



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield of Idaho
1602 21st Avenue
PO Box 1106
Lewiston, Idaho 83501

Group Master Application - For Group Size 2-99

Please complete and submit this application to our office **no later than 15 days prior to the effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate sheet of paper.

NEW/RENEWAL COVERAGE FOR GROUPS OF 2-99

Requested Effective Date _____

SECTION 1 - GROUP INFORMATION			
Group's Legal Name		Company Structure Sole Proprietorship Corporation Partnership Other _____	
Doing Business As (DBA)	Name to be used by Regence Legal DBA	Location of Business Headquarters	
Employer Federal (EIN) and State (if applicable) Tax ID Numbers		SIC Code and Industry Description 	
Name and Title of President, Owner, CEO		Group's Primary Language (if other than English)	
Physical Business Address Required (No PO Box or PMB)		Mailing Address (if different from Physical Business Address)	
City, State and ZIP Code		City, State and ZIP Code	
County	Phone Number () Fax Number ()	County	Phone Number () Fax Number ()
PRIMARY GROUP CONTACT			
Name (First, MI, Last)		Title	
Phone Number ()	Fax Number ()	E-mail Address	
GROUP ADMINISTRATOR (if different from primary contact)			
Name (First, MI, Last)		Title	
Phone Number ()	Fax Number ()	E-mail Address	
OTHER CARRIER INFORMATION			
MEDICAL: Does your group have current Medical coverage? No Yes If yes, name of carrier _____ Date coverage will end _____		WORKERS' COMPENSATION: Does your group have Workers' Compensation coverage? No Yes If yes, name of carrier _____	
PHARMACY: Does your group have current Pharmacy coverage? No Yes If yes, name of carrier _____ Date coverage will end _____		DENTAL: Does your group have current Dental coverage? No Yes If yes, name of carrier _____ Date coverage will end _____	
Will you be offering more than one medical insurance carrier to your employees? No Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>		Will you be offering more than one dental insurance carrier to your employees? No Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>	
AGENT INFORMATION			
Agency Name		Agent (Producer) Name	
Agent E-mail Address		Agent Phone Number	Agent Number
Secondary Agent Name (if applicable)		Secondary Agent Phone Number	Secondary Agent Number
Commission Split: Agent #1 _____ % Agent #2 _____ %			
Additional Information			



SECTION 1 - GROUP INFORMATION (continued)

BILLING

Please select desired billing location: Physical Mailing Other		Do you require separate billing invoices by location? No Yes (If yes, please complete Additional Billing Location section(s) below)	
(Please indicate any differences to page one in spaces below)			
Business Name		Additional Billing Location Business Name	Additional Billing Location Business Name
Billing Address		Billing Address	Billing Address
City, State and ZIP Code		City, State and ZIP Code	City, State and ZIP Code
Phone Number () Fax Number ()		Phone Number () Fax Number ()	Phone Number () Fax Number ()
Contact and Title (if different than primary group contact)		Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)
Payment Type		Payment Type	Payment Type
Pay by Check Surepay (EFT)* Available for Innova, Engage, Activate and HSA Healthplan 2.0 products* * Please submit Surepay document		Pay by Check Surepay (EFT)* Available for Innova, Engage, Activate and HSA Healthplan 2.0 products* * Please submit Surepay document	Pay by Check Surepay (EFT)* Available for Innova, Engage, Activate and HSA Healthplan 2.0 products* * Please submit Surepay document

FEDERAL MANDATES

COBRA:

Group subject to COBRA? No Yes

COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (January – December), with the exception of federal government plans and church plans. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

OBRA:

Group subject to OBRA? No Yes

If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:

Group subject to TEFRA/DEFRA? No Yes

If you employed 20 or more full-time and/or part-time employees during each of the 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

ERISA:

Group subject to ERISA? No Yes

Is your plan year different than your renewal date? No Yes, list date _____

Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals covered by a health plan subject to ERISA, as well as most voluntarily established pension plans.

Schedule A / Form 5500 information required?

No Yes If yes, reporting time frame required _____



SECTION 2 - ELIGIBILITY INFORMATION

GROUP ELIGIBILITY (for purposes of determining group classification)

Note: An "eligible employee" is defined as an employee who on a full-time basis worked 30 or more hours/week in the preceding calendar year. The employer may specify the minimum of 20 to 30 hours per week.

