



BlueChoice® HealthPlan
Agent New Group Check List

Agent Name: _____ Agent Number: _____ Proposed Effective Date: _____

Group Name: _____ Submission Date: _____

- 1. Group Applications
• SG Request for Coverage (BCHPSGRFC 7/05)
• Master Group Application (BCHPMGA (rev. 7/05))
• Companion Life Application
• 2-19 Employees (Form # 12437M 1/01)
• 20-50 Employees (Form # 12575M 4/01)
2. Copy of the Accel-A-Rate proposal (5 pages total)
3. Premium Binder Check
4. Enrollment Application and Change Form
• One application per eligible employee, including declination, signed and dated
• One application on each employee in the waiting period, signed and dated
5. Personal Health Statement
• One per eligible employee for groups with 2-19 employees
6. Most Recent S.C. Quarterly Wage and Tax Statement/Proof of Business
All tax documents must include the appropriate Schedules
UCE-120 and UCE 101 (Must be reconciled-FT, PT, Termed, etc...)
Corporations (1120(S) with Schedule E & Schedule K1)
Sole Proprietor (1040 with Schedule C)
Sole Proprietor – Farmer (Form 943 & payroll records)
Partnerships – Spouse only (1065 with Schedule K1 & payroll records)
Partnerships – Partners (1040 with Schedule K1 & payroll records)
Non-Profit Business (Form 941 & payroll records)
• New hires and Owners not on the Quarterly Wage Statement
• Require a letter signed by the group containing # of hours worked per week and # of weeks per year for each person
• For newly organized groups that do not have any of the above documents, please provide
• Payroll records, business license, and the “Secretary of State” form.
• Within 30 days of the tax-filing deadline, the appropriate tax documentation must be submitted to BlueChoice HealthPlan Small Group Underwriting Department.
• We reserve the right to postpone the group until the appropriate tax documentation is received by the BlueChoice HealthPlan Small Group Underwriting Department.
7. Prior Carrier Bill (for full Creditable Coverage credit, both bills are required)
• Current bill and
• Bill one year prior to the requested effective date
OR
• Certificates of Creditable Coverage (HIPAA Certificates) for each employee
8. Health Statement for Each Employee >\$50,000 Life Insurance

CarolinaADVANTAGE Dual Options

1. Any High Deductible Health Plan (HDHP) can be used as a dual option with any open-access plan.
2. A group cannot have two HDHPs as a dual option.
3. A group can have a dual option with only two full-time eligible employees, as long as one person goes on each plan.
4. The bold plan is the low option. The plans listed directly underneath that plan are the open-access plans available as a high dual option.
5. Group should select a single blue heading along with one product under that same heading, or an HDHP.

Series II

Series II 80/60 \$250

Series II 100/60	\$5,000
Series II 80/60	\$1,000
Series II 80/60	\$1,500
Series II 80/60	\$2,000
Series II 80/60	\$2,500
Series II 70/50	\$750
Series II 70/50	\$1,000
Series II 70/50	\$1,500

Series II 80/60 \$500

Series II 100/60	\$5,000
Series II 80/60	\$1,500
Series II 80/60	\$2,000
Series II 80/60	\$2,500
Series II 70/50	\$750
Series II 70/50	\$1,000
Series II 70/50	\$1,500
Series II 70/50	\$2,000
Series II 70/50	\$2,500
Series III 70/50	\$1,500
Series III 70/50	\$2,000

Series II 80/60 \$750

Series II 100/60	\$5,000
Series II 100/60	\$8,000
Series II 70/50	\$2,000
Series II 70/50	\$2,500
Series II 60/40	\$3,000
Series III 70/50	\$1,500
Series III 70/50	\$2,000
Series III 70/50	\$2,500
Series III 70/50	\$3,000
Series III 70/50	\$4,000

Series II 80/60 \$1,000

Series II 100/60	\$5,000
Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000
Series III 70/50	\$2,000
Series III 70/50	\$2,500
Series III 70/50	\$3,000
Series III 70/50	\$4,000
Series III 70/50	\$5,000

