APPLICATION FOR GROUP HEALTH INSURANCE
GROUP AND INDIVIDUAL DIVISION

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
An Independent Licensee of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.
COLUMBIA, SOUTH CAROLINA
www.SouthCarolinaBlues.com

Application is hereby made for group health insurance for the eligible Employees and Dependents or Members of the Group

(herein referred to as the Applicant) for _____(Product Name).

Name of Applicant: _____
(Company's correct legal name)

Upon approval, the Effective Date of the Contract under this application shall be 12:01 a.m., standard time on the _____ day of _____, _____, and such coverage will continue until terminated in accordance with the provisions of the Contract between the Applicant and Blue Cross and Blue Shield of South Carolina.

Classification and Participation Requirements:

1. Employees must meet the requirements shown on the attached Benefits Request Form to participate in the Group Health Plan.
2. The Waiting Period selected by the Applicant is shown on the attached Benefits Request Form.
3. The Employer/Applicant must affirm it will meet the Participation Requirements shown below.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in the group health plan or the first day of the Waiting Period, whichever is earlier.

Late Enrollee: An Employee or Dependent who is eligible for enrollment at the initial enrollment by the Employer or during any open enrollment period but who declines enrollment and later seeks to enroll. Late enrollees may be excluded from coverage for a period of up to 12 months unless the exclusion period is shortened by the next open enrollment period.

Special Enrollment: Employees and/or Dependents who are eligible to enroll other than during the initial enrollment period or open enrollment as described in the Master Contract and the Certificate.

Blue Cross and Blue Shield of South Carolina complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Participation Requirements: The group must meet at least 70 percent participation. Group size and participation are determined after Employees with a valid waiver are removed. Valid waivers include coverage through other employer plans, Individual health insurance coverage, Medicare, Medicaid, or coverage through a veterans' or military program. A waiver is not considered valid if the person has no coverage, or for short-term health coverage, or mini-med products (not minimum essential coverage). Persons who are categorized as Section 1099 employees are not considered eligible for the group health plan.

Group Size	Enrollment	Participation Percent
2 or 3	All employees	100%
4	3	75%
5	4	80%
6 or 7	5	83% / 81%
8	6	71%
9 or 10	7	78% / 70%
11	8	73%
12	9	75%
13 or 14	10	77% / 71%
15	11	73%
16-50		70%

Employer must contribute a minimum of 50 percent of the single Employee cost. If the Employer contributes 100 percent of the single Employee premium, 100 percent of all eligible Employees must enroll in at least single coverage.

The statements furnished herein are true and correct to the best of my knowledge and belief, and they are offered to Blue Cross and Blue Shield of South Carolina, an independent licensee of the Blue Cross and Blue Shield Association, and/or Companion Life Insurance Company as part of an application for group insurance covering the employees or members of the firm or organization I represent, because Companion Life is a separate company from Blue Cross and Blue Shield of South Carolina, Companion Life will be responsible for all services related to life insurance. I understand that any misstatements or omission of information may be the basis for cancellation of any coverage granted.

The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from the policyholder's funds or from funds contributed by the insured persons, or from both.

The Applicant hereby expressly acknowledges its understanding that this application constitutes a Contract solely between the Applicant and the Corporation. The Corporation is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The "Association" permits the Corporation to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and that the Corporation is not contracting as the agent of the Association.

The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Corporation and that no person, entity or organization other than the Corporation shall be held accountable or liable to the Applicant for any of the Corporation's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Corporation other than those obligations created under other provisions of this Contract.

Dated at (City)_____, South Carolina, this _____ day of _____, _____

_____	**BLUE CROSS AND BLUE SHIELD**
Name of Applicant (Company's Name)	**OF SOUTH CAROLINA**
By:	By:
_____	_____
(Authorized Group Signature)	(Authorized Signature)

_____

(Agent Signature)

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Benefit Request Form (Groups of 2 – 50 only)

☐ New Group

☐ Change (Reason):_____

Requested Effective Date:_____/_____/_____

1. *Company /Employer Data (information required)* Group Number___ ___ - ___ ___ ___ ___ ___ - ___ ___

Company Name: _____

Physical Address:_____
(Street) (City) (County) (State) (ZIP)

Billing Address: _____
(if different from physical address) (Street) (City) (County) (State) (ZIP)

Nature of Business: _____

Identify How Taxes are Filed: ☐ Corp ☐ S Corp ☐ LLC ☐ Partnership ☐ Sole Proprietorship

☐ Agricultural/Farm ☐ Non-Profit ☐ For Profit ☐ New Business, not yet filed

List Each Owner(s)/Partner(s) and the Percent of Ownership: 1. _____/____%

2. _____/_____% 3. _____/_____%

Employer Identification No. (EIN):_____

Prior Carrier:_____ SIC Code: __ __ __ __

2. *Contact Information for Group Plan (required)*

Benefit Coordinator #1_____

(#1) Telephone:_____-_____-_____ Email:_____

Benefit Coordinator #2 _____

Email:_____

Agency Name:_____ Agent: _____ Agent Code _____ - _____

Agency Administrator:_____ Telephone: _____ - _____ - _____

Agent Email:_____

3. *Medical Participation (information required)*

Eligible employees must be actively at work an average of 30 hours per week.

