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Group Number

## SMALL GROUP MASTER APPLICATION Or Application for Amendment

The purpose of this form is for Blue Cross Blue Shield of Georgia, Inc. (BCBSGa), 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 minimum BCBSGa participation requirement for group health insurance is 75% of all eligible employees. Eligible employees do not include employees who refuse coverage because they are covered elsewhere as a spouse or dependent. A minimum of two (2) full-time employees must be enrolled on the group plan at all times in order to qualify for group coverage. We may terminate coverage with sixty (60) days notice if the Employer fails to maintain the minimum participation requirements. The contract may also be immediately cancelled for fraud.</p>				
Current Carrier				
Total Number of Employees (Full-time, Part-time, Seasonal)		Total Number of Eligible Employees		Number of COBRA Participants

### SECTION II - LIFE INSURANCE SCHEDULE OF BENEFITS

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

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**Group Number**

**SECTION III - REQUESTED COVERAGE INFORMATION**

1A. Coverages Requested: (Enter appropriate coverage plan number.)

Check if amending current coverage.

BCBSHP HMO Plan ____ HMO Plan ____ Blue Direct Plan ____ [Open Access] Plan ____	BCBSHP POS Plan ____ POS Plan ____ Blue Direct POS Plan ____ [Open Access] Plan ____	BCBSGa PPO Plan ____ PPO Plan ____ PPO Plan ____	BCBSGa Traditional Health Plan THP ____	BCBSGa Dental Plan ____ Replacement? ____ <input type="checkbox"/> Yes <input type="checkbox"/> No	BCBSGa Blue Vision <input type="checkbox"/> High Option Plan ____ <input type="checkbox"/> Mid Option Plan ____ <input type="checkbox"/> Low Option Plan ____
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EAP <input type="checkbox"/> EAP 1-3 Sessions <input type="checkbox"/> EAP 1-6 Sessions <input type="checkbox"/> Work/Life Program	Blue Freedom Rx Levels (if applicable) <input type="checkbox"/>
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1B. For 24 hour coverage list eligible owners and officers (additional premium required)

Name \_\_\_\_\_  
Name \_\_\_\_\_  
Name \_\_\_\_\_

1C. 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 <input type="checkbox"/>	Enhance <input type="checkbox"/>
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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 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 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