Series II 80/60 \$1,500

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000
Series III 70/50	\$2,500
Series III 70/50	\$3,000
Series III 70/50	\$4,000
Series III 70/50	\$5,000

Series II 80/60 \$2,000

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000
Series III 70/50	\$4,000
Series III 70/50	\$5,000

Series II 80/60 \$2,500

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000
Series III 70/50	\$5,000

Series II 70/50 \$750

Series II 100/60	\$5,000
Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000
Series III 70/50	\$2,500
Series III 70/50	\$3,000
Series III 70/50	\$4,000
Series III 70/50	\$5,000

Series II 70/50 \$1,000

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000
Series III 70/50	\$4,000
Series III 70/50	\$5,000

Series II 70/50 \$1,500

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000
Series III 70/50	\$4,000
Series III 70/50	\$5,000

Series II 70/50 \$2,000

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$5,000
Series III 70/50	\$5,000

Series II 70/50 \$2,500

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 60/40	\$5,000

Series II 100/60 \$5,000

Series II 100/60	\$8,000
Series II 100/60	\$10,000
Series II 70/50	\$8,000
Series II 70/50	\$10,000
Series II 60/40	\$3,000
Series II 60/40	\$5,000

Series II 100/60 \$8,000

Series II 100/60	\$10,000
Series II 70/50	\$8,000
Series II 70/50	\$10,000
Series II 60/40	\$5,000

Series II 100/60 \$10,000

Series II 70/50	\$8,000
Series II 70/50	\$10,000

Series II 70/50 \$8,000

Series II 70/50	\$10,000
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Series II 70/50 \$10,000

HDHPs Only

Series II 60/40 \$3,000

Series II 100/60	\$10,000
Series II 70/50	\$8,000
Series II 70/50	\$10,000
Series II 60/40	\$5,000

Series II 60/40 \$5,000

Series II 70/50	\$8,000
Series II 70/50	\$10,000

Series III

Series III 70/50 \$1,000

Series II 100/60	\$10,000
Series II 70/50	\$8,000
Series II 60/40	\$5,000

Series III 70/50 \$1,500

Series II 100/60	\$10,000
Series II 70/50	\$8,000
Series II 60/40	\$5,000

Series III 70/50 \$2,000

Series II 100/60	\$10,000
Series II 70/50	\$8,000
Series II 70/50	\$10,000
Series II 60/40	\$5,000

Series III 70/50 \$2,500

Series II 100/60	\$10,000
Series II 70/50	\$8,000
Series II 70/50	\$10,000
Series II 60/40	\$5,000

Series III 70/50 \$3,000

Series II 70/50	\$8,000
Series II 70/50	\$10,000

Series III 70/50 \$4,000

Series II 70/50	\$8,000
Series II 70/50	\$10,000

Series III 70/50 \$5,000

Series II 70/50	\$8,000
Series II 70/50	\$10,000

HDHP

Qualified High Deductible Health Plans – eligible to use a Health Savings Account (HSA)

HDHP 80/60	\$1,500
HDHP 80/60	\$2,000
HDHP 80/60	\$2,750
HDHP 80/60	\$1,500
HDHP 100/60	\$2,750
HDHP 100/60	\$3,750
HDHP 100/60	\$5,000

Non-Qualified High Deductible Health Plans – eligible to use a Health Reimbursement Account (HRA)

HDHP 100/60	\$8,000
HDHP 100/60	\$10,000
HDHP 70/50	\$10,000



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: <input checked="" type="checkbox"/> 1st of the billing month following WP
2 – 6	90 or 180 Days	
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.

