EMPLOYER APPLICATION

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

REQUESTED EFFECTIVE DATE (MM/DD/YYYY)

GROUP # _____

☐ NEW PRIOR CARRIER _____ PRIOR FUNDING TYPE: ☐ SELF-FUNDED ☐ FULLY-INSURED ☐ LEVEL-FUNDED

☐ CHANGE TO EXISTING GROUP

SECTIONS OF FORM TO BE CHANGED: ☐ I ☐ II ☐ III

PLEASE FULLY COMPLETE ALL SECTIONS OF THIS APPLICATION EVEN IF SPECIFIC PROVISIONS REMAIN UNCHANGED.

SECTION I – EMPLOYER GROUP INFORMATION

LEGAL COMPANY NAME	LEGAL ENTITY
	☐ CORP ☐ LLC ☐ MUNICIPALITY ☐ NON PROFIT ☐ PARTNERSHIP ☐ POLITICAL SUBDIVISION ☐ TRUSTS ☐ UNIONS ☐ OTHER
DBA	
GROUP HEALTH PLAN NAME (IF DIFFERENT THAN LEGAL COMPANY NAME)	**EXCHANGE (IF APPLICABLE)**
	☐ BENEFIT STARTER ☐ OTHER

ARIZONA LOCATION STREET ADDRESS	CITY	ZIP CODE PLUS FOUR
	AZ	
BILLING ADDRESS ☐ **SAME AS STREET ADDRESS**	**CITY, STATE**	**ZIP CODE PLUS FOUR**

COUNTY	FEDERAL TAX ID NUMBER	ARIZONA STATE TAX ID NUMBER	PLAN YEAR ANNIVERSARY MONTH
			IF BLANK, BCBSAZ WILL ASSUME MONTH OF EFFECTIVE DATE.

HEADQUARTERS STATE (LEGAL ENTITY)	INCORPORATED STATE	TYPE OF BUSINESS

GROUP EXECUTIVE	TITLE

E-MAIL	PHONE NUMBER	FAX

CHIEF FINANCIAL OFFICER	TITLE

E-MAIL	PHONE NUMBER	FAX

CHIEF EXECUTIVE OFFICER	TITLE

E-MAIL	PHONE NUMBER	FAX

GROUP BENEFIT ADMINISTRATOR ☐ BILLING CONTACT	TITLE

E-MAIL	PHONE NUMBER	FAX

OTHER CONTACT PERSON ☐ BILLING CONTACT ATTACHED SHEET FOR ADDITIONAL CONTACTS	TITLE

E-MAIL	PHONE NUMBER	FAX

SECTION II – ADDITIONAL INFORMATION

1) DOMESTIC PARTNERS TO BE COVERED?	2) EMPLOYEE TERMINATION DATE
☐ YES ☐ NO	☐ END OF BILLING MONTH ☐ DATE OF LOSS OF ELIGIBILITY

3) NEW GROUP ENROLLMENT REGULATIONS

EMPLOYER'S ENROLLMENT WAITING PERIODS WILL BE WAIVED AT THE NEW GROUP'S INITIAL ENROLLMENT ☐ YES ☐ NO

4) RETIREE COVERAGE: DOES NOT APPLY TO GROUPS CONSIDERED SMALL FOR PURPOSES OF THE AFFORDABLE CARE ACT OR APPLICABLE STATE LAW (ACCOUNTABLE HEALTH PLAN).

RETIREMENT ELIGIBILITY	RETIREES TO BE COVERED? ☐ YES ☐ NO	IF YES: ☐ UNDER 65 ☐ 65 AND OLDER	RETIREES DEPENDENTS TO BE COVERED? ☐ YES ☐ NO	OTHER THAN NEWBORNS, ETC. FOR WHICH COVERAGE MAY BE MANDATED UNDER APPLICABLE ARIZONA LAW

5) RETIREMENT PARTICIPATION REQUIREMENTS

A) RETIREE MUST COMPLETE _____ YEARS OF SERVICE PRIOR TO RETIREMENT

B) RETIREE IS ELIGIBLE FOR COVERAGE ONLY THROUGH END OF BILLING PERIOD IN WHICH RETIREE REACHES AGE _____

C) OTHER: SEE ATTACHED

SECTION III – BROKER/CONSULTANT ☐ BROKER ☐ CONSULTANT

LAST NAME	FIRST NAME	MI

AGENCY NAME	SUITE NO.

STREET ADDRESS	CITY, STATE	ZIP CODE PLUS FOUR

PHONE NUMBER	FAX NUMBER

E-MAIL	NPN

GENERAL AGENT NAME (IF APPLICABLE)

SECTION IV – IMPORTANT - READ CAREFULLY

As the authorized representative of Company, I certify that the Company is the sole employer of the employees to be enrolled under this proposed contract for health insurance or services to administer the group health plan identified on this application. I also certify that the information provided on this Employer Application and all other applicable documents submitted in connection with this Application, is complete and accurate. I agree that Company shall promptly notify Blue Cross Blue Shield of Arizona (BCBSAZ) of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of dependents, and the termination date of any enrolled employee or dependent.

I understand and agree that BCBSAZ may, in its sole discretion, verify information with or through outside sources, including third party investigative firms, as BCBSAZ deems necessary or appropriate for finalizing its decision on this Application. I agree that if the information contained in this Application or other supporting documentation is incomplete, inaccurate, materially misleading, false, or fraudulent, that BCBSAZ has the right to (a) retroactively adjust the Company's rates and/or administrative fees if such information would have affected the rate/fee calculation; and (b) invalidate, or withdraw any rate/fee proposal, or terminate coverage for any group to the extent permitted by law. I understand and agree that this Application is not accepted until approved by BCBSAZ and that BCBSAZ's acceptance shall be based on information supplied by the Group, the requested benefits, and any other information obtained from outside sources. BCBSAZ's acceptance shall be evidenced by the execution of this Application by an authorized representative of BCBSAZ, at which time this Application shall become binding upon BCBSAZ and the group. Upon acceptance, this Application shall be attached to and shall become a part of the Group Master Contract or Administrative Services Agreement With/Without Stoploss (the "Contract"), as applicable. If the Company is enrolling outside the Open Enrollment period, I understand that the Company must contribute a minimum of 50% of the employee's health premium. To the extent permitted by applicable law, BCBSAZ may terminate the Contract in accordance with the Contract terms, including the Group's failure to meet certain obligations under the Contract such as failure to pay premium/fees or comply with coverage requirements.

The Group agrees that it is solely responsible for: (i) determining employee and dependent eligibility for coverage and coverage effective and terminations dates (including application of required open and special enrollment periods), (ii) complying with applicable laws in establishing eligibility and coverage effective and termination dates, and (iii) providing BCBSAZ with timely and accurate eligibility and coverage effective and termination date information. Additionally, Company represents and warrants that it does not impose a waiting period which exceeds 90 days. Company will promptly advise BCBSAZ of any change in this representation. Company understands and agrees that federal law requires Company to provide dependent coverage for children under age 26, and prohibits Company from imposing pre-existing condition waiting periods.

By including my e-mail address on the reverse side, I authorize BCBSAZ to send me information via e-mail. I also understand I may change my e-mail address or rescind this permission at any time by contacting BCBSAZ through **azblue.com**.

COMPANY AUTHORIZED OFFICER / OWNER / PARTNER

SIGNATURE	PRINT NAME
X	

TITLE	DATE

STREET ADDRESS	CITY, STATE	ZIP CODE PLUS FOUR

BCBSAZ AUTHORIZED SIGNATURE	PRINT NAME
X	

TITLE	DATE

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