



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Group Master Application

Please complete and submit this application to our office **no later than 15 days prior to the effective date** or there may be delays to the processing and activation of your group. If additional space is needed please attach a separate sheet of paper.

NEW/RENEWAL COVERAGE FOR GROUPS OF 100+

Requested Effective Date _____

SECTION 1 - GROUP INFORMATION

Group's Legal Name		Company Structure <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____	
Doing Business As (DBA)		Location of Business Headquarters	
Name to be used by Regence <input type="checkbox"/> Legal <input type="checkbox"/> DBA			
Employer Federal (EIN) and State (if applicable) Tax ID Numbers		SIC Code and Industry Description 	
Name and Title of President, Owner, CEO		Group's Primary Language (if other than English)	
Physical Business Address (No PO Box or PMB) Required		Mailing Address (if different from Physical Business Address)	
City, State and ZIP Code		City, State and ZIP Code	
County	Phone Number () Fax Number ()	County	Phone Number () Fax Number ()

PRIMARY GROUP CONTACT

Name (First, MI, Last)		Title
Phone Number ()	Fax Number ()	E-mail Address

OTHER CARRIER INFORMATION

Medical: Does your group have current Medical coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of carrier _____ Date coverage will end _____	Dental: Does your group have current Dental coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of carrier _____ Date coverage will end _____
Pharmacy: Does your group have current Pharmacy coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of carrier _____ Date coverage will end _____	Workers' Compensation: Does your group have current Workers' Compensation coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of carrier _____
Will you be offering more than one medical insurance carrier to your employees? <input type="checkbox"/> No <input type="checkbox"/> Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>	Will you be offering more than one dental insurance carrier to your employees? <input type="checkbox"/> No <input type="checkbox"/> Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>

AGENT INFORMATION

Agency Name		Agent (Producer) Name	
Agent E-mail Address		Agent Phone Number	Agent Number
Secondary Agent Name		Secondary Agent Phone Number	Secondary Agent Number
Agent Medical Commission: <input type="checkbox"/> Flat _____% <input type="checkbox"/> PEPM \$ _____ <input type="checkbox"/> PMPM \$ _____ <input type="checkbox"/> None		Commission Split %: Agent #1 % _____ Agent #2 % _____	
Agent Dental Commission: <input type="checkbox"/> Flat _____% <input type="checkbox"/> PEPM \$ _____ <input type="checkbox"/> PMPM \$ _____ <input type="checkbox"/> None		Commission Split %: Agent #1 % _____ Agent #2 % _____	

SECTION 1 - GROUP INFORMATION (continued)**BILLING**

Desired Billing Location (please mark one) <input type="checkbox"/> Physical <input type="checkbox"/> Mailing <input type="checkbox"/> Other (Please indicate any differences to page one below)		Do you require separate billing invoices by location? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please name billing location in space listed below)
Name	Additional Billing Location Name	Additional Billing Location Name
Billing Address	Billing Address	Billing Address
City, State and ZIP Code	City, State and ZIP Code	City, State and ZIP Code
Phone Number () Fax Number ()	Phone Number () Fax Number ()	Phone Number () Fax Number ()
Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)
Payment Type		
<input type="checkbox"/> Pay by Check <input type="checkbox"/> Surepay (EFT)*	<input type="checkbox"/> Pay by Check <input type="checkbox"/> Surepay (EFT)*	<input type="checkbox"/> Pay by Check <input type="checkbox"/> Surepay (EFT)*
<i>* Please submit Surepay document</i>	<i>* Please submit Surepay document</i>	<i>* Please submit Surepay document</i>

EMPLOYER CENTER

Online Reporting No Yes* Online Enrollment and eBilling No Yes*

*Primary Group Administrator for Employer Center: Name (First, MI, Last)	E-mail Address	Phone Number ()
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If more than two Secondary Group Administrators for Employer Center are required, indicate the number desired _____

For Online Enrollment, complete the following:

Allow employees to enroll themselves and update family information online No Yes
 If Yes, allow employees to change their address online No Yes

FEDERAL MANDATES**COBRA:**

Group subject to COBRA? No Yes

If you employed 20 or more full-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal COBRA laws. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

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.

