



# GROUP APPLICATION

Complete this application in black or blue ink.  
DO NOT USE A PENCIL OR A HIGHLIGHTER.

**2008 HIPAA COMPLIANT**

## GROUP INFORMATION

Proposed Effective Date \_\_\_\_\_ Group Number \_\_\_\_\_

Group Name \_\_\_\_\_ Federal Tax ID \_\_\_\_\_

Subsidiaries & Affiliates \_\_\_\_\_

Main Office Address \_\_\_\_\_ P. O. Box (if applicable) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Group Administrator \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

Nature of Business \_\_\_\_\_ SIC Code \_\_\_\_\_ Years in Business \_\_\_\_\_

Name of Prior Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

## CONTRIBUTION

The Employer is required to contribute at least 25% of the total health benefits premium. This includes retiree coverage if applicable.

### EMPLOYER CONTRIBUTION

	<u>Employee</u>	<u>Employee &amp; Child</u>	<u>Employee &amp; Spouse</u>	<u>Employee &amp; Children</u>	<u>Family</u>	<u>Retired</u>
Percentage	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %
or Dollar Amount	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

(If contributing dollar amounts, the dollar amount must equal at least 25% of the premium)

### EMPLOYER MUST COMPLETE THE FOLLOWING

	Full-Time	Part-Time	COBRA	Retired*	Total
Number of Employees					
Number Enrolling					

\*Retirees are not eligible under this program unless there is a formalized nondiscriminatory employer sponsored retirement program in effect. If so, please attach a description and documentation of the retirement program.

## ELIGIBILITY

Eligibility is the minimum number of hours an employee must work per week to be eligible for coverage. Mountain State Blue Cross Blue Shield permits an employer to define the minimum number of hours as between 20 and 37.5 hours per week.

\_\_\_\_\_ are the hours per week an employee must work under the Group Plan to be eligible for coverage.  
(required entry)

Please note, current employees working less than the number of hours listed who subsequently begin working the required number of hours must complete the probationary period before becoming eligible for coverage.

## PROBATIONARY PERIOD

The Probationary Period is the time (in months) an employee must work before being eligible for coverage. Probationary Periods greater than 12 months are not permissible.

- Check One:  Eligible on the date of hire (51+ groups only).  
 Eligible on the first day of the month after date of hire.  
 Eligible on the first day of the month after \_\_\_\_\_ months of service (Days are not permissible).
- Check One:  Probationary period is waived for all eligible employees on the group's initial effective date.  
 Probationary period is applied for all eligible employees.

## BENEFIT SELECTION OPTIONS

If your group is a new group or is making a benefit change, a copy of the applicable quote must be attached to this application.

### SUPER BLUE PLUS 2000

	<u>Deductible</u>	<u>Coinsurance (80%/20%)</u>	<u>Drug</u>
<input type="checkbox"/> Option 1	\$100/200	\$1,000/2,000	30%, \$10 minimum copay
<input type="checkbox"/> Option 2	\$250/500	\$1,000/2,000	30%, \$10 minimum copay
<input type="checkbox"/> Option 3	\$500/1,000	\$1,000/2,000	30%, \$10 minimum copay
<input type="checkbox"/> Option 4	\$1,000/2,000	\$1,000/2,000	30%, \$10 minimum copay
<input type="checkbox"/> Option 5	\$2,500/5,000	\$2,500/5,000	30%, \$25 minimum copay

### SUPER BLUE PLUS 2004

	<u>Deductible</u>	<u>Coinsurance (80%/20%)</u>	<u>Drug</u>
<input type="checkbox"/> Option 6	\$1,000/2,000	\$1,000/2,000	50%, \$25 minimum copay
<input type="checkbox"/> Option 7	\$3,000/6,000	\$1,000/2,000	50%, \$25 minimum copay
<input type="checkbox"/> Option 8	\$5,000/10,000	\$1,000/2,000	50%, \$25 minimum copay

### WV SMALL BUSINESS PLAN

(restrictions apply & must complete affidavit)

