

# Group Application for Blue Cross and Blue Shield of North Carolina Coverage

<input type="checkbox"/> New Group	Prospect Number:	<input type="checkbox"/> Renewal Group	<input type="checkbox"/> Renewal (As-is) <input type="checkbox"/> Renewal (Plan / Other Changes)	Group Number:	Effective Date:
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1. Name of Group:

Tax ID No (EIN):

2. Physical Address:
 

ADDRESS 1

ADDRESS 2

CITY

STATE

ZIP CODE

COUNTY

Billing Address:  
(if different from above)

ADDRESS 1

ADDRESS 2

CITY

STATE

ZIP CODE

3. Group Administrator:

Telephone Number:

Fax Number:

Email Address:

4. Divisions/Subsidiaries/Affiliates to be covered (attach list if necessary):
 

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Nature of Business: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Are you including any affiliated groups under your coverage that together make up a controlled group that is considered a single employer as defined under Section 414(b), (c), (m), or (o) of the Internal Revenue Code?

☐ Yes ☐ No **If yes**, how many total full-time equivalents are in the controlled group (all affiliated) commonly owned business? \_\_\_\_\_

5. Industry Type (NAICS Code):

6. Group is, as defined under the Patient Protection and Affordable Care Act, 45 C.F.R. §147.131, a(n)
 

☐ Religious eligible organization (EBSA Form 700 or written notice to HHS is required) that is organized and operated as a non-profit

☐ Closely held for-profit entity as defined by 45 C.F.R. §147.131(b)(4) (EBSA Form 700 or written notice to HHS is required) that is an eligible organization per 45 C.F.R. §147.131(b)

☐ Religious Employer

☐ None of the above

7. Is coverage being offered to all full-time employees? ☐ Yes ☐ No

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Group Name: \_\_\_\_\_

8. Group certifies whether or not it meets the definition of a Small Employer as defined by the North Carolina Small Employer Group Health Insurance Reform Act.

*North Carolina General Statute § 58-50-110(22b): a "Small employer" means, in connection with a nongrandfathered, nontransitional group health plan with respect to a calendar year and a plan year, an employer who meets the definition of small employer under 42 U.S.C. § 18024(b)(2): An employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. The number of employees shall be determined using the method set forth in section 4980H(c)(2) of the Internal Revenue Code.*

- ☐ Yes, as written before the passage of North Carolina Session Law 2013-357, AND is requesting a transitional plan  
☐ Yes, as written after the passage of North Carolina Session Law 2013-357, AND is requesting an ACA plan or small group self-funded plan  
☐ No

9. The Group certifies that all individuals enrolling for coverage meet the following definition of eligible employee: An eligible employee is an individual working 30 hours or more per week on a full-time basis with the employer reporting the FICA withheld by W2 Form on an annual basis. Persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible. An individual who is a "statutory employee" as that term is defined under Internal Revenue Code Section 3121(d)(3) and works on a full-time basis for the Group may be considered eligible for small group coverage only. Documentation of "statutory employee" status is required. ☐ Yes ☐ No

#### ORIENTATION/PROBATIONARY PERIOD:

10. **Health, Dental Blue, Dental Blue Select, Dental Blue Preferred, Blue 20/20:** Eligibility requirements to be applicable to future employees. **Note: "0 day orientation/probationary period" is only available for health coverage for groups of 6 or more eligible employees:**

- ☐ 1st of the month following 30 days ☐ Next day following 60 days ☐ 0 day, effective on date of hire  
☐ Next day following 30 days ☐ Next day following 90 days ☐ Self-Funded Groups Only:  
☐ 1st of the month following 60 days ☐ 0 day, effective 1st of the month following the date of hire (51+): Other \_\_\_\_\_ (not greater than 90 days)

At the time of initial enrollment, will all employees be enrolled as of the effective date of the group or should the probationary period apply?