ERISA:

Group subject to ERISA? No Yes

Is your plan year different than your renewal date? No Yes, list date _____

Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals in these entities, as well as most voluntarily established pension plans.

Schedule A / Form 5500 information required?

No Yes If yes, reporting time frame required _____

SECTION 2 - ELIGIBILITY INFORMATION

GROUP ELIGIBILITY (for purposes of determining group classification)

Note: An "eligible employee" is defined as an employee who on a full-time basis worked 30 or more hours/week in the preceding calendar year.

- Number of eligible employees in the preceding calendar year _____
- Do you have eligible employees employed outside the State? No Yes If yes, please indicate below.
Note: Group members who reside in the state of Hawaii are not eligible for coverage.
- Is the group a subsidiary or affiliate of another company? No Yes If yes, please explain _____

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

EMPLOYEE ELIGIBILITY (for purposes of determining who is eligible for group benefits)

Note: The minimum number of hours worked for eligibility are 30 hours in a normal work week.

- This plan covers employees working the minimum number of hours required for coverage.
The minimum number of hours to be eligible for coverage are: _____
- This plan provides domestic partner coverage: No Yes

3. New Hire Probationary Periods: Groups may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. All employees must be accounted for.	Actual Date of Hire	DAYS							
		First of the month following (place an X in box)							
		Date of Hire	30	60	90	120	180	365	Other
Class 1:									
Class 2:									
Class 3:									

3A. Waiving new hire probationary period on group's initial enrollment: No Yes

SECTION 3 - EMPLOYER CONTRIBUTION

The employer will pay the following percentages/dollars toward the monthly rate. If different classes are chosen, please indicate classes and contribution for each.

Note: Employer must contribute a minimum of 75% of the employee rate for insurance or 50% of the total cost of premium. There is no minimum employer contribution percentage for dependents.

	Class 1		Class 2		Class 3	
	Medical	Dental	Medical	Dental	Medical	Dental
Employee	% or \$	% or \$	% or \$	% or \$	% or \$	% or \$
Dependent	% or \$	% or \$	% or \$	% or \$	% or \$	% or \$

SECTION 4 - GROUP PARTICIPATION

Note: There is a minimum participation requirement of 75% after valid waivers.

- Total number of employees on payroll regardless of hours worked (Do not include COBRA participants).
- Less employees not eligible for coverage on this plan:
 - Employees working fewer than the minimum hours described in Section 2 Eligibility Information including those who are part-time.
 - Employees who are temporary, seasonal or substitute employees.
 - Employees who are fulfilling their New Hire Probationary Period described in Section 2 Eligibility Information.
 - Employees paid via IRS Form 1099.
- Equals subtotal number of employees eligible to enroll.
- Less number of employees waiving for **other qualifying coverage**.
- Equals total number of employees eligible to enroll.
- Number of employees who are **declining coverage**.
- Number of employee applications being submitted (for new groups only).
- Number of former and current employees covered by your group under COBRA.
- Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.
- Number of former and current employees not eligible for COBRA who are covered by a group extension plan.

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-	
	=
Medical	Dental
-	-
=	=

SECTION 5 - ACKNOWLEDGMENTS AND CERTIFICATIONS

If you have any questions about the benefits and services that are covered, provided, limited or excluded under the group coverage(s) to which this application applies, please contact your Sales Representative before signing this application.

Note: The Company as used here means the group applying for coverage as indicated in Section 1 of this application.

