BlueCross BlueShield of Florida Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

New Business Small Employer Application

Group Information

Group Name *(full and complete legal name is required)*

Doing Business As: (if applicable)

Nature of Business: / SIC Code:

Employer Classification

☐ Corporation ☐ Partnership ☐ Sole Proprietor

Group's Physical Address

☐ Non- Profit ☐ Other:

City State Zip

Decision Maker Name and Title:

Group's Mailing Address: *(if different from above)*

Contact Person Name and Title:

City State Zip

Phone Fax

Workers' Compensation Carrier:

e-Mail

Prior Health Insurance Carrier:

Tax ID#

Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

The original effective date of this Policy shall be

The Benefit Period of this Policy shall be:

☐ Calendar Year (1/1 - 12/31) ☐ Non-Calendar Year -

This Policy may be terminated by the applicant of BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

Eligibility Information

Employer Contribution:

Employee % Dependent %

Waiting Period

☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365

Add New Eligible Employees on:

☐ 1st day of billing cycle OR ☐ Date of hire

Term Eligible Employees on:

☐ Last day of billing cycle OR ☐ Termination Date

Coverage for new eligible employees may be effective as selected above, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements. (For Standard and Basic products the waiting period cannot exceed 90 days.)

What is the total number of employees, (including owners and partners, etc.), currently employed by your business?

# of new Full-time Employees still in waiting period? ☐

Total # of Part-time Employees. ☐

# of COBRA / FHICCA Continuants ☐

# of employees waiving BCBSF/HOI health benefits but are covered on another health benefit plan? ☐

# of employees waiving BCBSF/HOI health benefits without coverage elsewhere? ☐

Is your company a member of a Controlled Group of Corporations as referenced in section 414 of Internal Revenue Code of 1986 (26 U.S.C. §414(b), (c), (m), or (o))? ☐ Yes ☐ No

If yes, please give the legal names, addresses and employer identification numbers of all other legal entities within the Controlled Group of Corporations (use separate sheet if necessary):

Under Federal Law, if your group had 20 or more full and part-time employees, including owners and partners on at least 50% of the employer's work days of the preceding calendar year, you must provide employees with COBRA Continuation. If your group had less than 20 employees, your employees are eligible for coverage under the Florida Health Insurance Coverage Continuation Act ("FHICCA"). All full time employees are counted as one employee and each part-time employee is counted as a fraction of an employee. Owners, partners and others paid by the employer(s) are included. Self-employed / independent contractors and non-employee directors are not counted.

☐ COBRA Continuation

OR

☐ FHICCA

Please answer all of the following questions:

We are a ☐ Single Employer Plan OR a ☐ Multiple or Multi-Employer Plan

A Multiple Employer Plan is a plan sponsored by more than one employer. A Multi-Employer Plan is a plan jointly sponsored by employers and unions.

One or more employers in our group employed 20 or more full and/or part-time employees during the current or preceding calendar year. ☐ Yes ☐ No

Our group employed 100 or more full and/or part-time employees on 50 percent or more of the work days during the preceding calendar year. ☐ Yes ☐ No

Employers must have an application / refusal form on file with us completed for all eligible employees, even those who are not taking the health coverage, and submit those applications to Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. It is recommended that the employer also retain a copy of all applications. Only eligible employees who have met any applicable waiting period and who regularly work a minimum of 25 hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described above.

At least 70% of the eligible employees for Applicants with 4-50 employees and 100% of the eligible employees for Applicants with 1-3 employees must be enrolled under the Policy on the original Effective Date and throughout the term of the Policy. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage; applicant agrees to furnish any such request.

Health Plan Summary Information *(complete one section for each plan selected)*

☐ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Deductible: Per Person ___ Per Family ___	Coinsurance In-Network/Participating ___
Rates: ☐ Composite ☐ Table *(see attached rate sheet)*	Out of Network/Non-Participating ___
Employee ___ Employee/Spouse ___	Office Visit Copay:
Employee/Child(ren) ___ Family ___	Family Phy. ___
Other ___	All Other Providers ___

Health Plan Name	Rx Option *(indicate copayments)*
Deductible: Per Person ___ Per Family ___	Coinsurance In-Network/Participating ___
Rates: ☐ Composite ☐ Table *(see attached rate sheet)*	Out of Network/Non-Participating ___
Employee ___ Employee/Spouse ___	Office Visit Copay:
Employee/Child(ren) ___ Family ___	Family Phy. ___
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Employee/Child(ren) ___ Family ___	Family Phy. ___
Other ___	All Other Providers ___

Health Plan Name

Rx Option *(indicate copayments)*

Deductible:

Per Person Per Family

Rates: ☐ Composite ☐ Table *(see attached rate sheet)*

Employee Employee/Spouse

Employee/Child(ren) Family

Other

Coinsurance

In-Network/Participating

Out of Network/Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

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Rx Option *(indicate copayments)*

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Per Person Per Family

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Out of Network/Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

See the Group Master Policy for a complete description of benefits.

