Regence BlueCross BlueShield of Utah and its non-insurer subsidiary, Regence ValueCare
Regence HealthWise
Attn: Sales #28
P.O. Box 30270
Salt Lake City, Utah 84130-0270

C# __________ G# __________

Group Application Form

Official Company Name (As registered with the State of Utah)

Type of Business (Give Details)

Mailing Address (Include any Attention Line and Suite or Apt #), City, State, Zip

SIC Code

Billing Address (Include any Attention Line and Suite or Apt #), City, State, Zip

Telephone #
Fax #
E-mail address:

Chief Executive Officer | Health Benefits Decision Maker & Title | Health Benefits Group Leader

Network Option:
- ☐ BCBS
- ☐ ValueCare
- ☐ HealthWise*

*(not available on HSA)

Health Option:
- ☐ BlueEssentials
- ☐ BluePreferred
- ☐ BlueClassic

Dental Option:
☐ BCBS ☐ ValueCare

HSA Qualified Plan:
- ☐ Regence HSA Healthplan

HSA Banking Partner:
- ☐ US Bank
- ☐ HSA Bank
- ☐ Wells Fargo
- ☐ Other ________

Life Options: Carrier: ☐ Regence Life & Health - *P.O. Box 1271 MS E3A, Portland, OR 97207 (domiciled in Oregon)*

BENEFIT

Employee Life and AD&D ___________ | Supplementary Life ☐ Yes ☐ No ____________
Dependent Life ___________ | Voluntary Life ☐ Yes ☐ No ________
ST Disability ☐ Yes ☐ No ___________ | Other ☐ Yes ☐ No ___________
LT Disability ☐ Yes ☐ No ___________

Health Coverage Code | Drug Coverage Code | Dental Coverage Code | Vision Coverage Code | 24 Hr. Coverage ☐ Yes ☐ No

Eligibility Waiting Period: ***Please indicate ONE CHOICE ONLY.***
Effective 1st billing period following ☐ Date of hire or ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 6 months from date of hire.
☐ Other (explain)____
NOTE: Date of hire Eligibility Waiting Periods must be approved by Underwriting.

Requested Effective Date: ___________________________
Requested Renewal Date: ___________________________

Send COB Cards? ☐ Yes ☐ No

Including Data for Credit on?
Deductible ☐ Yes ☐ No
Stoploss ☐ Yes ☐ No

Send IDs to: ☐ Subscriber ☐ Other ____________ ☐ No IDs

Send Cert. of Creditable Coverage to: ☐ Group ☐ Both Group & Sub ☐ Subscriber ☐ Do not mail Certs

Type of Group: ☐ Local ☐ Self-Funded ☐ Individual ☐ National

Agent/Agency Name ________________________ Commission % ____________ Agent/Agency # ________________
Producer Name ________________________ Phone ________________ Fax ________________
Agent/Agency Name ________________________ Commission % ____________ Agent/Agency # ________________
Producer Name ________________________ Phone ________________ Fax ________________
Onyx Customer ID # ________________ Agent e-mail ________________________
Sales Executive Name ________________ SE# _________ Renewal Rep# _________ Account Exec# _________ Team ___________
Pooled with ________________ Assoc Code _____________ Initial Sales Received Date _____________ Sales Complete Date ______________
Comments: ____
____

Application for Group Health Care Contract

(MUST BE COMPLETED BY AN AUTHORIZED COMPANY OFFICIAL)

Application is hereby made by (Company Name as registered with the State of Utah) ________________________, hereinafter called the Group, to Regence BlueCross BlueShield of Utah, its non-insurer subsidiary, Regence ValueCare, and/or Regence HealthWise, hereinafter called Regence BCBSU, for a new or renewal Health Care Contract. Official Company Mailing Address (Including Suite, if any) ________________________

City ________________________ State _________________ ZIP _________________

COBRA:
Group subject to COBRA? ☐ No ☐ Yes

ERISA:
Group subject to ERISA? ☐ No ☐ Yes
Is your plan year different than your renewal date? ☐ No ☐ Yes, list date __________________

OBRA:
Group subject to OBRA? ☐ No ☐ Yes

If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January- December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:
Group subject to TEFRA/DEFRA? ☐ No ☐ Yes

If you employed 20 or more full-time and/or part-time employees during each of 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

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Application for Group Health Care Contract *(Continued)*

GROUP DEMOGRAPHICS:
The following represents an accurate accounting of employees working for this Group as of the date of application.