I certify that I am an officer or employee of the Company, that I am duly authorized to execute this application on behalf of the Company, and that the Company:

- a) Authorizes any person or other entity to release to Regence BlueCross BlueShield of Utah any information requested by Regence BlueCross BlueShield of Utah in connection with this application's processing.
- b) Acknowledges, where permitted by law, that Regence BlueCross BlueShield of Utah may choose not to approve this application and any premium deposit will be returned if the application for group coverage(s) is not approved.
- c) Acknowledges that coverage is not in effect until Regence BlueCross BlueShield of Utah accepts this application, establishes an effective date of coverage and issues the group contract(s) to the Company.
- d) Acknowledges that, if it is approved by Regence BlueCross BlueShield of Utah, this application will form a part of the group contract(s) issued by Regence BlueCross BlueShield of Utah and agrees that the Company will be bound by the terms and the conditions of entire group contract(s).
- e) Acknowledges that eligibility standards (e.g., waiting period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.
- f) Acknowledges that it has selected the group coverage(s) to be offered to its employees, that its selection of this group coverage(s) was based upon written information provided by Regence BlueCross BlueShield of Utah, and that no broker, agent, or consultant was or is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.
- g) Agrees to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Regence BlueCross BlueShield of Utah for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Regence BlueCross BlueShield of Utah, upon its request verifications of employee participation levels.
- h) Agrees that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence BlueCross BlueShield of Utah, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.
- i) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.
- j) Agrees to deliver, or otherwise make available to enrollees, all Regence BlueCross BlueShield of Utah paper or online member documents and other coverage-related materials upon request by Regence BlueCross BlueShield of Utah.
- k) Agrees to make all coverage options available to all eligible employees and dependents who satisfy eligibility requirements.
- l) Acknowledges that benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and Regence BlueCross BlueShield of Utah in accordance with the group contract(s).
- m) Acknowledges that Regence BlueCross BlueShield of Utah must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc).
- n) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Regence BlueCross BlueShield of Utah, that Regence BlueCross BlueShield of Utah does not provide health care services, and that Regence BlueCross BlueShield of Utah cannot guarantee any results or outcomes of care. We are responsible for the quality of health care you receive only as provided by law.
- o) Certifies under penalty of perjury that all statements made and information provided in this application are accurate and complete to the best of its knowledge or belief and acknowledges that Regence BlueCross BlueShield of Utah will rely in part on the information in this application as the basis for Regence BlueCross BlueShield of Utah's decision on whether to approve this application and issue any group contract(s). For the protection of all of Regence BlueCross BlueShield of Utah's members, fraud or intentional misrepresentation of material facts by the Company may result in Regence BlueCross BlueShield of Utah taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, Regence BlueCross BlueShield of Utah will have the right to collect any claims payments or other damages. If Regence BlueCross BlueShield of Utah continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that Regence BlueCross BlueShield of Utah will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by Regence BlueCross BlueShield of Utah.
- p) Agrees that any controversy or claim between the Company and Regence BlueCross BlueShield of Utah arising out of or relating to the group contract(s), or the breach thereof, whether involving a claim in tort, contract, or otherwise, shall be subject to final resolution through binding arbitration. The Company and Regence BlueCross BlueShield of Utah agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs, and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in Salt Lake County, Utah (UT), unless mutually agreed otherwise by the parties. If any enrollee or former enrollee (or person claiming to be an enrollee or former enrollee) makes any claim or brings any action or proceeding arising out of or relating to the group contract(s) to which Regence BlueCross BlueShield of Utah or the Company becomes a party, Regence BlueCross BlueShield of Utah and the Company agree to cooperate in the defense of such claim, action, or proceeding and to resolve any controversy or claim between Regence BlueCross BlueShield of Utah and the Company through arbitration under this paragraph only after the resolution of the enrollee's (or alleged enrollee's) claim.
- q) Appoints the agent of record indicated in Section 1 - Group Information (if any) to represent it in matters of group coverage benefits provided by Regence BlueCross BlueShield of Utah. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.
- r) Acknowledges that if the Company has an agent, that agent may receive bonuses, commissions, administrative services 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 the Company's business, the products the Company purchases, the agent's volume of business with Regence BlueCross BlueShield of Utah, and other services the agent provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information please contact the agent for the Company.

SIGNATURE

Group Authorized Signature



Official Title



Signature Date