Health Savings Account (HSA) Banking Arrangement *(optional with HSA compatible health plans)*
Are you choosing BCBSF's integrated HSA banking arrangement ☐ Yes ☐ No
(if left blank, the response is assumed to be no.)

Coverage Acceptance or Refusal
I acknowledge that I was offered the opportunity to purchase the state mandated small business BASIC and STANDARD health benefit plans and the BASIC and STANDARD health benefit plans offered in connection with a health reimbursement arrangement.

☐ Declined such coverage.

☐ Accepted such coverage. *If accepting, please complete and attach a Small Employer Application Addendum.*

Rate Information
Premiums/Prepayment fee are payable on or before the due date. Regular Billing – Employee applications should be submitted thirty (3) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination. The Rates established for this Policy will not be changed for the first twelve (12) months following the original Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective date.

Applicant Responsibilities/Acknowledgements
The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and Certificate of Coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's original Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness. Applicant hereby acknowledges receipt and review of the BCBSF/HOI Confidentiality Notice and agrees to abide by said notice. Applicant acknowledges that it may be liable to BCBSF/HOI and/or others should it fail to comply with the requirements of said notice. If I am applying for **BlueSelect,** I acknowledge that all eligible employees live, reside or work in the Service Area. I acknowledge receipt of (1) a description of the exclusive providers; (2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; (3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; (4) a description of limitations on referrals to restricted exclusive providers and to other providers; and (5) a description of BCBSF's quality assurance program and grievance procedure. I further acknowledge that I understand the restrictions of the BlueSelect product. If applicant chose the HSA Banking Arrangement, applicant agrees to obtain from each employee, enrolling in a high deductible health plan issued or administered by BCBSF and establishing in HSA in conjunction therewith, the employee's signed authorization (in a form acceptable to BCBSF) that authorizes BCBSF to disclose to BCBSF's preferred bank (or other bank selected by applicant) such information, including protected health information, of the employee as the bank may require to establish and maintain the employee's HSA, facilitate direct deposits to the employee's HSA, and comply with the terms of the bank's depository agreement. Applicant acknowledges and agrees that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of applicant's choice subject to the terms and conditions of such agreements, including fee, as the bank may require. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.

If applicant is applying for Miami-Dade Blue, applicant acknowledges there is no participating provider network outside of Miami-Dade County, and that members will be responsible for all charges that exceed BCBSF's payment amount for services received from non-participating providers. I certify that the information included in this application is correct to the best of my knowledge. I understand that this information will be used to determine my group's compliance with BCBSF and/or Health Options, Inc. eligibility and Underwriting Guidelines, as well as the applicability of State and Federal laws relating to my group and plan. BCBSF and/or Health Options, Inc. reserves the right to request a UCT-6 or other documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and Underwriting Guidelines, as well as validate the applicability of State and Federal laws. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Final premiums, benefits and effective date are subject to approval by BCBSF corporate headquarters.

Issuance of the Group Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title

Date	Blue Cross and Blue Shield of Florida, Inc./Health Options, Inc./Licensed Agent (Print)	

	Signature of Agent	Agent License Identification Number

Rate Information

Group Number:

Group Name:

Anniversary Date:

Effective Date:

Health Benefit:

	Male EE	Female EE	Male EE + Spouse	Female EE + Spouse	Male EE + Child	Female EE + Child	Male EE + Family	Female EE + Family
1-29								
30-39								
40-49								
50-54								
55-59								
60-64								
65 +P								

Final premiums, benefits and effective date are subject to approval BCBSF corporate headquarters.
Issuance of the Group Policy, by BCBSF/HOI will be deemed acceptance of this application.

Date | Signature of Applicant | Print/Type Name & Title

Date | Blue Cross and Blue Shield of Florida, Inc./Health Options, Inc./Licensed Agent (Print)

Signature of Agent | Agent License Identification Number

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