or affiliated entity filed for protection or operated under federal or state bankruptcy laws? ☐ Yes ☐ No
15. Changes made via Web (BlueAccess and eHealth Services) to be transmitted by or accepted from:

	Group	**Employee**	**Group/Employee**	**Group/Broker**	**Group/Employee/Broker**
Employee address changes	☐	☐	☐	☐	☐
Coordination of Benefits changes	☐	☐	☐	☐	☐
Enrollment changes	☐	☐	☐	☐	☐

16. Initial ID card mailing goes to: ☐ Group ☐ Subgroup ☐ Employee ☐ Broker ☐ Acct Sales Exec/Acct Exec
17. Future ID card mailing goes to: ☐ Group ☐ Employee
18. Notes: ____________

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Section B – Plan Eligibility

1. Does the Employer have any current group coverage with BlueCross BlueShield of Tennessee? ☐ Yes ☐ No
   If "Yes," please give the current group number or name: ______________________
2. Employer Contribution: Employee Medical: ____% Employee Dental: ____% Employee VisionBlue: ____%
3. Requested billing cycle (renewal date will change **if** different than effective date): ☐ 1st ☐ 15th ☐ Other: ____________
4. Did you have 51 or more employees in the preceding year (include **all** employees)? ☐ Yes ☐ No

	Number **Eligible** at the effective date of this coverage			Number **Enrolling** at the effective date of this coverage		
	Medical	Dental	Vision	Medical	Dental	Vision
Full-time Employees and Owners/Partners						
COBRA / State Continuation						
Employees waiving this coverage but **have other group coverage**.						
Permanent Part-Time Employees (if coverage offered)						
Retirees (if coverage offered)						

Section C – HRA / FSA / HSA

1. Is the Employer offering a BCBST HRA? ☐ Yes ☐ No
2. Is the Employer offering a BCBST FSA? ☐ Yes ☐ No
3. Is Employer contributing to a HSA? ☐ Yes ☐ No
   3a. HSA Bank Selection: ☐ Wells Fargo ☐ First Horizon Msaver ☐ Other ____________

Section D – Broker Information

1. Primary Broker's BCBST ID (SSN or Tax ID #): ______________________
2. Co-Broker's BCBST ID (SSN or Tax ID #): ______________________
3. Do you want a copy of the Contract (EOC included)? ☐ Yes ☐ No

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