



APPLICATION FOR GROUP BENEFIT AGREEMENT(S)/GROUP POLICY FOR EMPLOYER GROUPS WITH 250+ EMPLOYEES

GROUP INFORMATION – The Group applicant certifies the following information:

Group's Legal Name:		Type of Business:			
Street Address (P.O. Box is not acceptable)	City	County	State	Zip	
Email address:					
<i>If this is a self-funded group, please include the HIPAA designated rep. information below</i>					
Designated Representative's Name:				Title:	
Designated Representative's Address (if different than above):					
Street Address (P.O. Box is not acceptable)	City	County	State	Zip	
Form of Organization:					
<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Taft-Hartley Trust* <input type="checkbox"/> Government Entity (non-schools) <input type="checkbox"/> School (non-JPA) <input type="checkbox"/> Association* <input type="checkbox"/> Union <input type="checkbox"/> MET* <input type="checkbox"/> JPA* <input type="checkbox"/> Fraternal Order <input type="checkbox"/> Other _____					
*Attach trust document, JPA document or association by-laws, as appropriate. An Agreement/Policy will NOT be issued unless the appropriate document is received.					
Employees of the following subsidiaries or affiliates are to be included:					

COVERAGE(S) REQUESTED AND CONTRIBUTIONS The Employer will contribute the following percentage of the subscription charge/premium on behalf of its employees for the coverage(s) requested:

<input type="checkbox"/> BlueCross PPO Plan[®] Employee _____% Dependent _____%	<input type="checkbox"/> BlueCrossHMO Plan[®] Employee _____% Dependent _____%	<input type="checkbox"/> Power Select HMO Employee _____% Dependent _____%	<input type="checkbox"/> BlueCard Employee _____% Dependent _____%
<input type="checkbox"/> FFS# Dental Plan Employee _____% Dependent _____%	<input type="checkbox"/> PPO Dental[®] Employee _____% Dependent _____%	<input type="checkbox"/> Pwr CareAdv PPO Employee _____% Dependent _____%	<input type="checkbox"/> BC Plus# Medical Employee _____% Dependent _____%
<input type="checkbox"/> Dental Net Plan[®] Employee _____% Dependent _____%	<input type="checkbox"/> Choice Dental[®] Employee _____% Dependent _____%	<input type="checkbox"/> Other (specify) Employee _____% Dependent _____%	<input type="checkbox"/> See Participating Employer Application
<input type="checkbox"/> Employee Supplemental Life Employee _____%	<input type="checkbox"/> Employee Accidental Death and Dismemberment Employee _____%		
<input type="checkbox"/> Employee Life (Basic) Employee _____%	<input type="checkbox"/> Dependent Life Dependent _____%		

Subscription charges/premiums under a Group Benefit Agreement/Group Policy are to be payable monthly unless otherwise indicated in the Agreement/Policy. #FFS–Fee-For-Service; BC Plus–Blue Cross Plus Plans

FLEXIBLE SPENDING ACCOUNT ADMINISTRATION

EMPLOYEE ELIGIBILITY

Eligible employees are:

- Active full-time employees who work at least 30 hours per week
- Active full-time employees working _____ hours per week
- Part-time employees working _____ hours per week
- Retirees; must be covered under group plan prior to retirement. Check all additional requirements that apply:
 - completed _____ years of service with employer prior to retirement
 - is at least _____ years of age on the date of retirement
 - is eligible for employer's pension plan
 - retirement on or before (date) _____ retirement on or after (date) _____
 - Other (specify): _____

Total number of employees: _____ Total number of employees ineligible: _____

Total number of active full-time eligible enrolling employees: _____ Total number of part-time or temporary employees: _____

Total number of employees covered under an additional HMO or other health plan (other than Blue Cross/CaliforniaCare): _____

PROBATIONARY PERIOD/ELIGIBILITY DATE:

Eligibility Date is always on the FIRST DAY of the month following waiting period unless otherwise specified.

The waiting period for employees: one month two months three months Other _____
 Other than FIRST DAY of month: Eligible on _____ day from date of hire or Other _____

Do you have any CalCOBRA eligible participants? YES NO If yes, provide listing to BCC.

DOMESTIC PARTNERSHIP:
(Please note that if boxes left unchecked the DP coverage automatically defaults to Statutory AB2208.

- | | |
|---|---|
| 1. <input checked="" type="checkbox"/> Statutory AB 2208 | 1a. <input type="checkbox"/> Statutory AB 2208 with DP COBRA |
| 2. <input type="checkbox"/> Statutory AB 2208 Plus | 2a. <input type="checkbox"/> Statutory AB 2208 Plus with DP COBRA |
| 3. <input type="checkbox"/> Blue Cross Standard | 3a. <input type="checkbox"/> Blue Cross Standard with DP COBRA |
| 4. <input type="checkbox"/> SF / LA Ordinance (Includes DP COBRA coverage) | |
| California law requires that Blue Cross/BC Life cover a legally registered domestic partner of a subscriber/an employee to the same extent, subject to the same terms and conditions, and in the same way that they cover a dependent spouse of a subscriber/an employee. There are no COBRA continuation rights for the domestic partner or the domestic partner's children. Blue Cross/BC Life offers coverage options that are more liberal than the law requires. If you want a coverage option that is more liberal than the law requires, please check any box above, other than Statutory AB 2208. | |

CURRENT CARRIER(S):

Is this plan intended to replace any existing group coverage? YES NO

If YES, name of group carrier(s): _____

Current group carrier proposed termination date: _____

GENERAL AGREEMENT AND SIGNATURE

Effective date requested: _____ (Actual date will be assigned by Blue Cross if application is accepted)
Application is hereby made to Blue Cross of California (Blue Cross) or the appropriate affiliated company for a Group Benefit Agreement/Group Policy providing coverage identified above. If this application is accepted, an Agreement/Policy will be issued which will set forth the terms, benefits and conditions of the relationship between the Group and Blue Cross. This application will become part of that Agreement/Policy.

Upon acceptance of the application, the Group will inform all persons who are eligible for coverage that they may apply for Blue Cross coverage under the Agreement/ Policy.

It is understood that no agent or representative except the President, a Vice President, or the Secretary has power on behalf of Blue Cross to bind Blue Cross to accept risk, issue an Agreement/ Policy, or commit to particular provisions of an Agreement/ Policy. No coverage will come into effect unless and until this application is accepted. If accepted, the terms of the relationship will be defined entirely within a Agreement/ Policy.

Any dispute between a person covered under the Agreement/Policy and Blue Cross must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, not by law suit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the person covered and Blue Cross are giving up the right to have any dispute decided in a court of law before a jury.

I understand and agree to all of the above.

Dated at _____ on, _____

By: _____ Name and Title: _____
(Authorized Signature) (Print Name and Title of Officer, Partner or Proprietor)

Authorized Broker of Record:

Broker No.:

Broker Commission to be %: _____

FOR BLUE CROSS USE ONLY

Application is: Accepted Rejected Case No. _____

Effective: _____ Underwriter: _____ Date: _____

CONDITIONAL RECEIPT:

This will acknowledge receipt of \$ _____ (\$ _____ of this amount is for Blue Cross coverage and the balance is for other coverage(s)) from _____ as a deposit against the subscription charge/premium that would become payable if Blue Cross of California accepts this application for group coverage. This amount will be refunded if Blue Cross declines this application for group coverage. Any offer of coverage is based on the information supplied by the Group. **If we discover that any such information is incomplete or inaccurate, we reserve all rights and remedies and may, at our option, withdraw or modify the offer.**

Date: _____ By: _____
(Signature)