GROUP SIZE REVIEW FORM – Fax to 803-714-6461

Group's Name: _____ Tax ID Number: _____

Group Number(s): _____ Anniversary Date: _____

Group Insurance Contact: _____

Telephone #: _____ Fax: _____

E-mail Address: _____

1. All employees as indicated on payroll records (#2 plus #3): _____

2. Full-time employees: _____

3. Part-time employees: _____

4. COBRA/State Continuation participants: _____

5. Total full-time employees including COBRA (#1 minus #3): _____

A. # of COBRA participants (same as #4): _____

B. # covered by spouse on same group: _____

C. # serving probationary period: _____

D. TOTAL of A through C: _____

6. Total # of eligible employees (#5 minus D): _____

7. Total enrolled with BlueChoice HealthPlan indicated on latest bill: _____

Other Information (if applicable)

Total # of retirees covered: _____ # under 65: _____ # over 65: _____

I HEREBY CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.*

Signature: _____ Date: _____

Print Name and Title: _____

BlueChoice HealthPlan reserves the right to request additional information to include Wage and Tax documentation to support these numbers.

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.

MASTER GROUP APPLICATION

Application is hereby made for Coverage as set forth in the attached BlueChoice[®] HealthPlan of South Carolina, Inc. Contract as stated on this Master Group Application.

EMPLOYER INFORMATION

FULL LEGAL NAME OF EMPLOYER:

PHYSICAL ADDRESS OF EMPLOYER:

MAILING ADDRESS OF EMPLOYER:

(if different)

EMPLOYEE AND DEPENDENT INFORMATION

CLASSIFICATION OF ELIGIBLE EMPLOYEES:

All full-time, active Employees working at least 30 hours a week at least 48 weeks a year. To be considered Actively at Work, the Employee must not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-Related Factor. If the Employee does not meet this requirement, Coverage will begin on the first day of the month corresponding with the Contract Effective Date after the requirement is met.

PERIOD OF CONTINUOUS EMPLOYMENT AS PRE-REQUISITE TO ELIGIBILITY:

Coverage for new Employees hired following the Contract Effective Date will commence on the first date of the month corresponding with the Contract Effective Date following _____ days of employment.

This Waiting Period may not be waived for individual Employees. The group may waive the Waiting Period only for Employees during the initial enrollment of the new group. All eligible Employees must be offered Coverage.

Waiting Period options are:

- ♦ Groups with 2 to 6 Employees, the Waiting Period must be 90 or 180 days.
- ♦ Groups with 7 to 19 Employees, the Waiting Period can be 30, 60, 90, or 180 days.
- ♦ Groups with 20 to 50 Employees, the Waiting Period can be 30, 60, 90, 180, or 365 days.

Note: The Waiting Periods of 180 days and 365 days are available for groups with high Employee turnover such as hotels, restaurants, etc.

CLASSIFICATION OF ELIGIBLE DEPENDENTS:

An eligible Dependent is: 1) the Subscriber's legal spouse; or 2) the Subscriber's natural child, adopted child, foster child, step child, or child for whom the Subscriber has legal custody or legal guardianship and who is under 26 years of age.

BENEFIT PROVISIONS

PRE-EXISTING CONDITIONS LIMITATIONS AND OTHER WAITING PERIODS:

THIS SECTION ONLY APPLIES TO PERSONS WHO ARE 19 YEARS OF AGE OR OLDER

Important Note: Persons who are under 19 years of age will not be subject to the Contract's Pre-existing Condition exclusion, if any. Transitional Rules: A Covered Person under age 19 who was subject to the Pre-existing Condition exclusion prior to the first day of the first Benefit Period beginning on or after September 23, 2010, will no longer be subject to that exclusion as of the first day of the first Benefit Period beginning on or after September 23, 2010.

1. Any services or charges for services for Pre-existing Conditions are not covered under this Contract when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to the Enrollment Date.
2. The Pre-existing Condition Exclusion lasts until the earlier of:
 - A. The Member has not received medical care, treatment or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends sometime after the Effective Date of coverage; or
 - B. 12 months after the Enrollment Date.

In the case of a Late Enrollee, the Pre-existing Condition Exclusion begins on the Enrollment Date and lasts for 18 months.

3. Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.
4. A period of Creditable Coverage does not count if there is at least a 63-day period where the Employee or Dependent was not covered under any Creditable Coverage.
5. Any period that an Employee or Dependent is in a Waiting Period under a Group Health Plan, or is in an affiliation period, may not be taken into account in determining the 63-day period.
6. The Pre-existing Condition Exclusion does not apply to pregnancy if maternity benefits are offered with this Contract or to Genetic Information in the absence of a diagnosis of the condition related to the information.
7. The Pre-existing Condition Exclusion does not apply to a newborn child, a child who is adopted or placed with an Employee or Employee's spouse for the purpose of adoption before he or she reaches age 18 if the Employee applied for coverage and premiums were paid within 31 days from the birth, adoption or placement for adoption.

PARTICIPATION REQUIREMENTS

Total Full-time Eligible Employees	Participation Required
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

EMPLOYER’S SIGNATURE

Effective date of coverage under this application shall be 12:01 a.m., Eastern Time on the **(circle one) first / fifteenth** day of _____, 20____, at the address indicated above. Such Coverage will continue until terminated in accordance with the provisions of the Contract between the Employer and the Corporation. It is understood and agreed that the Employer shall cause to be paid to the Corporation, in advance, the Premium specified in Schedule A of the Contract. This Premium is made on behalf of the Employer’s Employees who meet the eligibility requirements specified in this application and who elect to be Covered by the Corporation. This application shall form part of the Contract issued by the Corporation.

The Employer may accept this Contract either by signature of this Master Group Application or by making the required Premiums to the Corporation. Such acceptance renders all terms and provisions hereof binding on the Corporation and the Employer.

BLUECHOICE[®] HEALTHPLAN OF SOUTH CAROLINA, INC.

By: _____
(Authorized Signature)

By: _____
(Authorized Signature)

Title: _____

Title: President and Chief Operating Officer

Date: _____

Date: _____

[®] Registered marks of the Blue Cross and Blue Shield Association

DEFINITIONS

The terms defined below shall have their defined meaning whenever they are capitalized in this Master Group Application or in the Master Group Contract.

Contract Effective Date – the date the Coverage goes into effect.

Creditable Coverage - coverage of an individual under any of the following:

1. A Group Health Plan;
2. Health Insurance coverage;
3. Medicare;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE OR CHAMPUS;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employee Health Benefits Program;
9. A public health plan (any plan established or maintained by a State, the U.S. government, a foreign country or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage); or
10. A health benefit plan under the Peace Corps Act.
11. Short term health; or
12. A State Children's Health Insurance Program (S-CHIP).

Creditable Coverage does not include coverage consisting solely of those benefits excepted from the definition of Health Insurance Coverage.

Enrollment Date - the date of enrollment under the Group Health Plan or, if earlier, the first day of the Waiting Period for the enrollment.

Late Enrollee - an eligible Employee or Dependent who enrolls in Carolina Advantage other than during:

1. the first period in which the Employee or Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
2. a Special Enrollment period.

Late Enrollees may be excluded from coverage for up to 12 months; then have a six month Pre-existing Condition limitation.

Special Enrollment Period – a period of time when an Employee who is eligible but not enrolled for Coverage under the terms of the Contract, or a dependent of the Employee if the dependent is eligible but not enrolled for Coverage under the terms, may enroll for Coverage during a Special Enrollment Period.

To be eligible to participate in a Special Enrollment Period, each of the following four conditions must be met.

1. The Employee or dependent was covered under a group health plan or had Health Insurance Coverage at the time Coverage was previously offered to the Employee or dependent; and
2. The Employee stated in writing at the time that coverage under a group health plan or Health Insurance Coverage was the reason for declining enrollment, but only if the Corporation required such a statement at the time and provided the Employee with notice of the requirement and the consequences of the

requirement at the time.

3. The Employee's or dependent's coverage:
 - A. was under a COBRA continuation provision and the coverage under the provision has exhausted;
or
 - B. was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated;
 - C. was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.
4. Under the terms of the plan, the Employee requests the enrollment not later than 30 days after the date of exhaustion of coverage described in 3 A above or termination of coverage or employer contribution described in 3 B above.