	<u>Deductible</u>	<u>Coinsurance (80%/20%)</u>	<u>Drug</u>
<input type="checkbox"/> Option 9	\$1,000/2,000	\$1,000/2,000	50%, \$25 minimum copay
<input type="checkbox"/> Option 10	\$3,000/6,000	\$1,000/2,000	50%, \$25 minimum copay
<input type="checkbox"/> Option 11	\$5,000/10,000	\$1,000/2,000	50%, \$25 minimum copay

### SUPER BLUE PLUS 2008

	<u>Deductible</u>	<u>Out-of-Pocket Max Excluding Deductible (80%/20%)</u>	<u>Drug</u>
<input type="checkbox"/> Option 12	\$500/1,000	\$3,000/6,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 13	\$1,000/2,000	\$3,000/6,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 14	\$1,500/3,000	\$3,000/6,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 15	\$2,500/5,000	\$3,000/6,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 16	\$5,000/10,000	\$3,000/6,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
		<u>(70%/30%)</u>	
<input type="checkbox"/> Option 17	\$500/1,000	\$4,500/9,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 18	\$1,000/2,000	\$4,500/9,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 19	\$1,500/3,000	\$4,500/9,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 20	\$2,500/5,000	\$4,500/9,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%
<input type="checkbox"/> Option 21	\$5,000/10,000	\$4,500/9,000	<input type="checkbox"/> 30% <input type="checkbox"/> 50%

### HIGH DEDUCTIBLE HEALTH PLAN

(must review with Sales office)

	<u>Deductible</u>	<u>Out-of-Pocket Max Excluding Deductible</u>	<u>Drug</u>
<input type="checkbox"/> Option 22	\$3,000/6,000	\$2,500/5,000	50%, Subject to Deductible
<input type="checkbox"/> Option 23	\$5,000/10,000	\$5,000/10,000	50%, Subject to Deductible

### LIMITED BENEFIT (\$25,000 calendar year max)

	<u>Deductible</u>	<u>Drug</u>
<input type="checkbox"/> Option 24	\$250/500	50%, Generic Only

### NON-STANDARD BENEFITS

Option is only for groups sized 51+. If a Non-Standard benefit is selected, a copy of the proposal including rates must accompany this application.

### VISION

Standard (for groups sized 10+)  
 Non-Standard (for groups sized 51+) If a Non-Standard benefit is selected, copy of the proposal including rates must accompany this application.

**COBRA INFORMATION**

- 1) YES \_\_\_\_ NO \_\_\_\_ Within the last year, did you have 20 or more full and/or part-time employees on at least 50% of your typical business days?
- 2) How many full time equivalents did/do you employ? PRIOR YEAR \_\_\_\_\_ CURRENT YEAR \_\_\_\_\_
- 3) YES \_\_\_\_ NO \_\_\_\_ If you answered "yes" to question one and if you have 20 or more full time equivalent employees, do you elect to contract with Mountain State Blue Cross and Blue Shield's Third Party COBRA Administrator to administer your COBRA benefits?
- 4) List your COBRA eligible members below. (Name, Qualifying Event, Date of Event. Attach separate paper if necessary)

NAME	QUALIFYING EVENT	DATE OF EVENT

**MEDICARE INFORMATION**

- 1) YES \_\_\_\_ NO \_\_\_\_ In the PRECEDING year, did your group employ at least 20 or more full and/or part-time employees for 20 or more calendar weeks?
- 2) YES \_\_\_\_ NO \_\_\_\_ In the CURRENT year, does your group employ at least 20 or more full and/or part-time employees for 20 or more calendar weeks?
- 3) YES \_\_\_\_ NO \_\_\_\_ Within the last year, did you have 100 or more full and/or part-time employees for 50% of your typical business days?
- 4) YES \_\_\_\_ NO \_\_\_\_ Are there any employees over age 65?  
If YES, complete the table below as indicated. (Attach separate paper if necessary)

