

7. **DISABLED CONDITION**

Are there any employees, dependents, COBRA participants, or retirees who are disabled? YES NO
If "YES", then a "TOTALLY DISABLING CONDITIONS" form must be completed for each disabled person, and submitted along with the individual's enrollment form.

126+ GROUP IMPLEMENTATION QUESTIONNAIRE

(DOUBLE CLICK ON BOXES AND SELECT "CHECKED")

Note: "✓" indicates BCC standard. Any non-standard provisions must have prior Underwriting Approval.

8. **DEPENDENT ELIGIBILITY**

The employee's unmarried nature child, stepchild, or legally adopted child, if IRS dependent, will be covered up to age 19, or if over the age of 19, until his / her 25th birthday, provided he / she is a full-time student (12 or more credits); **OR**

up to age _____ if IRS dependent and / or full-time student (12 or more credits)

YES Do you want Legal Guardianship language included in the contract? *If you select NO, then an employee*

NO *with court ordered legal guardianship over a dependent child could not cover that child under this health plan.*

EXCEPTION CHECKED: No Dependent Coverage Spouse Only coverage

9. **APPROVED LEAVE OF ABSENCE**

Employee remains eligible during an approved leave of absence up to 6 months

Other: _____

10. **EVIDENCE OF COVERAGE / CERTIFICATE**

A. If other than the Legal name is to appear on the EOC / Certificate, list name below:

DBA _____

Other _____

11. **EVIDENCE OF COVERAGE / CERTIFICATE (continued)**

B. Initial EOC's / Certificates will go to the Group, unless otherwise specified below:

Deliver to BCC Sales Rep Deliver to Broker Deliver to TPA

At address below (P.O. Box's are not acceptable):

Company Name: _____

Street Address: _____

City, State, Zip: _____

Attention: _____

C. Does Group request SPF information in the certificate? YES NO

If "Yes", the completed Summary Plan Description Instruction Form must be attached.

D. Spanish language EOC's / Certificates are available for standard plans. Indicate by benefit plan, the number of Spanish booklets needed:

Blue Cross HMO: _____ Blue Cross PPO: _____ PB PPO Dental: _____ Dental Net: _____

E. The EOC will be printed with the standard format, paper and cover stock, without a union bug, unless a customized EOC is requested.

Check here for customized printing. (MUST HAVE PRIOR UNDERWRITING APPROVAL)

F. EOC's: Please print 150% of enrolled lives YES NO

G. EOC's: Please print minimum quantities of EOC's / amendments and provide electronic copy of the EOC / amendment. The electronic copy will be used for (check **one**):

PC Viewing Only Downloading for client's internet Use by broker / consultant only

12. **CERTIFICATES OF PRIOR COVERAGE (HIPAA)**

Blue Cross of California

Other _____

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(DOUBLE CLICK ON BOXES AND SELECT "CHECKED")

Note: "✓" indicates BCC standard. Any non-standard provisions must have prior Underwriting Approval.

13. WHERE WOULD YOU LIKE THE INITIAL IDENTIFICATION CARDS MAILED?

- Company address (as indicated on Application for Group Benefit(s) Agreement)
- Employee's residence (as indicated on enrollment application)
- Broker
- Blue Cross Sales Office
- Other: _____

14. WHERE WOULD YOU LIKE THE MAINTENANCE IDENTIFICATION CARDS MAILED?

- Company address (as indicated on Application for Group Benefit(s) Agreement)
- Employee's residence (as indicated on enrollment application)
- Broker
- Blue Cross Sales Office
- Other: _____

15. SUBSIDIARIES / MULTIPLE LOCATIONS

If you have other company locations or subsidiaries, please list below name(s) and address(s) of all additional companies and subsidiary locations (if needed, attach a separate listing)

A. Company Name / Location: _____
Address: _____ City, State, Zip: _____

B. Company Name / Location: _____
Address: _____ City, State, Zip: _____

C. Company Name / Location: _____
Address: _____ City, State, Zip: _____

16. UNION EMPLOYEES

Are any employees covered under a collective bargaining agreement? YES NO
If yes, include continuation during labor dispute provision in EOC / Certificate? YES NO

17. OTHER CARRIERS

Will you continue to contract with any other carrier(s) for your health insurance needs? YES NO
If yes, please list the carrier's names and coverage's (medical, dental, etc.)

Carrier: _____ Coverage(s): _____
Carrier: _____ Coverage(s): _____
Carrier: _____ Coverage(s): _____

18. WORKERS' COMPENSATION

Please provide current contact information for your Workers' Compensation carrier.

Carrier Name: _____ Contact Name: _____
Address: _____
Phone #: _____ Fax #: _____ E-mail: _____

19. PRIOR CARRIER COORDINATION

Please provide the name and phone number of an individual with your prior health carrier with whom we can coordinate for medical case management and transitional assistance.

Contact Name: _____ Phone Number: _____