The following applies to a Dependent Special Enrollment Period.

5. If a group health plan makes coverage available with respect to a dependent of an individual, the individual is a participant under the plan, or has met any Waiting Period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period, and the person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer offering Health Insurance Coverage in connection with the group health plan shall provide for a Dependent Special Enrollment Period during which the person may be enrolled under the plan as a Dependent of the individual and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as Dependent of the individual if such spouse is otherwise eligible for coverage.
6. A Dependent Special Enrollment Period must be not less than 31 days and begins on the later of:
 - A. the date dependent Coverage is made available; or
 - B. the date of the marriage, birth, or adoption or placement for adoption.
7. If an individual seeks to enroll a dependent during the first 31 days of a dependent Special Enrollment Period, the Coverage of the dependent shall become effective:
 - A. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.
 - B. in the case of a dependent's birth, or a dependent's adoption or placement for adoption, within 31 days of birth, as of the date of the birth; or
 - C. in the case of a dependent's adoption or placement for adoption beyond 31 days from the date of birth, the date of the adoption or placement for adoption.
8. A dependent spouse or minor dependent or dependent child of an Employee, if the dependent is eligible, but not enrolled for Coverage, shall be permitted to enroll under a Dependent Special Enrollment Period, under the terms of this plan if a court has ordered that Coverage be provided for the dependent under a Member's health insurance plan and a request for enrollment is made within 30 days after the issuance of the court order.

Carolina ADVANTAGE

Enrollment Application and Change Form

Important Instructions

Coverage does not become effective under any circumstances until an application has been approved by BlueChoice HealthPlan.

- Please print in ink or type.
- The application must be completed in full and signed where indicated.
- Completed application must be received by BlueChoice HealthPlan's Membership Department within 30 days from the signature date and sent to BlueChoice HealthPlan, Membership Department, AX-425, P.O. Box 6170, Columbia, S.C. 29260-6170.

INSTRUCTIONS FOR MULTIPLE BENEFICIARY DESIGNATIONS

- A. If a married woman is to be named as beneficiary, indicate her full given name (example: Mary R. Doe, not Mrs. John Doe).
- B. If two or more beneficiaries are designated, the proceeds will be distributed equally, unless shares are indicated differently by the insured.
- C. When a minor or mentally incompetent person is designated as beneficiary, it will be necessary for a legal guardian to be court appointed before the proceeds can be distributed.
- D. If no beneficiary is designated, or there is no living beneficiary at the time of the insured's death, the proceeds will become payable to the estate of the insured.
- E. Primary Beneficiary – the person to receive life proceeds, if living, at the time of the insured's death. Contingent Beneficiary – the person to receive life proceeds if no primary beneficiary is living at the time of the insured's death.



**BlueChoice[®]
HealthPlan**

South Carolina

An independent licensee of the
Blue Cross and Blue Shield Association

INTERNAL USE ONLY

New Enrollment
 Effective Date: _____

Change
 Effective Date: _____

Pre-X Date: _____

A. IF MAKING A CHANGE

ENROLLMENT CHANGE DATE DUE TO:

Marriage Birth/Adoption Termination COBRA Applicant – Start Date: _____ End Date: _____
 Death Address Change Other: _____

B. TO BE COMPLETED BY ALL EMPLOYEES

1. Employee Actively At Work COBRA Retired

2. Social Security No. 3. Employee – Last Name First Date of Birth Sex: Male
 _____ - _____ - _____ _____ _____ MM DD CCYY Female

4. Mailing Address Street or P.O. Box City State ZIP Code

5. Home Phone Work Phone 6. E-Mail Address:
 _____ - _____ - _____ _____ - _____ - _____ _____

7. Name of Employer: 8. Full-time Date of Hire:

Job Title or Description: BlueChoice HealthPlan Group Number: Dept. No.: Payroll No.:

C. MEMBERSHIP AND COVERAGE INFORMATION

Check for Type of Contract: Standard HDHP **Reason for Waived Coverage:**

Medical Comprehensive Dental Insurance with another company
 S – Single
 F – Employee/Spouse/Children
 D – Employee/Children
 8 – Employee/Spouse
 0 – No Benefits

Other - Explain: _____

D. COMPLETE FOR ALL FAMILY MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

List All Family Members To Be Covered or Affected By A Change. Do Not Use Nicknames.