NAME	DOB	SSN	ELIG. DATE PART A	ELIG. DATE PART B

- 5) YES \_\_\_\_ NO \_\_\_\_ To the best of your knowledge, are any of your employees or their dependents disabled?  
If YES, complete the table below as indicated. (Attach separate paper if necessary)

NAME	NATURE OF DISABILITY	DATE OF DISABILITY	ACTIVELY at WORK (Y/N)	LAST DATE OF WORK

**GROUP POLICY INFORMATION**

- 1) YES \_\_\_\_ NO \_\_\_\_ Within the last year, did your organization participate in a multiple employer group health plan in which there was at least one employer who had 100 or more full and/or part-time employees for 50% of your business days?
- 2) YES \_\_\_\_ NO \_\_\_\_ Do you have a formal short-term disability program?  
If YES, indicate carrier \_\_\_\_\_

**GROUP POLICY INFORMATION CONTINUED**

- 3) YES \_\_\_\_ NO \_\_\_\_ Do you have a formal long-term disability program?  
If YES, indicate carrier \_\_\_\_\_
- 4) YES \_\_\_\_ NO \_\_\_\_ Does your long-term disability plan provide group health benefits at the same contribution level as full-time employees? If no, what is YOUR (**employer**) contribution level? \_\_\_\_\_
- 5) YES \_\_\_\_ NO \_\_\_\_ Do you have a formalized nondiscriminatory employer sponsored retirement program?  
If YES, please attach documentation of the program.
- 6) YES \_\_\_\_ NO \_\_\_\_ Do you file an IRS/Department of Labor form 5500 or 5500C for your health benefits?  
If YES, list reporting period for the form filing FROM \_\_\_\_\_ TO \_\_\_\_\_
- 7) YES \_\_\_\_ NO \_\_\_\_ Have you completed the IRS/SSA/HCFA Data Match questionnaire?
- 8) YES \_\_\_\_ NO \_\_\_\_ Is your group health plan established or maintained for its Employees by a federal, state, or local government, governmental agency, or instrumentality?
- 9) YES \_\_\_\_ NO \_\_\_\_ Is your plan established or maintained for its Employees by a church or by a convention or association of churches?
- 10) YES \_\_\_\_ NO \_\_\_\_ If you answered yes to the above question (#9), does your plan qualify as tax exempt under the Internal Revenue Code Section 501(c)(3)?
- 11) YES \_\_\_\_ NO \_\_\_\_ Is your Plan/Group governed by the Employee Retirement & Income Security Act of 1974 (ERISA)?

**IMPORTANT: Please do not cancel your current health care coverage unless and until you have received written acceptance from Mountain State Blue Cross & Blue Shield (MSBCBS). This Group Application is not a contract for health care benefits. The mere completion of this Group Application does not obligate MSBCBS to pay benefits for health care services. MSBCBS shall not be obligated to pay benefits for health care services unless and until this Group Application is accepted in writing by an officer of MSBCBS and only as long as the Group continues to qualify under the terms of the Group Contract with MSBCBS, including timely payment of premiums.**

Signature:

Witness:

\_\_\_\_\_  
Full or Corporate Name of Applicant

\_\_\_\_\_  
Authorized Signature and Title

\_\_\_\_\_  
Representative of MSBCBS

Signed at \_\_\_\_\_

on \_\_\_\_\_ 20\_\_\_\_\_

**MSBCBS's policy of equal employment opportunity is to recruit, hire, promote, re-assign, compensate, and provide training for all job classifications without regard to race, color, religion, sex, age, national origin, handicap, or veteran status including Vietnam-era veterans and all disabled veterans.**

**This agreement is subject to the provisions of Executive Order 11246, as amended and the regulations at 41 CFR parts 60-1 through 60-60, and 38 USC 2012 and section 603 and the regulations at 41 CFR parts 60-250 and 60-741, which are herein incorporated by reference.**

Agent of Record

I hereby recognize \_\_\_\_\_ (print name) to receive credit for this application according to company rules and regulations, provided she/he is licensed by the State Insurance Department of West Virginia.