South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Companion Life

Companion Life is a separate company that does not offer BlueCross BlueShield of South Carolina products. These products are offered by Companion Life, not BlueCross BlueShield of South Carolina. BlueCross BlueShield of South Carolina has no responsibility for these products.

Group Request For Coverage

Business Blue℠ Product Line

On behalf of this health plan, TCC administers benefits. TCC is a separate third party administrator that administers health plans.

☐ New Group
Administered By:
☐ BlueCross ☐ TCC
☐ Renewal
☐ Change (Reason): _____

1. *Company Information* Group Number: __ __ - __ __ __ __ __ - __ __ __

Company Name: _____ Requested Eff. Date: _____ / _____ / _____

Physical Address: _____
(Street) (City) (County) (State) (ZIP)

Mailing Address: _____
(Street) (City) (County) (State) (ZIP)

Billing Address (if different from mailing address): _____
(Street) (City) (County) (State) (ZIP)

Group Located Within City Limits: ☐ Yes ☐ No SIC Code: __ __ __ __ Nature of Business: _____

Identify How Taxes are Filed: ☐ Corp ☐ S Corp ☐ LLC ☐ Partnership ☐ Sole Proprietorship ☐ Agricultural/Farm
☐ Non-Profit ☐ For Profit ☐ New Business (not yet filed)

List Each Owner(s)/Partner(s) and the Percent of Ownership: 1. _____ / ____% 2. _____ / ____% 3. _____ / _____%

Mail ID Cards: (check one) ☐ Agent ☐ Group Mail the New Group Package: (check one) ☐ Agent ☐ Group

Employer Identification No. (EIN): _____

2. *Contact Information*

Group Administrator: _____ Title: _____

Telephone: _____ - _____ - _____ Fax: _____ - _____ - _____ E-mail: _____

Agency Name: _____ Agent: _____ Agent Code: _____ - _____

Agency Administrator: _____ Telephone: _____ - _____ - _____ E-mail: _____

3. *Participation Information*

Eligible employees must be actively at work a minimum of 30 hours per week, 48 weeks a year.

A. Total Employees, including Part-Time . . . . . _____
(Employers with 51 or more Employees are eligible for enhanced mental health benefits.)

B. Full-Time Employees. . . . . _____

C. Not Eligible
Employees in Waiting Period . . . . . _____
Husband/Wife employed with the Same Employer _____
Total . . . . . _____

D. Eligible Employees . . . . . _____
(Subtract C from B)

E. Employees Not Electing Coverage . . . . . _____
(Employees not covered by this plan.)

F. Enrolled Employees. . . . . _____

Total Full-Time Eligible Employees	**Allowed Number of Employee(s) Not Electing Coverage**
Less than 4	None
4 to 7	1
8 to 11	3
12 to 14	4
15 or more	A minimum of 60% of the total full-time eligible employees.

- Group Dental participation = 75% of those enrolled in Business Blue℠ Complete plans must take dental except:
  2 - 6 size groups = 100% of those enrolled in health must enroll in dental. Enrollment status must be the same for health and dental.
  7 - 50 size groups with dental only coverage must have a minimum of 7 enrolled employees, with at least 75% of all full-time eligible employees enrolled.
- Health & Dental/Vision status must be the same for all members of Business Blue℠ Secure and Business Blue℠ Basic.

G. Employer Contribution *(Minimum 25% contribution required for health. If 100%, then all full-time employees must enroll.)*

Employee Health: _____% Employee Dental: _____% Employee Life: _____%

H. Waiting Period for New Employees *(1st or 15th day of the month following full-time date of hire):*
Groups with 7 or more enrolled employees: ☐ **30** days ☐ **60** days ☐ **90** days ☐ **180** days
Groups with 2 - 6 enrolled employees: ☒ **90** days *(mandatory)*

I. Group Life Insurance: Participation Requirement = Same as Health (**Underwritten by Companion Life)**

4. *Underwriting Information*

Please complete **ALL** of the following questions:

A. Do you currently have Workers' Compensation coverage? ☐ NO ☐ YES, name of carrier: _____

B. Are there any out-of-state locations to be covered by this plan? ☐ NO ☐ YES, please list the City, State, ZIP Code and the number of Employees: _____

C. Are there any Employees who are not actively at work or disabled? ☐ NO ☐ YES, please list the Employee's name, reason not at work, nature of disability and prognosis: _____

D. Are there any individuals, including any dependents covered by or eligible for, State Continuation or COBRA coverage? ☐ NO ☐ YES, please list the name, qualifying date, coverage end date and the current status/prognosis.

E. List present and prior carriers for past 3 years: _____ From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

F. Please provide details of any of the following questions answered "yes" in the space provided below:

1. Have any employees or dependents to be covered incurred claims in excess of $2,500 in the last 12 months? ☐ Yes ☐ No
2. In the past 10 years, have any employees or dependents to be covered been treated for any of the following conditions or health problems: heart or circulatory disease, diabetes, organ or tissue transplant (pending or completed) kidney failure or disease, emphysema, cystic fibrosis, cirrhosis of the liver, sickle cell anemia, AIDS, cancer of any kind, including Hodgkin's disease, leukemia, malignant melanoma, sarcoma, lymphoma or brain tumors? ☐ Yes ☐ No
3. Are any employees or spouses now pregnant? ☐ Yes ☐ No
   If yes, when is the expected due date? _____
   Are multiple births expected or is there a history of pregnancy complications? ☐ Yes ☐ No
4. In this section or in an attached signed document, please provide details of any "yes" answers to questions 1 and 2:

