Employer Enrollment Application
For 2–50 Employee Small Groups
Georgia

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.

Please complete in blue or black ink only.

Section A: Company Information

Company name	Group administrator name	Employer tax ID no. (required)

Company street address	City	County	State	ZIP code
Billing address – If different from above	City	County	State	ZIP code

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government unit/agency ☐ Limited Liability Company (LLC)
☐ Labor union trust ☐ Other _____

SIC code – Required only if applying for Life and Disability coverage	Type of business (be specific)	Date business established

Company contact name	Title

Primary phone no.	Fax no.	Email address

Additional company contact name	Title

Primary phone no.	Fax no.	Email address

Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

_____

_____

_____

Open Enrollment

Our standard open enrollment period is at least 31 days before the Group's renewal date and 31 days after, which is held no more often than once in any 12 consecutive months. If you want a different open enrollment period, please enter the start and end dates. The open enrollment period does not apply to Life & Disability products.	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)

Section B: Application Type

☑ New enrollment	Requested effective date (MM/DD/YYYY)

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Life and Disability products are underwritten by Greater Georgia Life Insurance Company (GGL), independent licensee of the Blue Cross and Blue Shield Association.
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.
The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Employer tax ID no. (required)

Section C: Type of Coverage

1. Medical Coverage – Please list the selected product name and contract codes

PPO Plans	Product Name	Contract Code
BlueChoice PPO		

POS Plans	Product Name	Contract Code
Blue Open Access POS		
Pathway Enhanced		

HMO Plans	Product Name	Contract Code
BlueChoice Healthcare Plan		

Choose your medical contribution for each month – only **one** choice is allowed.

Contribution option 1 (sample text: Traditional option – We will contribute (50% to 100%): _____% per employee _____% per dependent (optional).

Contribution option 2 (sample text: Percentage of plan option – We will contribute: _____% to _____plan)

For Health Savings Account (HSA) plans:

☐ Group will establish Health Savings Account (HSA) with Blue Cross and Blue Shield of Georgia facilitating with a banking services provider.

☐ Group will establish Health Savings Account (HSA) but does not want Blue Cross and Blue Shield of Georgia to facilitate in the creation of the account.

HSA administrator name	Phone no.	Email address

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

Name	Name	Name

2. Dental Coverage – check all that apply
NOTE: To offer Dental Prime and/or Dental Complete plans, please use the Dental Prime and Complete employer application.

☐ BCBSGA Dental Adult	☐ BCBSGA Dental Family	☐ BCBSGA Dental Pediatric
☐ BCBSGA Dental Adult Enhanced	☐ BCBSGA Dental Family Enhanced	☐ BCBSGA Dental Pediatric Enhanced
		☐ None

Choose your dental contribution for each month

_____% per employee _____% per dependent (optional).

3. Vision Coverage – select one plan option

Full Service		Materials Only Plans
☐ BCBSGA Blue View Vision A1	☐ BCBSGA Blue View Vision B1	☐ BCBSGA Blue View Vision MO1
☐ BCBSGA Blue View Vision A2	☐ BCBSGA Blue View Vision B2	☐ BCBSGA Blue View Vision MO2
☐ BCBSGA Blue View Vision A3	☐ BCBSGA Blue View Vision B3	☐ None
☐ BCBSGA Blue View Vision A4	☐ BCBSGA Blue View Vision B4	
☐ BCBSGA Blue View Vision A5	☐ BCBSGA Blue View Vision C1	
	☐ BCBSGA Blue View Vision C2	
	☐ BCBSGA Blue View Vision C3	
	☐ BCBSGA Blue View Vision C4	

Choose your vision contribution for each month

_____% per employee _____% per dependent (optional).

Employer tax ID no. (required)

4. Life and Disability Coverage – check all that apply.

Life Products	Disability Products
Choose Life Product and Group Contribution Percentage: ☐ None ☐ Basic Life & AD&D_____% ☐ Basic Dependent Life_____% ☐ Optional/Voluntary Life*_____% ☐ Optional/Voluntary AD&D*_____% ☐ Optional/Voluntary Dependent Life*_____% *Available for Groups of 20+	**Choose Disability Product and Group Contribution Percentage:** ☐ None ☐ Short Term Disability_____% ☐ Long Term Disability_____% ☐ Voluntary Short Term Disability*_____% ☐ Voluntary Long Term Disability*_____% *Available for Groups of 20+

STD benefits for employees eligible for state disability plans in CA, HI, NJ, NY, PR or RI will be integrated with the state mandated program in that state. The volume calculated for monthly premium will be based on the total benefit amount, and not reduced by the state mandated benefit.