A. **Total Number of Owners & Employees** __________

B. Total Owners & Employees **not** eligible for coverage because:
- Part-time or working fewer than required hours per week __________
- Other (specify) ________________________________ __________

C. **Subtotal of Eligible Owners & Employees (A minus B)** __________

D. Eligible Owners & Employees **not** currently enrolling because:
- Waiving coverage because **covered by another employer** __________
- Waiving coverage because **chooses no coverage** __________
- New Hires **within waiting period** __________

E. **Employees Enrolling at Group's Effective Date (C minus D)** __________

F. How many in 'E' have dependents? __________

G. How many in 'F' enrolled their dependents? __________

H. How many in 'E' are COBRA or State Extension enrollees? __________

COBRA ELIGIBILITY

I. How many terminated employees and/or their dependents are currently eligible for COBRA or State Extension but have not applied? __________

CONTRIBUTION TO HEALTH PREMIUMS:
The **Employer** agrees to pay the following **percentages** of the total health premiums:

_________% of the Single coverage rate
_________% of the Two-party coverage rate
_________% of the Family coverage rate

CONTRIBUTION TO HSA:
(if applicable)

$_________ For Single Coverage
$_________ For Family Coverage

CONTRIBUTION TO LIFE PREMIUMS:
The **Employer** agrees to pay the following **percentages** of the total life premiums:

_________% of Employee Life and AD&D
_________% of Dependent Life
_________% of Short-term Disability
_________% of Long-term Disability
_________% of Supplementary Life
_________% of Other ___________

COMPANY STRUCTURE: LIST ALL PARENT, SUBSIDIARY OR OTHER COMPANIES AFFILIATED BY COMMON OWNERSHIP

In what state is the Company headquartered? ____

☐ Sole Proprietorship
☐ Partnership
☐ Corporation ☐ Parent
☐ LLC ☐ Subsidiary
☐ LLP ☐ Not Applicable

Company Name	Address	Owner(s)	Ownership %

Federal Tax ID (EIN) ____________________________

EMPLOYEE/DEPENDENT ELIGIBILITY PROVISIONS:

To be eligible, an employee must: (a) be permanently employed working at least _____________ hours per week for the Group; (b) be in an employer/employee relationship as defined by Federal Tax Laws; (c) have Federal and State (including FICA) taxes and any uncontributed portion of the health premium withheld on a payroll deduction basis; (d) be covered by employer-paid Workers Compensation; and (e) be accepted into one of the health programs sponsored by this Group in accordance with the provisions of this and any other written agreements between the Group and Regence BCBSU.

Eligible dependents include an eligible employee's legal spouse and dependent children, as defined in the Booklet. Exceptions to these Eligibility Provisions are specifically set forth as follows: ____

GENERAL:

Does this policy replace an existing policy? ☐ Yes ☐ No If yes, list prior insurance carrier(s):______________________ Renewal Month ___________

Groups with a maximum rate up, moving off anniversary, will be assessed a one-time 25% surcharge of their annual premium.

Has this Company ever been enrolled with Regence BCBSU? ☐ Currently ☐ Yes ☐ No If yes, please give cancel date: Month _____ Year ____

Is Regence BCBSU the only insurance carrier of Health Coverage in the group? ☐ Yes ☐ No If no, please list the other insurance carrier(s) to be offered: ________________

Does your company carry Workers Compensation insurance? ☐ Yes ☐ No **If yes, list carrier:** ______________________________

Please complete the following for those enrollees **not** covered by Workers Compensation. Please include an explanation.

Name	Job Title	Explanation

All enrollees not required by law to carry Workers Compensation coverage and who do not carry such coverage must be enrolled in 24-hour coverage. All enrollees required by law to carry Workers Compensation must do so.

The Group's completion and submission of this "Application for Group Health Care Contract" to Regence BCBSU shall be deemed an offer to contract and, if Regence BCBSU chooses to issue a health care contract to the Group, that issuance shall be Regence BCBSU's acceptance of the Group's offer.

This insurance will become effective when it is accepted by Regence BCBSU for Health and Regence Life and Health Insurance Company for Life and/or Disability as applicable.

I agree that the information as completed in this "Application for Group Health Care Contract" is true and recognize that Regence BCBSU, and Regence Life and Health Insurance Company, will rely upon this information in issuing coverage. I further understand and agree that other provisions (e.g., coverage, rates, etc.) may change throughout the contractual period with 30 days prior written notice by Regence BCBSU. Likewise, if any of the provisions contained herein change, I agree to notify Regence BCBSU in writing within 30 days of the change to obtain approval for such change. This Contract incorporates the Booklet and Application with the Group Contract and with such incorporation constitutes the entire agreement between Regence BCBSU and the Group. Regence BCBSU's agreement to provide certain administrative services for the Group should not be construed as, and the parties specifically agree does not, constitute Regence BCBSU's agreement to act as Benefit Administrator, as defined in the Employee Retirement Income Security Act of 1974 (ERISA), for the employer's group health plan or any portion of it.

If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Utah. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with Regence and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

Employer Signature	Employer Title	Date Signed
Agent/Producer Signature (if applicable)	Agent Title	Date Signed