A. Total Employees, including Part-Time ..... _____

B. Full-Time Employees ..... _____

C. Employees in Waiting Period ..... _____

D. Eligible Employees ..... _____

Eligible employees must be actively at work an average of 30 hours per week.

E. Waivers/Refusals ..... _____

F. Enrolled Employees ..... _____

G. Employer Contribution: Employee Health _____% Employee Life_____%
(minimum 50% required for Health)

H. Waiting Period for new employees ☐ 30 days* ☐ 60 days** ☐ 90 days Exact

*1st of the month following end of waiting period/ full-time date of hire
**Months with 28 and 31 days are considered one month and would be the same as 30 days

4. *Medical Loss Ratio Survey (information required)*

Under the Patient Protection and Affordable Care Act (PPACA), insurance companies must report their medical loss ratio (MLR) to state and federal agencies. They must also pay rebates if they do not meet certain MLR targets. The MLR rebate is based on the group's size.

Every year, we will need you help to provide information about your group's size and total eligible employees. The information you provide will help determine if your group is "small" or "large" under PPACA and whether you will qualify for a rebate.

Please complete **ALL** of these questions:

A. Please answer the following regarding your group size during the preceding calendar year.

NOTE: *If your business did not exist in the preceding year, answer the questions below based on the average number of employees that are expected to be employed on business days of the current calendar year.*

What was the total average number of employees in your company in the preceding calendar year? _____

NOTE: *The number of employees is determined by averaging the total number of all employees on business days during the preceding calendar year. This includes each full-time, part-time, and seasonal employee.*

B. Is your group considered a non-governmental, non-ERISA plan (i.e. church plan)? ☐ Yes ☐ No
If yes, please affirm which method you will use to distribute the subscriber portion of your rebate, should you be eligible for one.

☐ We will reduce the subscriber's portion of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan

☐ We will provide a cash refund only to subscribers who were covered by the group health policy on which the rebate is based.

☐ We will not provide assurance of the above. BlueCross BlueShield of South Carolina will distribute 100 percent of any medical loss ratio rebate evenly and directly to our subscribers.

5. *Additional Information (if applicable)*

Please complete **ALL** questions to determine eligibility for Continuation of Coverage (COBRA or State Continuation):

A. Please list all out-of-state locations covered by this plan and their number of employees:

Employees	*City*	*State*	*ZIP Code*	*Percentage of Ownership*

B. Do you own any other company under "common control" that should be considered with this group for group size purposes? "Common control" is defined in the Internal Revenue Code, § 414 (b) and (c).

☐ **Yes** ☐ **No** **If yes, please list below:**

C. In the previous calendar year, did you have 20 or more employees on more than 50 percent of your company's typical business days?

☐ **Yes** ☐ **No**

Please note: Both full-time and part-time employees are counted. Part-time employees are counted as a fraction of an employee with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.

D. Please identify all employees who are currently disabled or not actively-at-work:

Name

E. Please list any employees and/or dependents covered by any State Continuation or COBRA coverage:

Name	*Reason for Coverage*	*Qualifying Date*	*Coverage Ends*
		____/____/___	____/____/___
		____/____/___	____/____/___
		____/____/___	____/____/___