	Last Name	First	Sex	Date of Birth Mo. Day Yr.	Social Security No.	Height	Weight
Yourselves	_____	_____	_____	____	____	____	____
Spouse	_____	_____	_____	____	____	____	____
Child	_____	_____	_____	____	____	____	____
Child	_____	_____	_____	____	____	____	____
Child	_____	_____	_____	____	____	____	____
Child	_____	_____	_____	____	____	____	____

Life and/or Disability coverage is provided by Companion Life Insurance Company

Companion Life is a separate life insurance company that does not provide BlueChoice HealthPlan products or services. Companion Life is solely responsible.

Types and Amounts of Coverage Requested: <input type="checkbox"/> Life \$ _____ <input type="checkbox"/> AD & D \$ _____ <input type="checkbox"/> Dep. Life \$ _____ <input type="checkbox"/> STD \$ _____ <input type="checkbox"/> LTD \$ _____	Earnings: (Check One) \$ _____ (Amount) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Life Class _____
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List Primary Beneficiary(ies) (Last Name, First, Middle Initial) Relationship

Primary Beneficiary(ies): _____

Contingent Beneficiary: _____

Life Only (Life insurance coverage is provided by Companion Life Insurance Company)

E. OTHER INSURANCE INFORMATION

Are you or any dependents to be covered by this policy enrolled in Medicare? Yes No HIC # or Policy #: _____

If yes: Medicare A - Effective Date: ____/____/____ Medicare B - Effective Date: ____/____/____

Name of Person(s): _____ Name of Person(s): _____

Does anyone being covered by this policy have any other Health, Dental or Drug coverage? Yes No If Yes, complete this section.

Policyholder's Name: _____ ID Card Number: _____

Name of Insurance Co.: _____ Policy No.: _____ Effective Date: ____/____/____

Policyholder's Employer: _____

List All Persons Covered: 1. _____ 2. _____ 3. _____

Indicate type of services covered by this policy: Hospital Physician/Medical Prescription Drugs Dental

F. HEALTH INFORMATION TO BE COMPLETED BY ALL EMPLOYEES

Please complete the following questions for you or any dependents to be covered:

a. In the last 12 months has any person had in excess of \$2,500 medical expenses? Yes No

b. In the last three years has anyone been denied insurance for health reasons or been issued an exclusion rider? Yes No

c. Are you or your spouse now pregnant? If yes, provide expected delivery date: _____. Yes No

d. Is there a history of infertility, complicated pregnancy, multiple births, premature birth or sick newborn? Yes No

e. Is any person currently disabled or not actively at work? Yes No

f. Has any individual to be enrolled taken prescription drugs in the last 12 months? Yes No

g. Within the last 10 years has any person been hospitalized, had surgery, consulted or been treated by a physician for an injury or illness other than flu, colds, sore throat or routine checkups? Yes No

h. Has any person used any form of tobacco or nicotine substitute in the last 12 months? Yes No

If you answered yes to any of the above questions, please provide the dates and details below in the next section.

SEPARATE PERSONAL HEALTH STATEMENTS MUST ALSO BE COMPLETED FOR GROUPS WITH 2-19 ELIGIBLE EMPLOYEES.

