(2-50 Eligible Employees)

SMALL GROUP MASTER APPLICATION

Or Application for Amendment

Group Number

Anthem® Lumenos Case Number

The purpose of this form is for Blue Cross and Blue Shield of Georgia, Inc. (BCBSGa) and Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP) and Greater Georgia Life (GGL) to evaluate rating for the company's request for group insurance coverage. Please answer all questions. This form must be signed and dated by an officer of the company.

SECTION I – EMPLOYER INFORMATION

Legal Name of Employer	Telephone Number	
Street Address	County	Chamber Member ☐ Yes ☐ No
Billing Address	EIN #	

City	State	ZIP Code	Nature of Business	Years in Business
Group Administrator Name	Group Administrator E-mail Address			Group Administrator Fax No.

The minimum BCBSGA participation requirement for group health insurance is the greater of 2 enrolled employees or 75% of all eligible employees and this minimum must be enrolled on the group plan at all times in order to continue to qualify for group coverage. When determining participation, the eligible employee population does not include employees who refuse coverage because they are covered as a spouse or dependent on another group policy, have TriCare through the military, are enrolled in Medicare, or are part-time or seasonal. We may terminate coverage with sixty (60) days' notice if the Employer fails to maintain the minimum participation requirement. The contract may also be immediately cancelled for fraud.

Total Number of Active Employees Full-time ________ Part-time ________

Total Number of Eligible Employees (30 hrs. or more per week) ________
If less than 30 hrs. per week written approval from Underwriting Director required.

Number of Employees Currently Enrolled in Health Plan ________

Total Number of Employees in Employee Waiting Period ________

Number of COBRA Participants ________ BCBSGa COBRA Administration? ☐ Yes ☐ No If yes, is premium included in Binder Check? ☐ Yes ☐ No

Current Group Carrier	**Effective Date**	**Type of Coverage**	**Type of Funding**

If enrolling employees from a subsidiary, please complete the following:

Name of Subsidiary	Nature of Business		
Street Address	City	State	ZIP Code

SECTION II – REQUESTED COVERAGE INFORMATION

1a. Coverages Requested: ☐ New Coverage ☐ Amending Existing Coverage

Medical Plans (Please indicate plan number)

☐ HMO ________
** must offer a second plan with an out-of-network option.* ________
☐ HMO-Open Access ________
** must offer a second plan with an out-of-network option.* ________
☐ POS ________ ________
☐ POS-Open Access ________ ________
☐ PPO ________ ________
☐ Blue Essential (Hospital/Surgical) ________ ________

☐ Anthem ® Lumenos HSA-Qualified ________
☐ Anthem ® Lumenos HRA ________
☐ Anthem ® Lumenos HIA ________
☐ Anthem ® Lumenos HIA+ ________

HSA Bank: ☐ Mellon ☐ Other: ________
If Anthem® Lumenos Plan is elected, is employer funding all or part of the member's deductible? ☐ Yes ☐ No

EmployeeElect ☐ Yes** ☐ No

*** If selecting EmployeeElect, please add plan numbers to comment section of this application. (1c)*

Specialty Plans

☐ Dental ________
Replacement ☐ Yes ☐ No
Bundled ☐ Yes ☐ No
Unbundled ☐ Yes ☐ No

☐ Vision ________
Check if Vision voluntary ☐

EAP (minimum group size 10+)
☐ Basic EAP 3 sessions
☐ Enhanced EAP 4 Sessions
☐ Enhanced EAP 6 Sessions
(if selecting EAP please complete additional form)

1b. For 24 hour coverage, list eligible owners and officers (additional premium required)

Name	Name	Name

1c. Comments

Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. are independent licensees of the Blue Cross and Blue Shield Association. Life and Disability products underwritten by Greater Georgia Life insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
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2.	Employer Contribution (minimum 50% of single employee premium is required for Medical. Indicate the percentage.)	Employee Health ______ % Employee Dental ______ % Employee Vision ______ %	Dependent Health ______ % Dependent Dental ______ % Dependent Vision ______ %
3.	What is the length of employee waiting period? (EWP) # Days ___________ (cannot exceed 180 days) If more than one EWP please indicate in the comments area (Question 1c in Section II.)		
		Medical Products	**Life/DI Products**
3a.	Will coverage be effective on the date of hire?	☐ Yes ☐ No	☐ Yes ☐ No
3b.	Will coverage be effective on the first day following the employee waiting period?	☐ Yes ☐ No	☐ Yes ☐ No
3c.	Will coverage be effective on the first day of the month following the employee waiting period?	☐ Yes ☐ No	☐ Yes ☐ No
4.	Do you wish to waive the employee waiting period at initial enrollment?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION III – LIFE INSURANCE SCHEDULE OF BENEFITS

Life and Disability options:

Basic Benefits & Employer Contributions:

☐ Basic Term Life/AD&D* ________ %
☐ Dependent Term Life ________ %
☐ Short-Term Disability ________ %
☐ Long-Term Disability* ________ %

Note: if basic benefits are 100% employer paid, 100% enrollment required.

Optional Benefits & Employer Contributions:

☐ Optional Life ________ %
☐ Optional AD&D ________ %
☐ Voluntary Short Term Disability ________ %
☐ Voluntary Long Term Disability ________ %

Are there Grandfathered employees? ☐ Yes ☐ No
If yes, how many? ______________

Are you requesting coverage for any non-active employees? ☐ Yes ☐ No
If Yes, attach completed Eligibility Information Form.

SCHEDULE OF BENEFITS (Completion not required if submitting a signed proposal)

Employee Class/Eligibility Description	Requested Benefit	Benefit Amount

LIFE/AD&D benefits reduce to 65% at age 65 and further reduce to 50% of the original amount at age 70 and terminate at retirement.

COMPLETE ONLY IF YOU ARE APPLYING FOR SHORT TERM DISABILITY BENEFITS

SHORT-TERM DISABILITY Benefits begin on the _______ consecutive day of Accidental Disability or _______ consecutive day of Sickness Disability and continue for a maximum period of _______ weeks. Benefits are non-occupational unless specified otherwise __________. The Pre-existing Condition Limitation provision is for Voluntary Short Term Disability 12/12.

SECTION IV – EFFECTIVE DATE OF COVERAGE

The proposed Effective Date of the Group Master Contract or Amendment, if issued, is 12:01 a.m. (Eastern Time) on the _____ day of _______ (month), ________(year). The first Contract anniversary date shall be on the _____ day of _______ (month), ________(year) whether or not the two dates are separated by twelve (12) months. The Group Master Contract or Amendment, if issued shall remain in force unless terminated in accordance with the terms of the Group Master Contract or Amendment. The premium due date shall be the first of each month.

Signature of BCBSGa/BCBSHP/GGL Representative X	Date	Signature of Employer's Authorized Representative X	Date
Printed Name of BCBSGa/BCBSHP/GGL Representative		Printed Name of Employer's Authorized Representative	

AGENT INFORMATION		INTERNAL USE ONLY
Signature of ☐ Agent, ☐ Counselor or ☐ Direct No-Agent X	GA License No.	Confirmed BCBSGa Appointed ☐ Yes ☐ No* *(*If no is checked, this document cannot be accepted.)*
I, ____________________________________ signed above; certify that I have an active Georgia License and BCBSGa appointment. If this is not true then I understand that I cannot represent BCBSGa and this policy holder.		

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