Capital BlueCross
Independent Licensee of the BlueCross BlueShield Association

P.O. Box 773132
Harrisburg, PA 17177-3132
www.capbluecross.com

☐ UPDATE ☐ NEW OR RENEWING

APPLICATION FOR GROUP BENEFITS

IF UPDATE ONLY, COMPLETE SECTION 1 AND PROVIDE SIGNATURE.

INCOMPLETE GROUP APPLICATION MAY RESULT IN A DELAYED IMPLEMENTATION.

NO. OF APPS.	GROUP NUMBER	ASSOC. CODE	PROPOSED EFF. DATE

APPROVAL GIVEN BY	UNDERWRITING	☐ APPROVED (details below)	☐ DENIED

FOR OFFICE USE ONLY

1. GROUP INFORMATION

COMPANY NAME	POLICY MAKER NAME	TITLE

PHYSICAL ADDRESS (STREET) (CITY) (STATE) (ZIP) (COUNTY)	PHONE ( )	FAX ( )

EMAIL ADDRESS	NATURE OF BUSINESS	SIC CODE

BILLING ADDRESS (PO BOX, SUITE) (STREET) (CITY) (STATE) (ZIP)

GROUP LEADER'S NAME & TITLE (ADMINISTRATOR)

NEW EMPLOYEES ELIGIBLE TO ENROLL/APPLY ☐ DATE OF HIRE ☐ BILLING DATE ☐ 1ST OF MONTH FOLLOWING DATE OF HIRE ☐ OTHER _____

TAX IDENTIFICATION NUMBER	DATE BUSINESS ESTABLISHED	**NUMBER OF HOURS YOUR EMPLOYEES MUST WORK PER WEEK TO BE ELIGIBLE FOR GROUP COVERAGE**

2. PRIOR CARRIER INFORMATION/OTHER INSURANCE

REPLACING PRIOR CARRIER? ☐ YES ☐ NO	PRIOR CARRIER CANCELLATION DATE	
NAME OF ALL OTHER CARRIER(S) **CURRENTLY** OFFERED BY YOUR GROUP	TYPE OF COVERAGE OFFERED: ☐ TRAD ☐ PPO ☐ HMO ☐ POS ☐ RX ☐ OTHER	
WORKERS' COMPENSATION CARRIER	EFFECTIVE DATE OF POLICY	POLICY NUMBER

3. COVERAGE SELECTION / 4. EMPLOYER CONTRIBUTION

	PRODUCT NAME	PRODUCT NAME	PRODUCT NAME	**EMPLOYEE**: PERCENT PREMIUM PAID BY GROUP	**SPOUSE/DEPENDENT INFORMATION**: PERCENT PREMIUM PAID BY GROUP
PPO					
HMO					
TRADITIONAL					
OTHER					
DRUG					
*SENIOR*SM					
DENTAL					
VISION					

DO YOU WANT TO PROVIDE COVERAGE FOR DOMESTIC PARTNERS? ☐ YES ☐ NO

HOW WOULD YOU LIKE US TO ADMINISTER YOUR BENEFIT PERIOD? ☐ CALENDAR YEAR (JAN - DEC) ☐ BENEFIT YEAR (RENEWAL - RENEWAL)

5. FEDERAL AND STATE REQUIREMENTS

DOES EMPLOYER EMPLOY 20 OR MORE EMPLOYEES UNDER THE MSP LAWS? ☐ YES ☐ NO
DOES EMPLOYER EMPLOY 100 OR MORE EMPLOYEES UNDER THE MSP LAWS? ☐ YES ☐ NO

IF YOU HAVE AN ERISA PLAN YEAR, PLEASE PROVIDE _____ (MM/DD)

IS YOUR GROUP SUBJECT TO COBRA, AS DEFINED BY FEDERAL REGULATIONS? (HAVE YOU EMPLOYED 20 OR MORE EMPLOYEES DURING AT LEAST 50% OF THE PRECEDING CALENDAR YEAR?) ☐ YES ☐ NO

WHAT WAS YOUR AVERAGE NUMBER OF EMPLOYEES DURING THE **PRIOR** CALENDAR YEAR? ☐ 1 EMPLOYEE ☐ 2–50 EMPLOYEES ☐ 51–100 EMPLOYEES ☐ 101 OR MORE EMPLOYEES

6. ENROLLMENT/APPLICATION COUNT

EMPLOYEE INFORMATION				UNDERWRITING USE ONLY		
	ACTIVE (20 hrs/wk or more)	RETIRED 65 & OVER	COBRA	TOTAL NUMBER OF CONTRACTS/POLICIES TO BE UNDERWRITTEN ACTUAL		
	ENROLLED	ENROLLED	ENROLLED	ELIGIBLE	ENROLLED	(A) APPROVED (D) DENIED
PPO						
HMO						
TRADITIONAL						
OTHER						
DRUG						
SENIOR						
DENTAL						
VISION						

FOR OFFICE USE ONLY

TERMS AND CONDITIONS OF GROUP APPLICATION FOR COVERAGE

This application fully executed by an authorized representative of the group constitutes acceptance of all terms and conditions of the contract(s)/policies (referred to herein as contract[s]) issued in connection with the coverage(s) selected.

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

The Group will maintain the records necessary to the administration of the health care plan and will provide Capital BlueCross with all information necessary to administer the contract(s). Coverage will become effective when this application is accepted and approved by the home office of Capital BlueCross in accordance with its underwriting guidelines; including fulfillment of multiple option guidelines, and payment is received and processed. Capital BlueCross will notify you by letter if your coverage is approved. Acceptance of an initial deposit amount by Capital BlueCross **DOES NOT** constitute approval of coverage. Certain coverages (such as vision) are underwritten or provided by independent insurers that will issue their own policies.

If this application is accepted, it becomes part of the insurance contract between the group and Capital BlueCross. The group understands that Capital BlueCross will rely on all information provided in determining eligibility for coverage, setting premium rates, compliance with applicable laws and mandates and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. The Group understands that failure to comply with any such request may result in termination of coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The Group shall obtain signed enrollment forms from each individual that the Group identifies as being eligible for and enrolled in the Group's health benefits plan. The Group shall retain such enrollment forms for a period of at least six (6) years for each individual enrolled by the Group. In the alternative, if the Group utilizes an electronic enrollment system, or other means, the Group shall retain a record of such enrollment for a period of at least six (6) years for each individual enrolled by the Group. Such enrollment forms shall also include the Pennsylvania Insurance Fraud Warning Notice (Act 165 of 1994) which states:

> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

At the Group's request, Capital BlueCross shall provide enrollment forms to the Group.

PHOTOCOPIES AND/OR FACSIMILES OF THIS SIGNED & COMPLETED DOCUMENT SHALL BE AS VALID AS THE ORIGINAL. RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.

7. STOP! READ ABOVE CAREFULLY BEFORE SIGNING

GROUP POLICY MAKER	**DATE**
GROUP POLICY MAKER - *PRINT NAME*	
CAPITAL BLUE CROSS REP - *SIGNATURE REQUIRED*	**DATE**

CAPITAL BLUE CROSS USE ONLY		
DATE RECEIVED	**DEP. DATE**	**BY**
AMOUNT RECEIVED	**CHECK RETURNED TO GROUP**	