



New Group Renewal or Revision *(Please asterisk * amended sections.)*

Fully Insured Minimum Premium

Group No. _____ Dept. No. _____

Master Group Number: _____

Effective Date: The Master Group Contract shall be effective on _____ provided this Application is accepted by Blue Cross and Blue Shield of Nebraska (BCBSNE), and payment of the charges is made as provided in the Application. Changes in the terms of this Application may only be made during the anniversary month of the effective date, unless prior BCBSNE approval is obtained for an off-anniversary change.

APPLICANT INFORMATION

A. Applicant/Employer _____

Address _____
(PO Box) _____ (Street)

(City)

(State, Zip Code)

Billing Address (if different) _____
(PO Box) _____ (Street)

(City)

(State, Zip Code)

Group Leader/Group Health Plan Primary Contact (Name) _____

(Title) _____

(Phone) _____

(FAX) _____

(E-mail) _____

Employer (Tax) Identification Number (EIN) _____

B. Names of subsidiaries or affiliated organizations to be included (must be majority-owned – 51% or greater):

C. For new groups only: Will BCBSNE be processing claims for dates of service prior to the Contract effective date?
 Yes No If yes, attach copy of signed authorization. Note: These claims will be paid at the billed charge and will not be reviewed for deductible, copayment, duplicate claim, or any other claim processing reviews. The Group agrees to pay the applicable finance charge for this service.

D. Is the Group Health Plan subject to the Employee Retirement Income Security Act of 1974 (ERISA)? Yes No

E. Is the Group Health Plan subject to the Consolidated Omnibus Reconciliation Act (COBRA), as amended, during this calendar year? Yes No

If yes, does the group have a COBRA Administrator? Yes No

Please provide name of third-party COBRA Administrator: _____

F. Does the Applicant authorize BCBSNE to administer dependent coverage requests involving court-ordered alternate recipients, which will include reviewing and determining dependent coverage and notifications required by OBRA '93 regarding Qualified Medical Child Support Orders (QMSCO)? Yes No

G. Does the Applicant authorize BCBSNE to provide Certificates of Creditable Coverage to eligible employees/dependents, as provided by law? Yes No

H. Does the Applicant have an HSA or HRA Administrator? HSA HRA

If yes, please provide name of third-party Administrator: _____

I. Employee Data: The following is from and agrees with your payroll and personnel records:	Total
1. Total employees on the payroll (includes full-time, part-time, leased employees):	_____
2. Total eligible employees on the payroll on the effective date of the Contract	_____
3. Eligible employees not enrolling due to coverage	_____
a. Number of employees with creditable coverage (Medicare, Medicaid, Spousal coverage)	
b. Number of employees with individual coverage	
c. Number of employees not enrolling due to cost or other reasons	
4. Eligible employees enrolling on the effective date of the Contract	_____
5. Persons on COBRA or State Continuation Coverage	_____

ELIGIBILITY AND ENROLLMENT

A. An employee working a minimum of _____ hours per week (must be at least 17 ½) on a regular calendar year basis will be eligible for coverage on the group's next due date after such employee has completed an eligibility (probationary) waiting period of _____ days of service, and completes the applicable enrollment form. To remain eligible, the employee must continue to work the minimum number of hours per week required. If the Applicant includes Subgroups, the Subgroup Application shall indicate the eligibility (probationary) waiting period, and the minimum number of hours necessary for eligibility.

If an otherwise eligible employee is not actively at work on the effective date **for other than personal health reasons**, coverage for that employee will go into effect on the group's next due date following his/her return to active employment, subject to the receipt of an enrollment form within 31 days of the return-to-work date. As of the effective date indicated above, there are _____ such employees not actively working. (Attach list of names and corresponding social security numbers.)

For dependents who apply for coverage at the same time as the eligible employee, coverage will become effective on the same day as the employee.

Other eligibility provisions: _____

B. Retirees eligible? Yes No. (Attach list of retirees and copy of Retirement Program describing plan eligibility requirements and contribution toward the monthly charges.)

C. Board of Directors eligible? Yes No (Attach list of Board Members and Resolution passed approving the same contribution toward the health care plan as for employees.)

Does the group want to be included in BCBSNE's standard student process? Yes No

D. Enrollment Options – Membership Units: (Check all that apply)

Standard Membership Units

- Single – Employee Only
- Employee & Spouse
- Employee & Children
- Family

Alternate Membership Tiers

- Employee & One Dependent
- Employee & Two or More Dependents

Other Enrollment Provisions: _____

E. Waiting Periods for Pre-Existing Conditions (Health Coverage):

- Initial Enrollment of the Group Waived Enforced
(For groups of 99 or less, waiver applies only to those covered under the prior group contract. Attach prior billing.)
- Adding new employees/dependents within 31 days of eligibility..... Waived Enforced
- Late Enrollees (18-month waiting period) Waived Enforced

Other Waiting Period provisions: _____

F. Late Enrollment: Late enrollment is allowed only during the month prior to the annual renewal date. Enrollment Forms must be signed by the last day of open enrollment and must be received by BCBSNE in a timely manner.

Other provisions: _____

G. Dental Eligibility and Enrollment: Employees and dependents whose dental enrollment forms **are not** received by BCBSNE within 31 days of their eligibility, shall not be eligible to apply for dental coverage until the Annual Enrollment Month which follows the employee's eligibility date, unless BCBSNE approves a special enrollment period or waives this provision. Dental coverage for the first year following the Annual Enrollment Month will be limited to Coverage A only and premiums will not be reduced unless other late enrollment restrictions are otherwise specified on this Master Group Application or attachment(s).

If an enrolled employee voluntarily cancels his/her dental coverage, such employee (and his/her eligible dependents) may not re-enroll for two years from the first month following the date of cancellation, unless other restrictions are specified on this Master Group Application or attachment(s).