- ☐ All ☐ Probationary Period

11. **Choose one of the following to be applicable to employees terminating coverage:**

- ☐ End of the contract month following employment termination  
☐ Last day of employment (only available to groups of 6 or more eligible employees)

12a. **Domestic Partner Coverage Options**  
 (check all that apply):

- ☐ None ☐ Same Sex ☐ Opposite Sex

12b. **Self-Funded Groups Only (250+): Same Sex Spousal Coverage Option\*:**

Do you want to provide same sex spousal coverage? ☐ Yes ☐ No

\*If spouses are offered coverage, insured groups will automatically receive same sex spousal coverage.

#### GROUPS 51+:

13. Blue Cross NC standard eligibility allows for persons to be covered who are active, full-time employees, working 30 hours or more per week and their eligible dependents. Underwriting approval is required for any additional eligibility requests.

**Pre 65 Retirees (Before Eligible Retiree Coverage):**

**Other Special Eligibility (please specify):**

- ☐ Yes ☐ No

#### MUNICIPALITIES AND COUNTY GOVERNMENT ONLY:

If you employ Elected Officials, do you want to provide Elected Official coverage? ☐ Yes ☐ No

### Medical / Health and Dental Blue / Dental Blue Select / Dental Blue Preferred

14. **For Health Coverage:**

**Number of Eligible Employees:** \_\_\_\_\_

**Number of Enrolled Employees:** \_\_\_\_\_

15. Group Employer Contribution for health coverage (select one):

- ☐ Percentage ☐ Fixed

Employees: \_\_\_\_\_ % Dependents: \_\_\_\_\_ % Employees \$: \_\_\_\_\_ Dependents \$: \_\_\_\_\_

16. For Dental Coverage: Number of Eligible Employees: \_\_\_\_\_ Number of Enrolled Employees: \_\_\_\_\_

17. Will you offer dental coverage to: ☐ Employees only ☐ Employees and Retirees (only available to 51+)

18. Group Employer Contribution (percentage) for dental coverage: Employees: \_\_\_\_\_ % Dependents: \_\_\_\_\_ %

19. **For Self-Insured Dental Coverage:** Blue Cross NC offers a dental product which is intended to qualify as an excepted benefit (benefits include dollar limits on essential health benefits, i.e., pediatric dental services). In order to ensure the dental product qualifies as an excepted benefit, participants must be able to select or decline dental coverage independent from health coverage. **Failure to meet this requirement could implicate issues under the Patient Protection and Affordable Care Act.**

20. **Please provide the average number of employees at your company during the preceding calendar year. This average must include all individuals employed by your company, whether an employee was full-time, part-time, and/or seasonal. Important: The federal government requires the total average number, regardless of whether employees were eligible to enroll, and/or participated in the group insurance coverage. Only include temporary employees if they worked for your company (i.e., employees that receive a W-2).**

Number of Employees

Group Name: \_\_\_\_\_

21. All employer-sponsored group health plans must offer COBRA continuation coverage unless the employer is exempt from COBRA. (An employer is exempt if the group (i) employed fewer than 20 employees (including all full-time, part-time, and seasonal employees) on at least 50% of its working days during the preceding calendar year; or (ii) is a church plan or governmental plan as defined under the Internal Revenue Code.)

Is your group health plan required to comply with federal COBRA continuation coverage requirements for this contract year? ☐ Yes ☐ No

**Insured ONLY:** For the group health plans selected below (medical / dental only), will the group delegate COBRA administration (as outlined in the Group Contract) to Blue Cross NC's designee?

☐ Yes ☐ No, the group opts out of this service and will obtain its own COBRA administrator.

22. The Employee Retirement Income Security Act of 1974 (ERISA) regulates employee health benefit plans sponsored by most employers. Governmental Plans and church-sponsored plans (as defined by federal law) are exempt.

Will this coverage insure an Employee Welfare Benefit Plan that is regulated by ERISA? ☐ Yes ☐ No

If you checked yes, please identify a contact person for ERISA plan information.

