Small Group Request for Coverage (2-50)

GROUP INFORMATION

Requested Effective Date: ______/______/_______ (Mo. Day Yr.)　　Tax ID: ______________________

Group Legal Name: ____

Group Address: ____
(Street) (City) (State) (ZIP)

Group Mailing Address: ____
(PO Box) (City) (State) (ZIP)

Group Billing Contact: ______________________　　Executive Contact: ______________________

Title: ______________________　　Title: ______________________

Telephone: (________) ______________________　　Fax: (________) ______________________

E-mail Address: ______________________　　Number of Years in Business: ______________________

Nature of Business: ______________________　　SIC Code: ______________________

Do you provide worker's compensation for all of your employees? ☐ Yes ☐ No

If yes, carrier name and policy number: ____

If no, list employees not covered and reason: ____

CONTRIBUTION

Contribution by the Employer:

Single Medical: __________%　Dependent Medical: __________%　Dental: __________%　Life: __________%

The Employer must contribute at least 50% towards the cost of single medical.

WAITING PERIOD

Eligible Employees:	Waiting Period Options:	All Groups:
2 – 6	90 or 180 Days	☒1st of the billing month following WP
7 – 19	30, 60, 90 or 180 Days	
20 – 50	30, 60, 90, 180 or 365 Days	

PARTICIPATION

Eligible Employees:	Minimum Participation Requirements:
2 – 3	No waiver
4 – 7	1 waiver
8 – 12	3 waivers
13 – 16	4 waivers
17 – 19	6 waivers
20 +	60 percent of total, full-time eligible employees

Total # of FT eligible employees: ______　Total # of FT eligible employees enrolled: ______　Total # of new hires in Waiting Period: ______　Total # of PT employees: ______　Total # of enrollees: ______

ID CARD/CONTRACT DELIVERY INFORMATION

Send ID cards to: ______________________　　Send Contract to: ______________________

AGENT INFORMATION

Agent's Name: ______________________　　Agent Number: ______________________

Agent's Signature: ______________________　BlueChoice HealthPlan Sales Representative: ______________________

PLAN OPTIONS

☐ Please be sure to include a full proposal, including rates, for the plan design(s) you are requesting.

☐ If this is a dual option, you must complete a dual option checklist.

BCHPSGRFC 8/2011