Other provisions: _____

Check here if Dental Coverage not applicable:

H. Certificate of Coverage: BCBSNE will provide the group with an electronic version of the Certificate of Coverage. The group is responsible for providing this document to its enrolled employees. If the group requests BCBSNE send additional paper copies of the Certificate of Coverage to their employees, please check here:

MONTHLY CHARGES AND EMPLOYER CONTRIBUTION

- A. Does your plan have a Section 125 plan which offers employees cash in lieu of health plan benefits? Yes No
- B. It is understood that the amount shown as employer contribution will be paid by you without charge to the eligible employees and the remainder collected by you from the eligible employees by payroll deduction and remitted monthly to BCBSNE.

The monthly charges will not change prior to _____. This rate guarantee and continuation of coverage is subject to the Applicant continuing to meet BCBSNE underwriting guidelines, including minimum requirements for participation and contribution. If the number of covered employees increases or decreases 5% or more, or the terms of the Contract are changed, BCBSNE reserves the right to change the rates.

Other provisions: _____

	HEALTH OPTION 1		HEALTH OPTION 2	
	Employer Contribution	Total Monthly Charge	Employer Contribution	Total Monthly Charge
<input type="checkbox"/> Single	_____	_____	_____	_____
<input type="checkbox"/> Family	_____	_____	_____	_____
<input type="checkbox"/> Employee and Spouse	_____	_____	_____	_____
<input type="checkbox"/> Employee and Child/ren	_____	_____	_____	_____

	DENTAL	
	Employer Contribution	Total Monthly Charge
<input type="checkbox"/> Single	_____	_____
<input type="checkbox"/> Family	_____	_____
<input type="checkbox"/> Employee and Spouse	_____	_____
<input type="checkbox"/> Employee and Child/ren	_____	_____

BENEFIT DESIGNS – COVERAGE ELECTION

The Benefit Plan Design options are described in the Application Attachment Forms, as identified below.

Please indicate the Benefit Plan Design(s) requested by marking the applicable box(es) below, and complete the appropriate Attachment Form(s). **The applicable Attachment Form(s) must be attached to this Application.**

- BluePreferred PPO Master Group Contract – Standard Options – **App-Att-A**
- BluePreferred PPO Master Group Contract – HSA Options – **App-Att-B**
- Rx Nebraska Prescription Drug Program – **App-Att-C**
- Dental Coverage – **App-Att-D**
- Group Medicare Supplemental - Retirees Only – **App-Att-E**
- Nebraska BlueChoice Master Group Contract– **App-Att-F**
- BlueClassic Master Group Contract – **App-Att-G**
- BlueTraditional Master Group Contract – **App-Att-H**

A separate Endorsement Summary or list may be used to identify Endorsements and/or special coverage provisions for this group plan. If used, it becomes a part of this Master Group Application and is hereby incorporated by this reference.

- Yes**, Endorsement Summary/List attached.

AUTHORIZED PLAN CONTACTS

The HIPAA Privacy Rules provide that the Group Health Plan is a separate legal entity from the Employer/Plan Sponsor. In compliance with the Rules, it is necessary to designate Authorized Plan Contacts for the Group Health Plan.

The Group Health Plan (GHP) Primary Contact is indicated on page 1 of this Master Group Application. The GHP Primary Contact serves as BCBSNE's primary contact for the GHP, and may also designate additional Authorized Plan Contacts for the GHP. The GHP Primary Contact shall notify BCBSNE of any additions or deletions to the following list, by utilizing the Authorized Plan Contacts Form (8933).

We will automatically include your Group Health Plan's Agent of Record as one of your Authorized Plan Contacts. If you choose not to have the Group Health Plan's Agent of Record authorized to receive this information, please check here:

In addition, the following individuals may be given access to our Group Health Plan Information received from Blue Cross and Blue Shield of Nebraska in accordance to the requirements set forth within the HIPAA Privacy Rules.

Authorized Plan Contacts:

Name: _____

Title: _____

Name: _____

Title: _____

Name: _____

Title: _____

BCBSNE will not release protected health information (PHI) to fully insured groups, except as specifically agreed in writing by BCBSNE the Plan and Plan Sponsor. When there is a written agreement, all disclosure of PHI from BCBSNE shall be made to the Plan, or an Authorized Plan Contact.

APPLICANT CERTIFICATION AND SIGNATURE

I have read and understand the provisions of this Application for a Master Group Contract and certify that all information herein is true and accurate and agree to the provisions specified. I understand that if any information on this Application is in conflict with the proposal, BCBSNE reserves the right to recalculate and change the rates previously proposed, or to decline coverage. I understand the possible effect of canceling our current group plan coverage or administrative services prior to receiving final approval from BCBSNE.

By signing this application, I represent that I am authorized to obtain coverage on behalf of the Group Health Plan.

Signature Title Date

(Typed Name) (Typed Title) (Typed Date)

AGENT CERTIFICATION:

I certify that I have verified the information in this Application for a Master Group Contract with the records of the Applicant and it is true and accurate to the best of my knowledge.

Signature Title Date

(Typed Name) (Typed Title) (Typed Date)

ACCEPTANCE BY BLUE CROSS AND BLUE SHIELD OF NEBRASKA:

- This Master Group Application is accepted.
- This Master Group Application is accepted with the following changes: _____

Signature (Blue Cross and Blue Shield of Nebraska) Title Date

The noted changes in this part are acceptable.

Signature of Applicant Date

Please sign both the original and the copy. Retain the copy and return the original to Blue Cross and Blue Shield of Nebraska.

FOR OFFICIAL USE ONLY

Contract No.: Health _____ Dental _____ Med. Supp. _____

Endorsements: _____
