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Group Number

## LARGE GROUP MASTER APPLICATION Or Application for Amendment

The purpose of this form is for Blue Cross 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                                                               | Years in Business  |
| City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | State          | Zip Code                                                             | Nature of Business |
| <p>The Employer certifies that (enter specific number) _____ employees are eligible to make application for coverage on the date of this Group Master Application, and agrees that _____ or more of all eligible employees will have made application for membership before the Effective Date of Coverage. Otherwise this Group Master Application will be deemed to have been withdrawn. Further, the Employer agrees to maintain a minimum enrollment participation equal to the greater of 75% of all eligible employees, or _____ while the contract, if issued, is in force. We may terminate coverage with sixty (60) days notice, or convert the group to another category, if the Employer fails to maintain the minimum enrollment participation. We may cancel this contract immediately for fraud.</p> |                |                                                                      |                    |
| Current Carrier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Effective Date | Type Coverage                                                        | Type of Funding    |
| Total Number of Employees (Full-time, Part-time)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                | ERISA Group Yes <input type="checkbox"/> No <input type="checkbox"/> |                    |
| Number of Employees Currently Enrolled in Health Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | Total Number of Eligible Employees                                   |                    |
| Number of COBRA Participants                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                | Total Number of Employees in Employee Waiting Period                 |                    |

### SECTION II - LIFE INSURANCE SCHEDULE OF BENEFITS

| Employee Class Eligibility Description                                                                                                                                               | Basic Life/AD&D Amount(s)                                                                                                                                                                                                                                                                                                     | Dependent Life Spouse/Children | Short-Term Disability Amount(s) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------|
| <p><b>Employer Contribution:</b></p> <p>Basic Term Life/AD&amp;D _____%</p> <p>Dependent Term Life _____%</p> <p>Long-Term Disability _____%</p> <p>Short-Term Disability _____%</p> | <p><b>Probationary Period for:</b></p> <p>Those employed on or before effective date _____ days</p> <p>Those employed after effective date _____ days</p> <p>Other (specify) _____</p> <p><input type="checkbox"/> First day of month following Probationary Period</p> <p><input type="checkbox"/> Other (specify) _____</p> |                                |                                 |

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. 24 hour coverage, ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS ARE OCCUPATIONAL AND NON-OCCUPATIONAL. Other  \_\_\_\_\_

SHORT-TERM DISABILITY benefits begin on the \_\_\_\_\_ consecutive day of Accident Disability or \_\_\_\_\_ consecutive day of Sickness Disability and continue for a maximum period of \_\_\_\_\_ weeks. Benefits are non-occupational and terminate at age 70. The pre-existing Condition Limitation provision is 12/12 or Other  (specify) \_\_\_\_\_

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Group Number

**SECTION III - GROUP HEALTH PROFILE (100+ ONLY)**

Has anyone incurred health claims in excess of \$7,500 in the past 12 months and is the condition ongoing? Yes \_\_\_\_\_ No \_\_\_\_\_

| Specify: Employee, Dependent or COBRA | Age | Dollar amount of Claim | Diagnosis/Prognosis | Date of Last Treatment |
|---------------------------------------|-----|------------------------|---------------------|------------------------|
|                                       |     |                        |                     |                        |
|                                       |     |                        |                     |                        |

**SECTION IV - REQUESTED COVERAGE INFORMATION**

1A. Coverages Requested: (Enter appropriate coverage plan number.)  
 Check if amending current coverage.

| BCBSHP                                                                                                                                                                       | BCBSHP                                                                                                                                                                       | BCBSGa                                                                                                                                            | BCBSGa                                                                                                                                                                   | BCBSGa                                                                                        | BCBSGa                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| HMO Plan _____<br>HMO Plan _____<br>Chiro Rider Plan _____<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>[Open Access] Plan _____<br>Blue Direct Plan _____ | POS Plan _____<br>POS Plan _____<br>Chiro Rider Plan _____<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>[Open Access] Plan _____<br>Blue Direct Plan _____ | HDHP PPO Plan _____<br>PPO Plan _____<br>PPO Plan _____<br><br>Blue Power Health Fund<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Traditional Health Plan<br>THP _____                                                                                                                                     | Dental Plan _____<br>Replacement?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Blue Vision<br><input type="checkbox"/> High Option Plan<br><input type="checkbox"/> Mid Option Plan<br><input type="checkbox"/> Low Option Plan |
| <b>For Non-Standard Plan Only</b><br>Rx Copay<br>Generic \$ _____<br>Brand<br>In Formulary \$ _____<br>Not In Formulary \$ _____<br>Mail Order \$ _____                      | <b>For Non-Standard Plan Only</b><br>Rx Copay<br>Generic \$ _____<br>Brand<br>In Formulary \$ _____<br>Not In Formulary \$ _____<br>Mail Order \$ _____                      | <b>For Non-Standard Plan Only</b><br>Preferred Generic \$ _____<br>Preferred Brand \$ _____<br>Non-Preferred \$ _____<br>Mail Order \$ _____      | EAP<br><input type="checkbox"/> EAP 1-3 Sessions<br><input type="checkbox"/> EAP 1-6 Sessions<br><input type="checkbox"/> Work/Life Program<br>: *Not an Insured Product | Blue Freedom Rx<br>Levels<br>(if applicable <input type="checkbox"/>                          |                                                                                                                                                  |

1B. Comments

2. Mental Health/Substance Abuse options are listed on your group proposal. If seeking enhanced benefits complete Mental Health/Substance Abuse Parity Form.

|  |                |               |
|--|----------------|---------------|
|  | Standard _____ | Enhance _____ |
|--|----------------|---------------|

|                                                                      |                         |                          |
|----------------------------------------------------------------------|-------------------------|--------------------------|
| 3. Indicate the percentage of the premium to be paid by the employer | Employee Health _____ % | Dependent Health _____ % |
|                                                                      | Employee Dental _____ % | Dependent Dental _____ % |
|                                                                      | Employee Vision _____ % | Dependent Vision _____ % |

4. What is the length of employee waiting period? (EWP) EWP # Days \_\_\_\_\_ EWP can not exceed pass 6 months

|                                                                                                     |                              |                             |
|-----------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 4a. Will coverage be effective on the date of hire?                                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4b. Will coverage be effective on the first day following the employee waiting period?              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4c. Will coverage be effective on the first day of the month following the employee waiting period? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Do you wish to waive the employee waiting period at initial enrollment?                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**SECTION V - 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 due date shall be the first of each month.

Signed at \_\_\_\_\_ on \_\_\_\_\_ (month), \_\_\_\_\_ (day), \_\_\_\_\_ (year).

\_\_\_\_\_  
Signature of BCBSGa/BCBSHP/GGL Representative

\_\_\_\_\_  
Signature of Agent, Broker or Consultant of Record

\_\_\_\_\_  
Group Admin Name and Email Address

\_\_\_\_\_  
Group Fax Number

\_\_\_\_\_  
Company Name (Please Print)

\_\_\_\_\_  
Signature of Employer's Authorized Representative

\_\_\_\_\_  
Printed Name of Employer's Authorized Representative