



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association



An Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah and its non-insurer subsidiary, Regence ValueCare Regence HealthWise

Attn: Sales #28

P.O. Box 30270

Salt Lake City, Utah 84130-0270

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

# Group Application Form

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* <small>*(not available on HSA)</small>			<b>Health Option:</b> <input type="checkbox"/> BlueEssentials <input type="checkbox"/> BluePreferred <input type="checkbox"/> BlueClassic			<b>HSA Qualified Plan:</b> <input type="checkbox"/> Regence HSA Healthplan <b>HSA Banking Partner:</b> <input type="checkbox"/> Blue Healthcare Bank <input type="checkbox"/> HSA Bank <input type="checkbox"/> Wells Fargo <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>Dental Option:</b> <input type="checkbox"/> BCBS <input type="checkbox"/> ValueCare										<b>BENEFIT</b> Employee Life and AD&D _____ Dependent Life _____ ST Disability <input type="checkbox"/> Yes <input type="checkbox"/> No LT Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Supplementary Life <input type="checkbox"/> Yes <input type="checkbox"/> No Voluntary Life <input type="checkbox"/> Yes <input type="checkbox"/> No Other <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.										Requested Effective Date: _____				
<input type="checkbox"/> Other (explain) _____										Requested Renewal Date: _____				
<b>NOTE:</b> Date of hire Eligibility Waiting Periods must be approved by Underwriting.														
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 non-insurer 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.

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

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