1. Number of eligible employees in the preceding calendar year _____

2. Do you have eligible employees employed outside the State? No Yes If yes, please indicate below.

Note: Group members who reside in the state of Hawaii are not eligible for coverage.

3. Is the group a subsidiary or affiliate of another company? No Yes If yes, please explain _____

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

EMPLOYEE ELIGIBILITY (for purposes of determining who is eligible for group benefits)

Note: Groups with 2 to 50 eligible employees may not exceed 30 hours per week. Groups with 51 to 99 eligible employees may not exceed 40 hours per week. Eligible employees are based upon the number of employees used for the purposes of defining group classification above.

1. This plan covers employees working the minimum number of hours required for coverage.

The minimum number of hours to be eligible for coverage are: _____

2. If purchasing Innova, Engage, Activate or HSA HealthPlan 2.0 products, will domestic partner coverage be provided? No Yes

3. Probationary Periods: Groups may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. All employees must be accounted for. (If there are no classes, please enter all information in space provided for Class 1).	Actual Date of Hire (Group size 51-99 only)	DAYS						
		Coverage is effective on the first of the month following (please place an X in the appropriate box below)						
		*Date of hire	30	60	90	120	180	365
Class 1:								
Class 2:								
Class 3:								

3A. *Choose how Date of Hire (DOH) will be administered:

Effective date will always be 1st of the month following DOH, even if DOH is the 1st of the month.

Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

3B. Is probationary period waived on group's initial enrollment: No Yes

3C. For employees transferring from part-time to full-time status, the probationary period specified above should apply:

Beginning on the date transferred to full-time status Retroactive to the original date of hire



SECTION 3 - EMPLOYER CONTRIBUTION

The employer will pay the following percentages toward the monthly rate. If different classes are chosen, please indicate classes and contribution for each.

Note: The minimum employer contribution percentage is 50% towards the employee medical coverage. There is no minimum employer contribution percentage for dependents.

	Class 1		Class 2		Class 3	
	Medical	Dental	Medical	Dental	Medical	Dental
Employee	%	%	%	%	%	%
Dependent	%	%	%	%	%	%

SECTION 4 - GROUP PARTICIPATION

Note: 2 to 50 eligible employee groups - A minimum participation requirement of 85% for groups with 2 to 19 eligible employees, and 75% for groups with 20 or more eligible employees, after valid waivers.
 51 to 99 eligible employee groups - A minimum participation requirement of 75%, after valid waivers and in no event, less than 50% of the total eligible group.

1. Total number of employees on payroll regardless of hours worked (Do not include COBRA participants).	1	
2. Less individuals not eligible for coverage on this plan:		
a) Employees working fewer than the minimum hours described in Section 2 Eligibility Information including those who are part-time.	2a	-
b) Employees who are temporary, seasonal or substitute employees.	2b	-
c) Individuals paid via IRS Form 1099 (for groups of 51 to 99).	2c	-
3. Equals subtotal number of employees eligible to enroll.	3	=
4. Number of employees completing a waiver form for Other Qualifying Coverage.	4	
5. Number not enrolling due to serving a New Hire Probationary Period (described in Section 2 Eligibility Information).	5	
6. Number of employees completing a waiver form who are declining coverage. (No other qualifying coverage).	6	
7. Number of employee applications being submitted (for new groups only).	7	
8. Number of former and current employees covered by your group under COBRA.	8	
9. Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.	9	
10. Number of former and current employees not eligible for COBRA who are covered by a group extension plan.	10	



SECTION 5 - ACKNOWLEDGEMENTS AND CERTIFICATIONS

If you have any questions about the benefits and services that are covered, provided, limited or excluded under the group coverage(s) to which this application applies, please contact your Sales Representative before signing this application.

Note: The Company as used here means the group applying for coverage as indicated in Section 1 of this application.