Name and Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

23. Under federal law, the Plan Administrator may be required to provide a notice to Plan Participants who do not read English but are literate in another language, advising them of where they can get information and assistance concerning their benefits and member rights. The notice must be in their primary language and appear in the summary plan description (member booklet). The following information is being requested to determine if such a notice will be necessary. It may also assist Blue Cross NC in meeting special customer service needs.

For Groups 1-99: Are 25% or more of all plan participants literate only in the same foreign (non-English) language?

☐ Yes ☐ No

For Groups 100+: Are 10% or more (or 500) of the plan participants whichever is less, literate only in the same foreign (non-English) language?

☐ Yes ☐ No

If Yes, what is the primary language (e.g., Spanish)? \_\_\_\_\_

If Yes, what is the primary language (e.g., Spanish)? \_\_\_\_\_

24. The Group acknowledges that it agrees to pay Blue Cross NC the following rates for the benefits below.

**Please check the benefit plan(s) you have selected for your group.** If you will be contributing to an HSA during the benefit period, please verify benefit plans, annual contribution amounts, and the HSA administrator you will be contributing through.

**Blue Options<sup>SM</sup> (PPO) / Blue Care<sup>®</sup> (HMO) / Classic Blue<sup>®</sup> (CMM) / Blue Value 1-2-3<sup>SM</sup> (PPO) / Blue Value<sup>SM</sup> (POS) / Blue Select<sup>SM</sup> (PPO) 51+ / Blue Select Plus<sup>SM</sup> (PPO) / Blue Local<sup>SM</sup> with Atrium Health\* / Dental Blue / Dental Blue Select / Dental Blue Preferred 51+ / Blue 20/20**

If quote number/product name selected is not displayed, please enter quote number/product name under appropriate product.

\* The group understands that the plan selected has a local provider network limited to the Blue Local with Atrium Health network. The group certifies that all covered employees live in one of the following approved counties: Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Rowan, Stanly, and Union. The group acknowledges that not all Blue Cross NC contracted providers are in this plan's network. The group also acknowledges that if a covered employee uses a provider not in this plan's network, the employee may receive benefits at the out-of-network level.

Quote Number: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Quote number and rates for groups. Small employers enrolling in two plans must indicate high and low plan.

Group Name: \_\_\_\_\_

25. Are you pairing your benefit with an HRA? ☐ Yes ☐ No

If yes, please choose: ☐ Integrated Blue Cross NC Fund Administrator (Health Equity) ☐ Other Fund Administrator

Is the group an S-Corp? ☐ Yes ☐ No

If yes, are the owners electing coverage? ☐ Yes ☐ No If yes, please provide the name of the owner(s) \_\_\_\_\_

26. **FULLY INSURED SMALL GROUPS (1-50 Eligible Employees if Grandfathered or Transitional, Otherwise, 1-50 Full-Time Equivalents)**

Please select your HSA Administrator Option:

☐ Integrated Blue Cross NC Fund Administrator (Health Equity) ☐ Other Fund Administrator

27. **LARGE GROUPS (51+ Eligible Employees if Grandfathered, Otherwise, 51+ Full-Time Equivalents, 26+ Self-Funded)**

**Blue Options HSA<sup>SM</sup> - HSA Eligible Plans**

This section must be completed to ensure accurate enrollment. Please write in quote information below, if existing quotes do not reflect the Group's final choices. Any change in the amounts you listed below could result in a change to the rate you were quoted. Please also verify if fees should be included in the premium or deducted from the employee's HSA account. (51+)

		ANNUAL FUND CONTRIBUTION AMOUNT (in dollars)							HSA Administrator	Include in Premium	Deduct from Employee's HSA Account
	Quote Number	LOB	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family	Employee + 1 Other			
<input type="checkbox"/>											
<input type="checkbox"/>											
<input type="checkbox"/>											
<input type="checkbox"/>											

