



Independence Blue Cross
1901 Market Street, Philadelphia, PA 19103

Blue Solutions®

Application for New Small Employer Health Benefits – 2-50

This form and the Blue Solutions suite of plan designs can only be used when a group has between 2 and 50 total employees. Total employees represents all active full-time, part-time, and seasonal employees on the payroll as of the requested effective date.

Section I. Company Information

Full Legal Name of Company:

Tax ID#:

CID/Group #(internal use only):

Customer Address:

City:

State:

Zip:

Customer Contact:

Phone: ()

Fax: ()

Nature of Business:

Year in Business:

Customer Email Address:

Is there any Group Health Plan now in force and to be continued: Yes () No () Name of Carrier:

Total number of eligibles:

Total number of employees:

Amount of Premium paid by employer: 100% Partial _____% Other

Number of Hours Worked per Week for Eligibility: _____

Section II: Third Party Representation

Marketing Representative Name/Code:

Producing Agent:

Primary Broker/Association:

Broker/Association ID#:

Section III: Quote Conditions Signature

Available Benefits

• Groups with 2-50 employees (including active full-time, part-time, and seasonal workers) must select Blue Solutions® or Blue Solutions® Choice for small employers options, which includes prescription drug, vision and pediatric dental benefits. Groups can offer multiple Blue Solutions® Choice plans from the Choice product portfolio.

Participation Requirements

- Groups of 2-19 eligible lives (employees that qualify for benefits) must have 100 percent participation in combined or separate HMO/POS/PPO offerings. IBC requires a minimum of two enrolled lives.
- Groups with 20-50 eligible lives (employees that qualify for benefits) must have 75 percent participation, which includes all product lines. HMO/POS-only groups must also have 75 percent participation.
- Adult DHMO follows the medical guidelines, but Adult Dental PPO has different participation requirements. Adult PPO plans: Groups of 2-9 lives must have 100% participation. Groups of 10-50 lives must have a minimum of 10 enrolled or 20%. Waivers due to coverage under the spouse (spousal waiver) count toward participation.
- IBC will count waivers in the eligibility calculations.
- Credit is given for those eligible employees who opt out because they have coverage through a spouse, as an eligible dependent to 26, or are enrolled in Medicare or Medicaid. Only these types of opt-outs, or waivers, are excluded from the calculation to determine if a group meets the 100 percent participation requirement.
- Retiree-only groups will not be accepted. For groups covering retirees, 100 percent participation will be required for active and retired employees. The group must consist of a minimum of 75 percent active employees.

Employer contribution requirement

- For contributory plan offerings, you must contribute a minimum of 25 percent of the calculated gross monthly premium or 75 percent of the single-tier rate for each plan offered.
- For fully-insured accounts that offer a high deductible health plan (HDHP), the employer cannot fund more than 50 percent of the annual employee/family deductible; provide a secondary/supplemental benefit plan that augments the core health insurance plan; pay more than 50 percent of employee/family deductible costs through an allowance or claims payment; or provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible.

Rate tiers

- All rates will be offered on a standard four-tier basis effective January 1, 2011. Adult Dental PPO rates are per member effective January 1, 2014.

Submission guidelines

- All offerings are subject to final underwriting review and acceptance. Additional guidelines and policies may apply.

Additionally, I have appointed (Broker Agency / Association) to represent our employment group. I understand that, if eligible, commissions on the account will be paid by the carrier and additional compensation known as "override commissions" may be earned from the carrier for meeting overall sales and retention goals.

Print Name: _____

Title: _____

Signature: _____

Date: _____



Independence Blue Cross/Keystone Health Plan East Benefit Plans
Blue Solutions®

Application for New Small Employer Health Benefits – 2-50

Company Name: _____ **Effective Date:** _____

Copay Plans* (contract year)

- | | | |
|---|---|--|
| Product: <input type="checkbox"/> HMO
Plan: <input type="checkbox"/> Platinum Premier
<input type="checkbox"/> Platinum
<input type="checkbox"/> Gold Premier
<input type="checkbox"/> Gold Proactive | Product: <input type="checkbox"/> Direct POS
Plan: <input type="checkbox"/> Platinum Premier
<input type="checkbox"/> Platinum
<input type="checkbox"/> Gold Premier | Product: <input type="checkbox"/> PPO
Plan: <input type="checkbox"/> Platinum Premier
<input type="checkbox"/> Platinum
<input type="checkbox"/> Gold Premier |
|---|---|--|

Deductible Plans* (contract year)

- | | | |
|--|--|---|
| Product: <input type="checkbox"/> HMO
Plan: <input type="checkbox"/> Gold
<input type="checkbox"/> Silver Premier
<input type="checkbox"/> Silver Proactive
<input type="checkbox"/> Silver
<input type="checkbox"/> Bronze | Product: <input type="checkbox"/> Direct POS
Plan: <input type="checkbox"/> Gold
<input type="checkbox"/> Silver Premier
<input type="checkbox"/> Silver
<input type="checkbox"/> Bronze | Product: <input type="checkbox"/> PPO
Plan: <input type="checkbox"/> Gold
<input type="checkbox"/> Silver |
|--|--|---|

HRA and HSA Plans w/ Integrated RX * (contract year)

- | | |
|--|---|
| Product: <input type="checkbox"/> PPO HSA HDHP
Plan: <input type="checkbox"/> Platinum 50
<input type="checkbox"/> Gold 25
<input type="checkbox"/> Gold
<input type="checkbox"/> Gold 50
<input type="checkbox"/> Silver 25
<input type="checkbox"/> Silver
<input type="checkbox"/> Bronze Premier
<input type="checkbox"/> Bronze | Product: <input type="checkbox"/> PPO HRA
Plan: <input type="checkbox"/> Platinum 50
<input type="checkbox"/> Gold 25
<input type="checkbox"/> Gold
<input type="checkbox"/> Gold 50
<input type="checkbox"/> Silver 25
<input type="checkbox"/> Silver
<input type="checkbox"/> Bronze Premier
<input type="checkbox"/> Bronze |
|--|---|

Total Number of Personal Choice Applications Attached: _____
Total Number of Keystone Applications Attached: _____

- | | |
|---|--|
| <p align="center">IBC Dental Riders</p> Product: <input type="checkbox"/> HMO/DPOS
Plan: <input type="checkbox"/> Adult

Product: <input type="checkbox"/> ALL LOB <input type="checkbox"/> STAND ALONE
Plan: <input type="checkbox"/> Adult Preventive Dental PPO
<input type="checkbox"/> Adult Plus Dental PPO | <p align="center">United Concordia Dental</p> <input type="checkbox"/> Concordia Flex <input type="checkbox"/> Concordia Preferred
<input type="checkbox"/> Concordia Plus <input type="checkbox"/> Concordia Choice
<input type="checkbox"/> Option: _____ |
|---|--|

Dependent / Student Age: 26 / 26

* Includes prescription drug, vision, and pediatric dental benefits

