



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

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Group Request For Coverage Carolina Preferred

- New Group
Renewal
Change (Reason):

1. Company Information

Group Number

Company Name: Requested Eff. Date: Physical Address: Mailing Address: Billing Address: Group Located Within City Limits: Identify how taxes are filed: List each owner(s)/partner(s) and the percent of ownership: Mail ID Cards: Employer Identification No. (EIN):

2. Contact Information

Group Administrator: Telephone: Agency Name: Agency Administrator: Title: Fax: E-mail: Agent: Agent Code: Telephone: E-mail:

3. Participation Information

Eligible employees must be actively at work a minimum of 30 hours per week, 48 weeks a year.

A. Total Employees, including part-time. B. Full-time Employees C. Not Eligible D. Eligible Employees E. Employees Not Electing Coverage F. Enrolled Employees G. Employer Contribution H. Waiting Period for new employees

Table with 2 columns: Total Full-Time Eligible Employees, Allowed Number of Employee(s) Not Electing Coverage. Rows include categories like Less than 4, 4 to 7, 8 to 11, 12 to 14, 15 or more.

I. Group Life Insurance: Participation Requirement = Same as Health (Underwritten by Companion Life)

4. Underwriting Information

Please complete ALL of the following questions: A. Do you currently have Workers Compensation Coverage? B. Are there any out-of-state locations to be covered by this plan? C. Are there any Employees who are not actively at work or disabled?

4. Underwriting Information (continued)

D. Are there any individuals, including any dependents covered by or eligible for, State Continuation or COBRA coverage? NO YES, please list the Name; Qualifying Date; Coverage End Date and the Current Status/Prognosis.

E. List present and prior carriers for past 3 years. _____ From: _____ To: _____
 _____ From: _____ To: _____
 _____ From: _____ To: _____

F. Please provide details of any of the following questions answered "yes" in the space provided below:

1. Have any employees or dependents to be covered incurred claims in excess of \$2,500 in the last 12 months? Yes No
2. In the past 10 years, have any employees or dependents to be covered been treated for any of the following conditions or health problems: heart or circulatory disease, diabetes, organ or tissue transplant - pending or completed, kidney failure or disease, emphysema, cystic fibrosis, cirrhosis of the liver, sickle cell anemia, AIDS, cancer of any kind, including Hodgkin's disease, leukemia, malignant melanoma, sarcoma, lymphoma or brain tumors? Yes No
3. Are any employees or spouses now pregnant? Yes No
 If yes, what is the expected due date? _____
 Are multiple births expected or is there a history of pregnancy complications? Yes No
4. In this section or in an attached signed document, please provide details of any yes answers to questions 1 and 2:

First Name	Diagnosis	Diagnosis Date(s)	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Benefit Information

- Carolina Preferred (PPO)** 90/70 90/60 90/50 80/60 70/50 60/40
 Deductible \$250/500 \$500/1000 \$750/1500 \$1000/2000 \$2000/4000 \$2500/5000 \$5000/10,000
 Out-of-pocket \$1500/3000 \$2000/4000 \$2500/5000 \$3000/6000 \$5000/10,000

Options for Carolina Preferred:

- Office Visit \$15/30 Copayment Supplemental Accident
 Office Visit \$30/60 Copayment Chiropractic
 Office Visit \$40/80 Copayment Sustained Health
 Prescription Drug Card
 \$100 Prescription Drug Card Deductible then Copayment

Options for all Carolina Preferred/High Deductible Health Plans:

- Dental Standard Option
 Dental High Option
 Orthodontics (13-50 enrolled)
 2-6 enrolled – Dental status must match health status

High Deductible Health Plan

	<input type="checkbox"/> HD1		<input type="checkbox"/> HD2		<input type="checkbox"/> HD3		<input type="checkbox"/> HD4		<input type="checkbox"/> HD5	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$2,600	\$2,600	\$2,600	\$2,600
Deductible – family	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$5,200	\$5,200	\$5,200	\$5,200
Coinsurance	100%	60%	80%	60%	70%	50%	100%	60%	80%	60%
Out-of-pocket – single	\$1,500	\$3,000	\$3,000	\$4,500	\$3,000	\$4,500	\$2,600	\$5,200	\$5,200	\$7,800
Out-of-pocket – family	\$3,000	\$6,000	\$6,000	\$9,000	\$6,000	\$9,000	\$5,200	\$10,400	\$10,400	\$15,600
	<input type="checkbox"/> HD6		<input type="checkbox"/> HD7		<input type="checkbox"/> HD8		<input type="checkbox"/> HD9		<input type="checkbox"/> HD10	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	\$2,600	\$2,600	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$5,000	\$5,000
Deductible – family	\$5,200	\$5,200	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$10,000	\$10,000
Coinsurance	70%	50%	100%	60%	80%	60%	70%	50%	100%	60%
Out-of-pocket – single	\$5,200	\$7,800	\$3,500	\$5,500	\$5,500	\$7,500	\$5,500	\$7,500	\$5,000	\$10,000
Out-of-pocket – family	\$10,400	\$15,600	\$7,000	\$11,000	\$11,000	\$15,000	\$11,000	\$15,000	\$10,000	\$20,000

All contracts will be issued as: Calendar Year Deductible Benefit Period Deductible

Options for High Deductible Health Plans: Chiropractic Sustained Health

We will open HSA accounts through BlueCross BlueShield of South Carolina.

Note: Information provided on this form may be verified by phone, personal interview or other means prior to or after requested effective date.

The statements furnished herein are true and correct to the best of my knowledge and belief, and they are offered to Blue Cross and Blue Shield of South Carolina, an independent licensee of the Blue Cross and Blue Shield Association, and/or Companion Life Insurance Company as part of an application for group insurance covering the employees or members of the firm or organization I represent. I understand that any misstatements or omission of information may be the basis for cancellation of any coverage granted.

Coverage is not effective unless and until approved in writing by the Underwriting Department at the home office of Blue Cross and Blue Shield of South Carolina and/or Companion Life Insurance Company. Any existing coverage should not be terminated before receipt of approval.

Signed _____ Title _____ Date ____ / ____ / ____
(Principal or Executive Correspondent)

Signed _____ Date ____ / ____ / ____
Agent