I certify that I am an officer or employee of the Company, that I am duly authorized to execute this application on behalf of the Company, and that the Company:

- a) Applies for the group coverage(s) selected in the signed rate and benefits page(s) which form a part of the group contract(s) issued by Regence BlueShield of Idaho.
- b) Authorizes any person or other entity to release to Regence BlueShield of Idaho any information requested by Regence BlueShield of Idaho in connection with this application's processing.
- c) Acknowledges, where permitted by law, that Regence BlueShield of Idaho may choose not to approve this application and any premium deposit will be returned if the application for group coverage(s) is not approved.
- d) Acknowledges that coverage is not in effect until Regence BlueShield of Idaho accepts this application, establishes an effective date of coverage and issues the group contract(s) to the Company.
- e) Acknowledges that, if it is approved by Regence BlueShield of Idaho, this application will form a part of the group contract(s) issued by Regence BlueShield of Idaho and agrees that the Company will be bound by the terms and the conditions of entire group contract(s).
- f) Acknowledges that eligibility standards (e.g., waiting period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.
- g) Acknowledges that it has selected the group coverage(s) to be offered to its employees, that its selection of this group coverage(s) was based upon written information provided by Regence BlueShield of Idaho, and that no broker, agent, or consultant was or is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.
- h) Agrees to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Regence BlueShield of Idaho for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Regence BlueShield of Idaho, upon its request verifications of employee participation levels.
- i) Agrees that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence BlueShield of Idaho, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.
- j) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.
- k) Agrees to deliver, or otherwise make available to enrollees, all Regence BlueShield of Idaho paper or online member documents and other coverage-related materials upon request by Regence BlueShield of Idaho.
- l) Agrees to make all coverage options available to all eligible employees and dependents who satisfy eligibility requirements.
- m) Acknowledges that benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and Regence BlueShield of Idaho in accordance with the group contract(s).
- n) Acknowledges that Regence BlueShield of Idaho must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc).
- o) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Regence BlueShield of Idaho, that Regence BlueShield of Idaho does not provide health care services, and that Regence BlueShield of Idaho cannot guarantee any results or outcomes of care. Regence BlueShield of Idaho is responsible for the quality of health care you receive only as provided by law.
- p) Certifies under penalty of perjury that all statements made and information provided in this application are accurate and complete to the best of its knowledge or belief and acknowledges that Regence BlueShield of Idaho will rely in part on the information in this application as the basis for Regence BlueShield of Idaho's decision on whether to approve this application and issue any group contract(s). For the protection of all of Regence BlueShield of Idaho's members, fraud or misrepresentation of material fact by the Company for the purposes of defrauding Regence BlueShield of Idaho may result in Regence BlueShield of Idaho taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, Regence BlueShield of Idaho will have the right to collect any claims payments or other damages. If Regence BlueShield of Idaho continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that Regence BlueShield of Idaho will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by Regence BlueShield of Idaho.
- q) Agrees that any controversy or claim between the Company and Regence BlueShield of Idaho arising out of or relating to the group contract(s), or the breach thereof, whether involving a claim in tort, contract, or otherwise, shall be subject to final resolution through binding arbitration. The Company and Regence BlueShield of Idaho agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs, and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in Ada County, Idaho (ID), unless mutually agreed otherwise by the parties. If any enrollee or former enrollee (or person claiming to be an enrollee or former enrollee) makes any claim or brings any action or proceeding arising out of or relating to the group contract(s) to which Regence BlueShield of Idaho or the Company becomes a party, Regence BlueShield of Idaho and the Company agree to cooperate in the defense of such claim, action, or proceeding and to resolve any controversy or claim between Regence BlueShield of Idaho and the Company through arbitration under this paragraph only after the resolution of the enrollee's (or alleged enrollee's) claim.
- r) Appoints the agent of record indicated in Section 1 - Group Information (if any) to represent it in matters of group coverage benefits provided by Regence BlueShield of Idaho. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.
- s) Acknowledges that if the Company has an agent, that agent may receive bonuses, commissions, administrative services fees, or other compensation, including non-cash compensation from Regence BlueShield of Idaho. Incentives may be based on any of several factors, including the size of the Company's business, the products the Company purchases, the agent's volume of business with Regence BlueShield of Idaho, and other services the agent provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information please contact the agent for the Company.

SIGNATURE

Group Authorized Signature

Official Title

Signature Date