28. **Certification of Compliance with Federal and/or State Mandates:** Federal Social Security laws require employers to provide primary health care benefits under employer group health plans to certain individuals who are entitled to Medicare. The Group certifies and agrees that individuals eligible for Medicare, who are required to receive primary health care benefits under the Group's employee group health plan pursuant to federal Social Security laws, will be enrolled in a manner consistent with such laws. The Group hereby agrees to indemnify Blue Cross NC, hold it harmless against and reimburse it for any and all expenses paid or incurred by Blue Cross NC due to any act or omission of the Group or the employer inconsistent with the relevant Social Security laws, as amended.

**Blue 20/20 Vision**

29. (a) Will the Employer pay any amount towards the vision premium? ☐ Yes ☐ No
- (b) Employer (group) paid premium contribution percentage: For Employee: \_\_\_\_\_ % For Dependents: \_\_\_\_\_ %
- (c) Is your group vision plan exempt from COBRA? ☐ Yes ☐ No
- (d) For Vision Coverage: Number of Eligible Employees \_\_\_\_\_ Number of Enrolled Employees \_\_\_\_\_

**PLAN OPTIONS:** (select)**Note: Premiums are based on a Per Employee Per Month fee****Blue 20/20  
Exam Only****Exam copay**
☐ \$0 ☐ \$10 ☐ \$20 ☐ \$25

Employee Only \$ \_\_\_\_\_

Employee + Spouse/Domestic Partner \$ \_\_\_\_\_

Employee + Children \$ \_\_\_\_\_

Employee + Family \$ \_\_\_\_\_

**Blue 20/20  
Exam Plus****Exam copay**
☐ \$0 ☐ \$10 ☐ \$15 ☐ \$20 ☐ \$25
**Frame allowance**
☐ \$100 ☐ \$130 ☐ \$150 ☐ \$200 ☐ \$250 ☐ \$300
**Frame frequency**
☐ 1 per 12 months  
☐ 1 per 24 months
**Lens copay**
☐ \$10 ☐ \$25

Employee Only \$ \_\_\_\_\_

Employee + Spouse/Domestic Partner \$ \_\_\_\_\_

Employee + Children \$ \_\_\_\_\_

Employee + Family \$ \_\_\_\_\_

**Blue 20/20  
Lens & Frame  
Only****Material allowance**
☐ \$200 ☐ \$250 ☐ \$300

Employee Only \$ \_\_\_\_\_

Employee + Spouse/Domestic Partner \$ \_\_\_\_\_

Employee + Children \$ \_\_\_\_\_

Employee + Family \$ \_\_\_\_\_

**Payment Options:****30. Authorization for Bank Draft****New Groups:**

- ☐ **Automatic Bank Draft** - withdraw the Group's initial and subsequent monthly premium payments (recurring payments). This authorization will remain in effect until an authorized representative of the Group revokes it in writing at least 10 days prior to the date the account is scheduled to be charged. (Required for small group self-funded plans)
- ☐ **Monthly Payments Online** - withdraw the Group's initial premium payment (a one-time payment). The Group will log into Blue Cross NC's Employer Services website for each additional month they would like drafted.
- ☐ **Paper Transactions** - A check is enclosed for the premium payment. Future monthly payments will be made by check upon receipt of a paper invoice.

**Renewing Groups:**

Required for small group self-funded plans. The automatic bank draft options shown above are available to renewal groups as well. Renewal groups may elect the desired options by logging into Blue Cross NC's Employer Services website at <https://www.bluecrossnc.com/employer-services>.

Name of Bank Account Holder: \_\_\_\_\_

Bank Routing  
Transit Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

This number appears in the lower left-hand corner of your check.

Bank Account  
Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

This number appears to the right of the transit number and is separated from the transit number by symbols/spaces. Your number may be shorter than the boxes provided above.

See authorization for bank drafts under Statement of Understanding.

