

# Group Application Form

**Please complete and mail to:**  
 Regence BlueCross BlueShield of Utah, Sales Dept. #28  
 P.O. Box 30270, Salt Lake City, Utah 84130-0270

C# \_\_\_\_\_ G# \_\_\_\_\_

Official Company Name (As registered with the State of Utah)				Type of Business (Give Details)	
Mailing Address (Include any Attention Line and Suite or Apt #), City, State, Zip				SIC Code	
Billing Address (Include any Attention Line and Suite or Apt #), City, State, Zip				Telephone # Fax # E-mail address	
Chief Executive Officer		Health Benefits Decision Maker & Title		Health Benefits Group Leader	
<b>Network Option:</b> <input type="checkbox"/> BCBS <input type="checkbox"/> ValueCare <input type="checkbox"/> Healthwise <b>Dental Option:</b> <input type="checkbox"/> BCBS <input type="checkbox"/> ValueCare		<b>Health Option:</b> <input type="checkbox"/> BlueEssentials <input type="checkbox"/> BluePreferred <input type="checkbox"/> BlueClassic <b>HSA Qualified:</b> <input type="checkbox"/> High Ded Health Plan <b>Bank:</b> <input type="checkbox"/> Wells Fargo <input type="checkbox"/> None <input type="checkbox"/> Other _____		<b>Life Options:</b> Carrier: <input type="checkbox"/> Regence Life & Health - P.O. Box 1271 MS E3A, Portland, OR 97207 (domiciled in Oregon) <b>BENEFIT</b> Employee Life and AD&D _____ Supplementary Life <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Dependent Life _____ Voluntary Life <input type="checkbox"/> Yes <input type="checkbox"/> No _____ ST Disability <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Other <input type="checkbox"/> Yes <input type="checkbox"/> No _____ LT Disability <input type="checkbox"/> Yes <input type="checkbox"/> No _____	
Health Coverage Code		Drug Coverage Code		Dental Coverage Code	
				Vision Coverage Code	
				24 Hr. Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eligibility Waiting Period: <b>Please indicate ONE CHOICE ONLY.</b> Effective 1st billing period following <input type="checkbox"/> Date of hire or <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 6 months from date of hire. <input type="checkbox"/> Other (explain) _____ <b>NOTE:</b> Date of hire Eligibility Waiting Periods must be approved by Underwriting.				Requested Effective Date: _____  Requested Renewal Date: _____	
Send COB Cards? <input type="checkbox"/> Yes <input type="checkbox"/> No		Including Data for Credit on? Deductible <input type="checkbox"/> Yes <input type="checkbox"/> No Stoploss <input type="checkbox"/> Yes <input type="checkbox"/> No		Send IDs to: <input type="checkbox"/> Subscriber <input type="checkbox"/> Other _____ <input type="checkbox"/> No IDs	
		Send Cert. of Creditable Coverage to: <input type="checkbox"/> Group <input type="checkbox"/> Both Group & Sub <input type="checkbox"/> Subscriber <input type="checkbox"/> Do not mail Certs		Type of Group: <input type="checkbox"/> Local <input type="checkbox"/> Self-Funded <input type="checkbox"/> Individual <input type="checkbox"/> National	

Agent/Agency Name \_\_\_\_\_ Commission % \_\_\_\_\_ Agent/Agency # \_\_\_\_\_  
 Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Agent/Agency Name \_\_\_\_\_ Commission % \_\_\_\_\_ Agent/Agency # \_\_\_\_\_  
 Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Onyx Customer ID # \_\_\_\_\_ Agent e-mail \_\_\_\_\_  
 Sales Executive Name \_\_\_\_\_ SE# \_\_\_\_\_ Renewal Rep# \_\_\_\_\_ Account Exec# \_\_\_\_\_ Team \_\_\_\_\_  
 Pooled with \_\_\_\_\_ Assoc Code \_\_\_\_\_ Initial Sales Received Date \_\_\_\_\_ Sales Complete Date \_\_\_\_\_  
 Comments: \_\_\_\_\_

## Application for Group Health Care Contract

(MUST BE COMPLETED BY AN AUTHORIZED COMPANY OFFICIAL)

Application is hereby made by (Company Name as registered with the State of Utah) \_\_\_\_\_, hereinafter called the Group, to Regence BlueCross BlueShield of Utah, its subsidiary, Regence ValueCare, and/or Regence HealthWise, hereinafter called Regence BCBSU, for a new or renewal Health Care Contract.

Official Company Mailing Address (Including Suite, if any) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**GROUP DEMOGRAPHICS:** The following represents an accurate accounting of employees working for this Group as of the date of application.

- |  |  |
|--|--|
| A. Total Number of Owners & Employees _____<br>B. Total Owners & Employees <b>not</b> eligible for coverage because:<br>• Part-time or working fewer than required hours per week _____<br>• Other (specify) _____<br>C. Subtotal of Eligible Owners & Employees (A minus B) _____<br>D. Eligible Owners & Employees <b>not</b> currently enrolling because:<br>• Waiving coverage because <b>covered by another employer</b> _____<br>• Waiving coverage because <b>chooses no coverage</b> _____<br>• New Hires <b>within waiting period</b> _____ | E. Employees Enrolling at Group's Effective Date (C minus D) _____<br>F. How many in 'E' have dependents? _____<br>G. How many in 'F' enrolled their dependents? _____<br>H. How many in 'E' are COBRA or State Extension enrollees? _____<br>I. ERISA Governed Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>COBRA ELIGIBILITY</b><br>J. How many terminated employees and/or their dependents are currently eligible for COBRA or State Extension but have not applied? _____ |
|--|--|

*continued on other side ...*