G. HEALTH INFORMATION DETAILS

Patient's Name	Doctor's Name, Address & Phone #	Condition	Dates	Treatment/Medication	Results/Prognosis
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		

AUTHORIZATION TO RELEASE INFORMATION AND STATEMENT OF UNDERSTANDING

I hereby authorize the release of any medical or non-medical information about me or my eligible or enrolled dependents by any insurance company, medical professional, medical institution or other health care provider concerning the diagnosis, treatment and prognosis of any health condition, including drug or alcohol abuse. This authorization for release of my (our) past, present and future information, to include Medicare Parts A and B claims, is for eligibility determination for coverage or review or investigation of a claim. I understand that the benefits for which I (we) will be eligible are those disclosed in the group contract between BlueChoice HealthPlan and my employer. I also understand that my coverage may be voided or terminated or claims denied if material misstatements or misrepresentations have been made on this application subject to the Time Limit on Certain Defenses or Incontestability Provision. All statements made herein are complete and true to the best of my knowledge.

I HAVE READ AND FULLY UNDERSTAND EACH AND EVERY PART OF THIS APPLICATION FOR INSURANCE.

Applicant's Signature: _____ Date: _____

GENERAL NOTICE OF PRE-EXISTING CONDITION LIMITATION APPLIES TO BLUECHOICE HEALTHPLAN MEDICAL BENEFITS ONLY

This plan may contain a pre-existing condition exclusion. This means that if you have a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date, you might have to wait a certain period of time before that plan will provide coverage for that condition. This six-month period ends the earlier of the day before your coverage becomes effective (the effective date) or if you were in a waiting period for coverage, the day before the waiting period begins (the enrollment date). The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion extends for not more than twelve months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or eighteen months after the enrollment date in the case of a late enrollee. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

BlueChoice HealthPlan
Member Services Department
Post Office Box 6170
Columbia, SC 29260-6170
or call
1-866-858-3272
or 803-382-5309 in Columbia

DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.



**BlueChoice[®]
HealthPlan**
South Carolina



www.BlueChoiceSC.com

BLUECHOICE HEALTHPLAN • COMPANION LIFE INSURANCE COMPANY

EMPLOYER _____ GROUP NUMBER - - -

NAME OF EMPLOYEE _____ SOCIAL SECURITY NUMBER - -

1. In the last 10 years have you or anyone to be covered been diagnosed with, been treated or advised to seek treatment or testing for, had symptoms related to, or had any of the following:

CONDITION	YES	NO	CONDITION	YES	NO
AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or HIV (Human Immunodeficiency Virus)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sudden weight loss, night sweats, persistent fever, fatigue, or lymph node enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Date of last seizure _____		
Alcohol or drug dependency, abuse, or overdose	<input type="checkbox"/>	<input type="checkbox"/>	Type of seizure/epilepsy _____		
Arthritis (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Severe or persistent headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of spine, discs, back or muscles	<input type="checkbox"/>	<input type="checkbox"/>	Depression, anxiety or other mental condition	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of bones, joints, tendons, or ligaments	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system disorder, fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, allergies, or other respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy, multiple sclerosis, cerebral palsy, Parkinson's disease or Alzheimer's disease.	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema, Tuberculosis, or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Disorders of the breasts, genitals or reproductive system	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of eyes, ears, nose, or throat	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones or other disorders of urinary system	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or other malignant tumor	<input type="checkbox"/>	<input type="checkbox"/>	Hernia or prostate disorder	<input type="checkbox"/>	<input type="checkbox"/>
Tumor, cyst, or other growth	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear or menstrual disorder	<input type="checkbox"/>	<input type="checkbox"/>
Colitis, Crohn's disease, diverticulitis or other intestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>	Angina, heart attack, coronary artery disease or other disorders of the heart	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones or disorders of gall bladder	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of liver or spleen	<input type="checkbox"/>	<input type="checkbox"/>	Date diagnosed _____		
If hepatitis, specify type _____			Last 3 readings _____		
Ulcers, stomach or other digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	Dates _____ / _____ / _____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____		
Controlled by diet only <input type="checkbox"/> Yes <input type="checkbox"/> No			High cholesterol or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
Daily insulin dosage _____			Varicose veins, thrombosis, leg ulcers or other disorders of the circulatory system	<input type="checkbox"/>	<input type="checkbox"/>
Type and amount of oral medication _____			Anemia, hemophilia, or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid, goiter, pituitary, or adrenal gland disorder	<input type="checkbox"/>	<input type="checkbox"/>	Specify type _____		
Paralysis or neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>	Birth defect or deformity	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or TIA (transient ischemic attack)	<input type="checkbox"/>	<input type="checkbox"/>	Any other injury, disease or disorder not noted above?	<input type="checkbox"/>	<input type="checkbox"/>

