Capital BlueCross

Capital Blue Cross and its subsidiary,
Capital Advantage insurance Company (collectively "Capital")
Independent Licensees of the Blue Cross and Blue Shield Association

P.O. Box 773132
Harrisburg, PA 17177-3132
www.capbluecross.com

APPLICATION FOR GROUP BENEFITS

FOR **THIS APPLICATION TO** BE CONSIDERED, SHADED QUESTIONS MUST BE ANSWERED

GROUP NUMBER

PROPOSED EFF. DATE

UNDERWRITING ☐ APPROVED ☐ DENIED (details below)

COMPANY NAME

POLICY MAKER NAME & TITLE

PHONE ( )

FAX ( )

SALES ADDRESS (STREET) (CITY) (STATE) (ZIP) (COUNTY)

NATURE OF BUSINESS

SIC CODE

BILLING ADDRESS (PO BOX, SUITE) (STREET) (CITY) (STATE) (ZIP)

REPLACING PRIOR CARRIER? ☐ YES ☐ NO

NAME OF PRIOR CARRIER(S)

PRIOR CARRIER CANCELLATION DATE

NAME &ADDRESS OF AFFILIATES/SUBSIDIARIES

NAME OF ALL CARRIERS FOR PAST FIVE (5) YEARS

NEW EMPLOYEES ELIGIBLE TO ENROLL ☐ DATE OF HIRE ☐ BILLING DATE
☐ 1 ST OF MONTH FOLLOWING HIRE
☐ OTHER__________

NAME OF ALL HMO(s) CURRENTLY OFFERED BY YOUR GROUP

NUMBER OF EMPLOYEES ENROLLED IN EACH HMO

DATE BUSINESS ESTABLISHED

DO YOU PROVIDE AN INCENTIVE TO EMPLOYEES NOT TO TAKE COVERAGE? ☐ YES (IF YES, PLEASE EXPLAIN) ☐ NO

NUMBER OF HOURS YOUR EMPLOYEES MUST WORK PER WEEK TO BE ELIGIBLE FOR GROUP COVERAGE:

PRE-EXISTING CONDITION CLAUSE APPLICABLE? ☐ YES ☐ NO

DOES YOUR GROUP REQUIRE SCHEDULE A INFORMATION? ☐ YES ☐ NO

IF YES, PLAN YEAR ENDED __________(MONTH/DAY)

TYPE OF COVERAGE	BENEFIT CODE	EMPLOYEE INFORMATION: % PAID BY GROUP	EMPLOYEE: ACTIVE (20 hrs/wk or more) ELIGIBLE	EMPLOYEE: ACTIVE ENROLLED	EMPLOYEE: RETIRED UNDER 65 ENROLLED	EMPLOYEE: RETIRED 65& OVER ENROLLED	EMPLOYEE: OTHER ELIGIBLE	EMPLOYEE: OTHER ENROLLED	EMPLOYEE: OTHER COBRA ENROLLED	SPOUSE/DEPENDENT INFORMATION: % PAID By GROUP	SPOUSE: ACTIVE EMPLOYEES' SPOUSE ELIGIBLE	SPOUSE: ACTIVE EMPLOYEES' SPOUSE ENROLLED	SPOUSE: 65& OVER ENROLLED	SPOUSE: OTHER ELIGIBLE	SPOUSE: OTHER ENROLLED	UNDERWRITING USE ONLY: TOTAL NUMBER OF CONTRACTS TO BE UNDERWRITTEN – ACTUAL: ELIGIBLE	ACTUAL: ENROLLED	(A) Approved (D) Denied	DEPOSIT: INITIAL ESTIMATE OF CONTRACTS (1)	DEPOSIT: ESTIMATED RATE PER CONTRACT (2)	DEPOSIT: TOTAL BY LINE OF COVERAGE (1 x2)

TERMS AND CONDITIONS OF GROUP APPLICATION FOR COVERAGE

This application fully executed by an authorized representative of the Group constitutes acceptance by the Group of all terms and conditions of the contract(s) issued by Capital Blue Cross or its subsidiary Capital Advantage Insurance Company (collectively, "Capital"). Employees working less than 20 hours per week are not eligible unless otherwise noted. The Group will furnish and maintain the records necessary to the administration of the health care plan and will provide Capital the information necessary to administer the contract(s). Any settlement will be made in accordance with the terms of the contract(s). Coverage will become effective when this application is accepted and approved by the home office of Capital in accordance with its underwriting guidelines and payment is received and processed. Capital will notify you by letter if your coverage is approved. All final enrollment information must be consistent with statements made in this application. Acceptance of an initial deposit amount by Capital **DOES NOT** constitute approval of coverage. Capital reserves the right to return any payment if this application cannot be approved for coverage. Certain coverages (such as vision and dental) offered through Capital are underwritten or provided by independent insureres that will issue their own policies to groups purchasing such coverage .
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MONTHLY TOTAL $

NUMBER OF MONTHS $

DEPOSIT TOTAL FOR PERIOD

________TO________

GROUP POLICY MAKER - *SIGNATURE REQUIRED* DATE

GROUP POLICY MAKER - *PRINT NAME*

CAPITAL REP -*SIGNATURE REQUIRED* DATE

Capital's approval of enrollment within each type of coverage is contingent upon fulfillment of Capital's multiple option guidelines.

IMPORTANT

In order for Capital to provide health care coverage to your employees on the proposed effective date, Capital must receive from community rated groups the deposit total amount shown on *this form NO* LATER THAN:

CAPITAL USE ONLY

DATE RECEIVED

AMOUNT RECEIVED $

DEP. DATE BY

CHECK RETURNED TO GROUP

C-70(1/2002) ORIGINAL& 1ST COPY- Capital 2ND COPY -Customer 3RD COPY -Sales Representative