



Number of Eligible Employees:	Number of Participating Employees:	Internal Use Only Group Number:
Requested Effective Date: ____ (month) ____ (year)	First Renewal Date: ____ (month) ____ (year)	

EMPLOYER INFORMATION

1. Legal Name of Employer:		Tax ID Number:		NAICS Code:	
2. Physical Address:		City:	State:	Zip Code:	County:
3. Billing Address: (if different from above)		City:	State:	Zip Code:	
4. Name of Group Administrator:		Telephone Number:	Fax Number:	E-mail Address:	
5. Name of Contact for Premium Billing:		Telephone Number	E-mail Invoice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			E-mail Correspondence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E-mail Address			Alternate E-mail Address		
6. Type of Organization: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Church <input type="checkbox"/> Limited Liability Corporation					
7. Divisions / Subsidiaries / Affiliates to be Covered (attach list, if necessary): <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name: _____ Relationship: _____					
Address: _____ E-mail Address: _____					
City: _____ State: _____ Zip Code: _____					
Nature of Business: _____ Note: Eligibility must be received in a manner that will identify the location or group in which the individual is to be enrolled.					
Invoice should be sent to: <input type="checkbox"/> Main Office <input type="checkbox"/> Division Address <input type="checkbox"/> E-mail Address: _____					
8. (a) Will the Employer pay any amount towards the dental premium?		(b) Employer (group) paid premium contribution percentage:		(c) Are employee premiums paid on a pre-tax basis through a Section 125 plan?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		For Employee: _____ % For Dependents: _____ %		<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Ever Filed for Bankruptcy or in Process of Filing? <input type="checkbox"/> Yes <input type="checkbox"/> No			10. Has the Bankruptcy Court Approved Reorganization? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please provide documentation of approval to reorganize
If Yes, Indicate Chapter Filed: _____					

EMPLOYEE ELIGIBILITY

11. Eligibility Requirements to be Applicable to Newly Hired Employees:		
<input type="checkbox"/> 0 day probationary period, effective 1st of month following the date of hire	<input type="checkbox"/> Next day following 30 days	<input type="checkbox"/> 0 day probationary period, effective on date of hire
<input type="checkbox"/> 1st of the month following 30 days	<input type="checkbox"/> Next day following 60 days	
<input type="checkbox"/> 1st of the month following 60 days	<input type="checkbox"/> Next day following 90 days	
12. Coverage will terminate: <input type="checkbox"/> End of the contract month following employment termination		



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	Benefit Period Maximum Amount Selected	Employee Only (Tier)	Employee + Spouse (Tier)	Employee + Children (Tier)	Employee + Family (Tier)
<input type="checkbox"/> ** Standard Plan	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 (available on all plans except Standard Plan)	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> * Complete Plan		\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> * Complete Plan with Orthodontia		\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> * Enhanced Plan		\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> * Enhanced Plan with Orthodontia		\$ _____	\$ _____	\$ _____	\$ _____

* 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

Will BCBSNC-DBS administer COBRA for this plan? 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 or Complete Plan is chosen, prior creditable coverage may apply towards the dental waiting periods. In order to obtain prior credit, you must attach a copy of the latest bill from your previous carrier.

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. 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 BCBSNC in meeting special customer service needs.

For Groups 1-50: 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 51+: Do 10% or 500 of the persons covered by your plan, whichever is less, meet the following criteria:

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

PAYMENT OPTIONS

19. **Initial / First Month's Premium (a check for the entire first month's premium payable to BCBSNC-DBS 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.

Would you like Subsequent premiums drafted from your bank account? Yes No If yes, complete Question 20 (Authorization for Bank Draft).

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.

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 it meets the definition of Small Employer Group as follows: any individual or entity actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for the purpose of taxation by the State of North Carolina, shall be considered one employer.

The Group further 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.

STATEMENT OF UNDERSTANDING: 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: _____ Elected Official Coverage: Yes No

AGENT'S REPORT - Complete, If Applicable

Agent/Broker Name (Please Print):	Agent's E-mail Address:	Agent Code (BCBSNC Producer Number):	Agent Tax ID# or SSN:
		P _____	
Agency Name:	Agency Number:	Telephone Number:	Agency Tax ID#/EIN:
	A _____		
Agency 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			
Signature of Agent/Broker:		State License:	

Questions? Call Blue Cross and Blue Shield of North Carolina at 1-888-471-2738