2. For any condition checked Yes, please complete this section. Also list any medications not previously mentioned that are prescribed by a physician. If more space is needed attach a separate sheet.

Patient's Name	Doctor's Name, Address & Phone #	Condition	Dates	Treatment/Medication	Results/Prognosis
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		

I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by BlueChoice HealthPlan and/or Companion Life Insurance Company. Companion Life is a separate company that does not offer BlueChoice HealthPlan products. These products are offered by Companion Life, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these products.

Applicant's Signature: _____ Date: _____



**EMPLOYER PARTICIPATION APPLICATION FOR
THE JOINT EMPLOYER GROUP INSURANCE TRUST
FOR USE IN SOUTH CAROLINA ONLY**

1-800-753-0404

EMPLOYER INFORMATION

Firm Name _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ Firm Contact _____ Title _____
(person to contact concerning coverages)

Full-time Employees in Firm: _____ # Full-time Employees Enrolled: _____

Effective Date Requested: _____ SIC Code or Nature of Business: _____
(The firm's effective date will be the first or the 15th of the month following acceptance by Companion Life Insurance Company.)

How many years in this business? _____ How many years in this location? _____

Tax I.D. Number _____ Will this insurance replace existing insurance? _____

Name of existing carrier _____ Which coverages are being replaced? Life and AD&D STD

<input type="checkbox"/> Flat Amount Plan	Waiting Period Initial Enrollment	Waiting Period Future Employees
<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> One month	<input type="checkbox"/> One month
<input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Life and AD&D

Class Plan

Class	Description	Life and AD&D Amount	<input type="checkbox"/> Dependent Life
1	_____	\$ _____	<input type="checkbox"/> Yes
2	_____	\$ _____	<input type="checkbox"/> No
3	_____	\$ _____	Spouse: \$2,000
			Children: \$1,000
			Children
			14 days - 6 months: \$200

Percent of premium paid by employer _____ %
(A minimum of 25% is required.)

STD

Percent of Earnings

60% to a maximum benefit of (select one)

\$600/week \$_____/week

Benefit Period: 13 weeks 26 weeks

Benefits Begin: First Day (Accident)
Eighth Day (Illness)

Percent of premium paid by employer _____ %
(A minimum of 25% is required.)

Life and AD&D Total Monthly Premium	Dependent Life Total Monthly Premium	STD Total Monthly Premium	\$1.00 per Enrollee* (\$5.00 minimum)	Total Monthly Premium
\$ _____	+ \$ _____	+ \$ _____	=	\$ _____

Are any of the persons to be covered retired, currently hospitalized, disabled or on any extension of benefits? Yes No (If yes, give details.)

Participation Agreement (administered and underwritten by Companion Life Insurance Company)

The Participant does hereby apply for Group Insurance Benefits as set forth in the above "Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

Name of Trust: Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does he or she have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy. The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666. **The undersigned employer agrees that coverage shall not commence until this application has been approved by Companion Life Insurance Company and notice of approval has been transmitted to us.** As named employer, I understand that I should not cancel any existing coverage until notified that this application has been accepted by Companion Life.

Signature of Applicant _____	<p align="center">FOR HOME OFFICE USE</p> <p>Accepted by Administrator Effective: _____</p> <p>By: _____</p> <p>Title _____ Date _____</p>
Title _____ Date _____	
Signature of Agent/Broker _____ Date _____	
Printed Name _____	