



13. FOR GROUPS OF 51+: BCBSNC 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.

Domestic Partner Coverage Options (check all that apply):  None  Same Sex  Opposite Sex

Elected Official Coverage:  Yes  No Name of Elected Official: \_\_\_\_\_

### BENEFIT DESIGN OPTIONS

14. **PLAN OPTIONS:** (select one) **Note: Premiums are based on a Per Employee Per Month fee**

	Plan Type	Employee Only (Tier)	Employee + Spouse (Tier)	Employee + Child(ren) (Tier)	Employee + Family (Tier)
<input type="checkbox"/>	* Enhanced Plan with Orthodontia	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/>	* Enhanced Plan without Orthodontia	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/>	** Standard Plan	\$ _____	\$ _____	\$ _____	\$ _____

\* At least 20% of eligible employees with a minimum of **5** employees are required to enroll in this Plan option.

\*\* At least 20% of eligible employees with a minimum of **10** employees are required to enroll in this Plan option.

15. All employer-sponsored group dental 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). (Any notices required under COBRA remains the responsibility of the group.)

Is your group dental plan exempt from COBRA?  Yes  No

16. 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

Name and Title of ERISA Contact: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

17. This coverage is:  Replacing a BCBSNC Dental Plan  
 Replacing another Carrier's Dental Plan or  
 No Prior Carrier

**Note:** If the Dental Blue Select - Enhanced Plan is chosen, prior creditable coverage may apply towards the dental waiting periods. In order to obtain prior credit, you must attach a prior billing with covered persons' names and effective dates of coverage.

18. 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.

For Groups under 100 employees, do 25% or more of the persons covered by your plan meet the following criteria?

Literate only in a foreign (non-English) language?  Yes  No

If yes, what is their primary language (e.g., Spanish)? \_\_\_\_\_

For Groups of 100+ employees, do 500 or 10% of the persons covered by your plan meet the criteria listed above?  Yes  No

If more than one language is listed, state percentages of members literate in each language: \_\_\_\_\_

### PAYMENT OPTIONS

19. **Initial / First Month's Premium (a check for the first month's premium must accompany this application)**

The amount of the check is calculated, based upon the plan selected, by multiplying the number of employees times the fee for the type of coverage (tier) elected, and then by totaling all subtotals for each type of coverage (tier) elected.

Subsequent Premium Payments:  Bank Draft  Check

**20. Authorization for Bank Draft**

By signing below, I certify that I am an authorized user of the bank account designated below. I hereby request and authorize BCBSNC to charge subsequent premium(s) for Group Insurance described by this document to the bank account payable to the order of BCBSNC. I agree that BCBSNC'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. This authorization will remain in effect until it is revoked by an authorized user in writing at least 10 days prior to the date the bank account is scheduled to be charged. I agree that if such charges were dishonored, whether with or without cause and whether intentionally or inadvertently, BCBSNC shall have no liability whatsoever even though dishonor results in forfeiture of insurance.

Type of Account:  Checking  Savings

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

Bank Routing Transit Number: \_\_\_\_\_ Bank Account Number: \_\_\_\_\_

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

Signature of Account Holder: **X** \_\_\_\_\_ Date: \_\_\_\_\_  
 MM / DD / YYYY

**Please attach a VOIDED Check or Deposit Slip**

**21. Subject to the acceptance of this application by BCBSNC, the effective date of coverage pursuant to this application shall**

be 12:01 AM Eastern Time on the First day of \_\_\_\_\_ (month), \_\_\_\_\_ (year), provided that the initial monthly fees are paid, and coverage under the Group Contract will be for a period of 12 months, and that, unless terminated in accordance with the Group Contract, the Group Contract will be renewable for subsequent 12 month periods.

**CERTIFICATIONS**

GROUPS OF 1-50: 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 coverage. Documentation of "statutory employee" status is required.

In applying for this coverage, the Group further understands that the Group's tender of this application and fees as required by BCBSNC in no way binds BCBSNC to contract with the group. Submission of this application and requisite fees constitutes an offer by the Group, which may be accepted by BCBSNC by the earlier of the following events: BCBSNC's issuance of the Group Contract, or issuance of identification cards to the Group's members. The Group Contract issued by BCBSNC shall set out the terms of the agreement between the parties, and this application shall be incorporated therein by reference. Group agrees that BCBSNC's Group Contract shall be binding upon the parties as issued, without necessity of signature by the Group.

**By signing below, I understand that this application constitutes an offer, which shall constitute a binding contract upon acceptance by BCBSNC, and certify my authority to make such an offer on behalf of the Group. I further acknowledge my receipt and approval of a representative sample of BCBSNC's Group Contract.**

Authorized Signature (for the Group): \_\_\_\_\_ Date: \_\_\_\_\_  
 MM / DD / YYYY

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

**AGENT'S REPORT - Complete, If Applicable**

Agent / Broker Name (Please Print):			Agency Number:			Tax ID # (EIN):			
Tax ID # (EIN): <input type="text"/>			<b>OR</b> SSN:			<input type="text"/>			
Agency Name:			Telephone Number:			<input type="text"/>			
Mailing Address:			City:		State:		Zip Code:		County:
Is Agent or Broker licensed and appointed by BCBSNC for the types of insurance solicited where this group is located? <input type="checkbox"/> Yes <input type="checkbox"/> No				Agent Code Number (BCBSNC Producer Number):					
Signature of Agent/Broker:					State License:				