**31. Agent Fee Payments:**

In applying for this coverage, the self-funded groups (26+) and insured groups (100+) understand that they are responsible for reaching an agreement with the producer regarding agent fee payments. While Blue Cross NC is not responsible for producer agent fee, Blue Cross NC is available to help facilitate the process. A separate agreement where Blue Cross NC will bill the Group and accept producer agent fee payments from the Group on behalf of a producer is available.

**32. Effective Date of Coverage:**

Subject to the acceptance of this application by Blue Cross NC at its home office and the payment of applicable fees, the effective date of coverage for the group health plan, pursuant to this application, shall be 12:01 AM Eastern time on the \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

**33. Statement of Understanding:****Insured Groups Only (all sizes):**

By signing below, I certify that I am the authorized signer on behalf of the Group and that all information provided is complete and accurate. I further understand that submission of this application and requisite fees constitutes an offer and a binding contract upon acceptance, as applicable, by Blue Cross NC. Acceptance of the offer by Blue Cross NC shall be signified by the earlier of the following events: Blue Cross NC's issuance of the Group Contract or issuance of identification cards to the Group's members. The Contract issued by Blue Cross NC shall set out the terms of the agreement between the parties, and this application shall be incorporated therein by reference. Group agrees that the Contract shall be binding upon the parties as issued, without the necessity of signature by the Group. In the event Blue Cross NC issues the Group Contract electronically, it may be accessed via [www.bluecrossnc.com/employer-services](http://www.bluecrossnc.com/employer-services), or may be requested in writing by calling **1-800-446-8053**. A representative sample of the Contract is available upon request.

**Groups that select an HSA administered by Blue Cross NC's chosen HSA administrator:**

I understand that submission of this application and requisite fees constitutes an offer and a binding contract upon acceptance, as applicable, by Blue Cross NC's chosen HSA administrator. The Contract provided by Blue Cross NC and the HSA administrator shall set out the terms of the agreement between the parties.

**Fully Insured Small Group Disclosure (Required by NCGS 58-50-130(d)):**

By signing below, I attest to understanding that in connection with offering a health benefit plan, Blue Cross NC guarantees the availability and renewability of coverage for small employers; provides 12-month initial and renewal rate guarantees unless benefits are changed; and that benefits available and premiums charged for health benefit plans offered to small employers are available upon request.

**Self-Funded Groups:**

By signing below, I certify that I am the authorized signer on behalf of the Group and that all information provided is complete and accurate. I understand that as a self-funded group the Group will enter into an Administrative Services Agreement (ASA) with Blue Cross NC for claims administration that requires a separate signature. If the Group is purchasing HRA/FSA Administration through an administrator, a separate contract may be required.

**Groups who have selected Automatic Draft:**

I further certify that I am an authorized user of the bank account designated on this application ("Bank Account"). I hereby request and authorize Blue Cross and Blue Shield of North Carolina (Blue Cross NC) to charge the initial and/or subsequent premium payments, payments for health products, as I further certify, to the Bank Account payable to the order of Blue Cross NC. I agree that Blue Cross NC's rights in respect to the bank draft shall be the same as if it were a check drawn on the Bank Account and signed by me or another authorized user. I also authorize the financial institution to reduce the balance of the Bank Account by the amount of the bank draft. I agree that if such charges be dishonored, whether with or without cause and whether intentionally or inadvertently, Blue Cross NC shall have no liability whatsoever even though dishonor results in forfeiture of insurance. Finally, I understand that unless noted on this application all invoices will be available on the Blue Cross NC's Employer Services website ([www.bluecrossnc.com/employer-services](http://www.bluecrossnc.com/employer-services)) and I will not receive a paper invoice.

Signature of Authorized Official: \_\_\_\_\_ Date: \_\_\_\_\_

MM/DD/YYYY

Email Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Date: \_\_\_\_\_

MM/DD/YYYY

Agent Number: \_\_\_\_\_