DOCUMENTS THAT CONTAIN WHITE-OUT CANNOT BE ACCEPTED

Employer Group Application - EGA		
Section Line#	**Description**	**Instructions**
Section A - General Information		
1	Today's Date	Enter the date this form is completed
2	Requested Effective Date of Coverage	This is the date the coverage is to become effective.
	Initial Renewal Date	This is the 1st renewal date for the proposed rates of the current sale. List as month, day and year of first renewal (ie: 02/01/09).
3	Federal Employer Identification Number (FEIN)	Enter group's FEIN
4	Employer's Legal Name (as listed on your FEIN)	This is the group's complete legal name as listed on the FEIN, including dba name.
4a	Health Benefit Plan Name	Groups of 2-25 employees, skip this field. Groups of 26+ employees, enter Health Benefit Plan Name if you file with Dept of Labor.
5	Mailing Address	This is the address where routine communications should be mailed.
6	Name of Employer's Executive Decision Maker	Group representative that is authorized to make decisions for the group. This person must be employed by the group.
6a	Title	Title of the Employer's Executive Decision Maker
7	Legal Entity	Check appropriate account designation of group. If other is selected, specify on the line provided.
8	Subsidiaries under this Group Agreement	None or Yes must be checked. If yes is checked, enter subsidiaries names & addresses. If additional space is needed, enter same information on a separate page with group name and number indicated.
9	Does this Employer's plan qualify as an ERISA plan?	Must check yes or no.
Section B - Optional Coverage and Services		
Optional Coverages - Medical Only		
1	Behavioral Health	Must be checked accept or decline for each option.
2	Wellcare Rider	Must be checked accept or decline for each option.
Optional Services (applies to all options in a multi-option plan)		
1	COBRA Administration without INL	Must be checked accept or decline for medical and/or dental on groups of 20 or more employees.
2	COBRA Administration with INL	Must be checked accept or decline for medical and/or dental on groups of 20 or more employees.
3	Lifestyle Coaching	Groups less than 150 employees skip this section. Groups of 151+ employees, check yes or no to include or exclude Lifestyle Coaching.
Section C – Plan Eligibility (Medical and/or Dental)		
1	Number of employees	This is the total number of employees who work a minimum of 30 hours per week to include owners and/or partners.

2	Does the Employer elect the option to cover permanent Part-Time Employees	Yes or no must be checked for medical and/or dental
Section Line#	**Description**	**Instructions**
3	Are retirees covered?	Must be checked yes or no for medical &/or dental.
4	Special classes to be excluded	None or as follows must be checked for medical and/or dental. If as follows is checked, the excluded class must be indicated on the line provided.
5	Special classes to be included	All selections that apply must be checked for medical and/or dental. If unanswered the default will be "none". If "As Follows" is checked, a **group specific Special Plan Eligibility Provision Attachment A-2 Form** and prior approval may be needed. See BCBST Representative.
6	Waive the eligibility waiting period on initial enrollment?	Yes or no must be checked and all supporting documentation should match.
7	Medical/Dental Eligibility for New Hires	
One Class of Employees (All employees have the same eligibility period)		If there is only one eligibility period for all employees "Cover All Classes" should be completed for medical and/or dental. Days or Months should be checked with the appropriate number written on the line provided under Eligibility Period and, First Billing, Next Day or Day of should be checked to indicate effective/termination date of coverage.
If eligibility periods vary by class of employees **or** if <u>not</u> covering all classes.		If eligibility periods vary by class of employees or if not covering all classes, the sections below should be checked in the same manner as above, by class.
Other Classes		If the specific class is <u>not</u> identified in either of the above two selections (hourly, salary, management, non-management or all classes), the appropriate class name should be written on the line under Other Classes with the eligibility period and effective/termination date checked in the same manner as above, by class.
Do any Special Termination Arrangements apply?		Must be checked yes or no. If yes, **Special Billing Provisions Attachment A-3 Form** is required and each class must be listed.
8	Does the Employer elect a Rehire Provision?	Must be checked yes or no. If no is selected, no other action is needed. If yes is selected, the number of days a person can be laid off/terminated from their last date of employment & be considered a rehired employee must be indicated (ie: 30, 60, 90, 180 - cannot be 0 days) and days or months must be selected. The rehire days are not usually the same as the newly hired employees nor should it be zero.
Section D - Organization (Employer) Authorized Signature		
The person duly authorized by the group to execute the group agreement. The broker **cannot** sign for the group.		Signature, Date Signed, Printed Name of Signee & Title are all required fields.

Section Line#	Description	Instructions
Section E - Broker's Certification		
Primary Broker		
1	Broker's Name	This is the name of the Broker to receive the commission payment. Note: The Broker must already be an approved Broker to conduct business on behalf of BCBST
1a	BCBST ID #	This is the Broker's SS # or Tax ID # - it is needed before a payment can be made for Form 1099 reporting.
2	Address	This is the mailing address for the commission payment.
Co-Broker		
1	Co-Broker's Name	This is the name of the Co-Broker to receive the commission payment. Note: The Co-Broker must already be an approved Broker to conduct business on behalf of BCBST
1a	BCBST ID #	This is the Co-Broker's SS # or Tax ID # - it is needed before a payment can be made since we must report the money via 1099.
2	Address	This is the mailing address for the commission payment.
Broker Signature & Date Signed		Required
Co-Broker Signature & Date Signed		Required.
Section F - Company (BCBST) Acceptance		
Joan Harp Signature & date		To be completed by BCBST