6. ***Medical Benefit Selection (required for health benefits)***

	Product	Coinsurance	Single Deductible	Single Out of Pocket	Family Deductible	Family Out of Pocket
☐	**PPO Gold 1**	25%	$1,800	$4,500	$3,600	$9,000
☐	**PPO Gold 2**	40%	$1,200	$5,000	$2,400	$10,000
☐	**HD Gold 3**	0%	$3,200	$3,200	$6,400	$6,400
☐	**PPO Gold 5**	20%	$3,500	$5,000	$7,000	$10,000
☐	**PPO Gold 6**	50%	$800	$5,000	$1,600	$10,000
☐	**PPO Gold 7**	50%	$500	$8,700	$1,000	$17,400
☐	**PPO Gold 8**	20%	$2,500	$6,000	$5,000	$12,000
☐	**PPO Gold 9**	40%	$2,000	$6,500	$4,000	$13,000
☐	**PPO Gold 11**	15%	$2,450	$7,000	$4,900	$14,000
☐	**PPO Gold 12**	20%	$0	$9,100	$0	$18,200
☐	**PPO Silver 1**	35%	$3,500	$8,500	$7,000	$17,000
☐	**PPO Silver 2**	50%	$1,800	$8,200	$3,600	$16,400
☐	**PPO Silver 3**	40%	$5,000	$7,900	$10,000	$15,800
☐	**PPO Silver 4**	50%	$3,800	$8,150	$7,600	$16,300
☐	**PPO Silver 5**	40%	$3,900	$8,700	$7,800	$17,400
☐	**PPO Silver 6**	40%	$3,600	$8,700	$7,200	$17,400
☐	**HD Silver 9**	0%	$5,100	$5,100	$10,200	$10,200
☐	**PPO Silver 10**	0%	$6,500	$7,900	$13,000	$15,800
☐	**PPO Silver 11**	50%	$6,100	$9,000	$12,200	$18,000
☐	**HD Silver 14**	0%	$5,600	$5,600	$11,200	$11,200
☐	**PPO Silver 18**	0%	$8,450	$8,450	$16,900	$16,900
☐	**PPO Silver 19**	40%	$4,600	$8,500	$9,200	$17,000
☐	**PPO Silver 20**	40%	$4,700	$8,700	$8,700	$17,400
☐	**PPO Silver 21**	50%	$4,500	$7,900	$9,000	$15,800
☐	**PPO Silver 22**	50%	$3,900	$7,800	$7,800	$15,600
☐	**PPO Bronze 1**	50%	$7,000	$8,600	$14,000	$17,200
☐	**HD Bronze 2**	50%	$5,600	$7,200	$11,200	$14,400
☐	**HD Bronze 5**	0%	$8,000	$8,000	$16,000	$16,000
☐	**PPO Bronze 6**	0%	$7,800	$8,750	$15,600	$17,500
☐	**PPO Bronze 8**	50%	$8,000	$9,250	$16,000	$18,500
☐	**PPO Bronze 9**	50%	$6,300	$9,100	$12,600	$18,200
☐	**PPO Bronze 10**	30%	$0	$9,450	$0	$18,900

7. ***Benefit Period (information required)***

☐ Calendar Year ☐ Contract Year

8. ***Optional Benefits***

☐ Chiropractic Benefits

☐ Chamber Plus (if selected please include):

Chamber Name:_____

Chamber Agent Number:_____

9. ***Dental Products (Optional Benefits – choose only one plan design)***

MyBlueDental (Standard/ High Option)

A.

Existing Groups with a High or Standard Dental Option may keep their current dental coverage.
Please select current coverage to continue.

☐ Standard Option ☐ High Option ☐ Orthodontics *(only available on High Option)*

Dental Contribution _____ %
(minimum 25% required)

There is a six-month waiting period from the Member's Effective Date of coverage for Major Restorative Care. The Corporation will waive any part of the twelve-month waiting period that Members have already met under a previous Group Dental Plan if that plan has been in effect for at least six months. Any request for a waiver must include bills showing prior coverage.

Blue Dental 1, 2, and 3

B.

Group Dental Options (minimum of 2 Enrolled Employees):

☐ Blue Dental 1 ____Open Access _____Select (PPO)
Available only on Preferred Plans

☐ Blue Dental 2 ____Open Access _____Select (PPO)

☐ Blue Dental 3 ____Open Access _____Select (PPO)

Optional Benefit:

☐ Orthodontics (Available only with Preferred Plans)

There is a twelve-month waiting period from the Member's Effective Date of coverage for Major Restorative Care. The Corporation will waive any part of the twelve-month waiting period that Members have already met under a previous Group Dental Plan if that plan has been in effect for at least twelve months. Any request for a waiver must include bills showing prior coverage

PARTICIPATION REQUIREMENTS

Please check applicable space that matches the number of enrolled Employees.

A. Preferred Plans (minimum requirements):
_____10 or more Eligible Employees Enrolled
_____50% or more of Eligible Enrolled Employees
_____Contribution of 50% or more toward each Eligible Employee's single premium.
_____Orthodontics (Only available on Preferred Plans)

B. Standard Plans:
_____2 or more Eligible Employees Enrolled
_____Contribution of 50% or more toward each Eligible Employee's single premium.

C. Employer Contribution_____%
When the Employer contributes 100% of the premiums, all employees must participate in the dental plan.

Note: Information provided on this form may be verified by phone, personal interview or other means prior to or after requested effective date.

Authorized Signature:_____ ***Date:***_____