

## 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.