Prior Coverage

Has this group had life and/or disability coverage within 30 days of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name	Termination date
Life coverage ☐ Yes ☐ No		
Disability coverage ☐ Yes ☐ No		

Not Actively At Work Requirements for Life & Disability Products

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Greater Georgia Life may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied. 1) The employee's absence must be due to illness or injury. 2) The employee must be covered by the prior carrier on the day immediately prior to Greater Georgia Life's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Greater Georgia Life's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Employee name	Amount of insurance	Date of birth	Last date worked	Reason not working	Date expected to return	Insured by prior carrier	Request actively at work waiver	Waiver request approved	Underwriter approval
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Employer tax ID no. (required)

Section D: Eligibility

1. Total number of employees (including employed owners/officers): _____
2. Number of eligible full-time employees (minimum 30 hours per week): _____
3. Are part-time employees to be covered? ☐ Yes ☐ No
4. Number of employees enrolling in:
   Medical: _____ Dental: _____
   Vision: _____ Life/Disability: _____
5. Number of eligible DECLINING employees: _____
6. Number of INELIGIBLE employees: _____
7. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week? ☐ Yes ☐ No

   If yes, please explain what class(es) or number of work hours are required (must be at least 30 hours)

   _____
8. Probationary period/waiting period for **new employees**:

   ☐ None ☐ First of month after hire date ☐ 1 month
   ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days
9. New eligible enrollees will become effective on:

   ☐ First of month following completion of waiting period/probationary period

   ☐ Day following completion of waiting period/probationary periods (required for 90 day waiting period)

   The standard effective date is first of the month following the waiting period/probationary period.
10. Do you wish to offer coverage for domestic partners? ☐ Yes ☐ No
11. Under the Medicare Secondary Payer rules, which one applies for your group?

    ☐ Medicare is primary (less than 20 employees)

    ☐ Blue Cross and Blue Shield of Georgia is primary (20 or more employees)

    Blue Cross and Blue Shield of Georgia is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
12. Is your company currently subject to COBRA? (Employed 20 or more total employees on at least 50% of the working days in the previous calendar year?) ☐ Yes ☐ No
13. Termination effective date: ☐ End of month ☐ End of day

Employer tax ID no. (required)

Section E: General Agreement

Please read this section carefully before signing the application.

Please check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life may rely on this application in deciding whether to provide coverage. If the application is not complete, Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life , and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life. Any misstatements on the employees' applications or failure to report new medical information prior to the employee's effective dates may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life. The contract may be immediately cancelled for fraud.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life Insurance Company received the written notification of cancellation, and that no premiums will be refunded for any period between Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life Insurance Company receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Blue Cross and Blue Shield of Georgia and/or Greater Georgia Life Insurance Company will refund these premiums after 45 days from the premium deposit date.

- We agree to make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed; and,
- To maintain records and furnish to Greater Georgia Life or their designated agent(s), any information required in connection with administration of the insurance coverage; and,
- To provide notice of applicable conversion rights to eligible employees and eligible dependents; and,
- We will receive, on behalf of members, all notices delivered by Greater Georgia Life, and immediately forward such notices to persons involved, at their last known address, including certificates of coverage.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. Consultation with a tax advisor is recommended.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Sign here	Company officer signature X	Printed name	Title	Date (MM/DD/YYYY)

Employer tax ID no. (required)

Section F: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Blue Cross and Blue Shield of Georgia to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Blue Cross and Blue Shield of Georgia reviews and approved the application and the employer receives a written notice from Blue Cross and Blue Shield of Georgia.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Blue Cross and Blue Shield of Georgia shall be paid to an agent/broker/producer not appointed/approved by Blue Cross and Blue Shield of Georgia.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Blue Cross and Blue Shield of Georgia that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			**%**	**Second writing payable/sub-agent/producer/broker (Second writing agent not applicable in Maine and Virginia)**			**%**
Agency name		Agency ID no.		Agency name		Agency ID no.	
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker ID no.				Agent/producer/broker ID no.			
Payable/sub-agent/producer/broker ID no. if different				Payable/sub-agent/producer/broker ID no. if different			
Street address				Street address			
City	State	ZIP code		City	State	ZIP code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature		Date (MM/DD/YYYY)		Signature		Date (MM/DD/YYYY)	

For General Agent/Producer/Broker use only

General agent/producer/broker name		Agent/producer/broker ID no.	
Street address		City	State / ZIP code

Sales Representative

Sales representative name	Sales representative ID no.

BCBSGA USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)