   First Name: Diagnosis: Diagnosis Date(s): Treatment:

5. *Benefit Information*

All Contracts will be issued as:

☐ Calendar Year Deductible

☐ Benefit Period Deductible

Dual Option: ☐ Yes ☐ No

If yes, choose your Dual Option combination:

Dual Options may consist of the following combinations:

☐ Business Blue Complete (Preferred Blue®) with HDHP or HDHRA

☐ Business Blue Complete (Preferred Blue) with Business Blue Secure

☐ Business Blue Secure with HDHP or HDHRA

☐ Business Blue Secure with Business Blue Basic

☐ Business Blue Basic with HDHP or HDHRA

☐ Business Blue Complete with Business Blue Basic

- Dual options are only available to groups with seven or more employees enrolled and *may not* include a Business Blue Complete (Preferred Blue) with 90/70 coinsurance or with deductibles of $250 or $500.

☐ **Business Blue *Complete* (Preferred Blue)**	**Coinsurance: (pick one)**	**Deductible: (pick one)**	**Out-of-Pocket: (In/Out) (pick one)**
	☐ 90/70	☐ $250	☐ $1,500/3,000
	☐ 80/60	☐ $500	☐ $2,000/4,000
	☐ 70/50	☐ $1,000	☐ $3,000/6,000
	☐ 60/40	☐ $1,500	☐ $5,000/10,000
		☐ $2,000	
		☐ $3,000	

Options for* Business Blue *Complete (Preferred Blue):

☐ $20/$40 Office Visit Copayment ☐ Prescription Drug Card

☐ $35 /$60 Office Visit Copayment ☐ Supplemental Accident

☐ Chiropractic

☐ Sustained Health

☐ **Business Blue *Secure***

Coinsurance: (pick one)	Deductible: (In/Out) (pick one)	Out-of-Pocket: (In/Out) (pick one)
☐ 80/60	☐ $1,250/2,500	☐ $1,750/3,500
☐ 70/50	☐ $1,750/3,500	☐ $2,250/4,500
☐ 60/40	☐ $2,250/4,500	☐ $3,750/7,500
☐ 50/50	☐ $3,250/6,500	☐ $5,250/10,500
	☐ $4,250/8,500	
	☐ $5,250/10,500	

Options for* Business Blue *Secure:

☐ Supplemental Accident
☐ Sustained Health
☐ Dental/Vision (not available if another dental option is selected)

***Prescription Drug Options:* (Must choose one)**

☐ Drug Card ☐ Secure Card ☐ Secure Card 100
☐ Secure Generic Card ☐ Blue Rx℠

☐ **Business Blue *Basic*** (pick one)

	☐ Plan 1		☐ Plan 2		☐ Plan 3		☐ Plan 4	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	$500	$1,500	$500	$1,500	$1,000	$3,000	$1,000	$3,000
Deductible – family	$1,500	$4,500	$1,500	$4,500	$3,000	$9,000	$3,000	$9,000
Coinsurance	80%	60%	60%	40%	80%	60%	60%	40%
Out-of-Pocket – single	Unlimited		$5,000	$10,000	$5,000	$10,000	$5,000	$10,000
Out-of-Pocket – family	Unlimited		$10,000	$20,000	$10,000	$20,000	$10,000	$20,000

Options for* Business Blue *Basic:

☐ Supplemental Accident
☐ Sustained Health
☐ Dental/Vision (not available if another dental option is selected)

	☐ Plan 5		☐ Plan 6		☐ Plan 7		☐ Plan 8	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	$1,500	$4,500	$1,500	$4,500	$2,500	$5,000	$5,000	$10,000
Deductible – family	$4,500	$13,500	$4,500	$13,500	$5,000	$10,000	$10,000	$20,000
Coinsurance	80%	60%	60%	40%	80%	60%	70%	50%
Out-of-Pocket – single	$6,000	$12,000	$6,000	$12,000	$7,500	$15,000	Unlimited	
Out-of-Pocket – family	$12,000	$24,000	$12,000	$24,000	$15,000	$30,000	Unlimited	

***Prescription Drug Options:* (Must choose one)**

☐ Basic Card ☐ Basic Card 100
☐ Basic Generic Card ☐ Blue Rx℠

☐ **Business Blue℠ *High Deductible Health***
(HSA Qualified HDHP)

	☐ HD1		☐ HD2		☐ HD3		☐ HD4		☐ HD5	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$2,600	$2,600	$2,600	$2,600
Deductible – family	$3,000	$3,000	$3,000	$3,000	$3,000	$3,000	$5,200	$5,200	$5,200	$5,200
Coinsurance	100%	60%	80%	60%	70%	50%	100%	60%	80%	60%
Out-of-Pocket – single	$1,500	$3,000	$3,000	$4,500	$3,000	$4,500	$2,600	$5,200	$5,200	$7,800
Out-of-Pocket – family	$3,000	$6,000	$6,000	$9,000	$6,000	$9,000	$5,200	$10,400	$10,400	$15,600

	☐ HD6		☐ HD7		☐ HD8		☐ HD9		☐ HD10	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	$2,600	$2,600	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$5,000	$5,000
Deductible – family	$5,200	$5,200	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$10,000	$10,000
Coinsurance	70%	50%	100%	60%	80%	60%	70%	50%	100%	60%
Out-of-Pocket – single	$5,200	$7,800	$3,500	$5,500	$5,500	$7,500	$5,500	$7,500	$5,000	$10,000
Out-of-Pocket – family	$10,400	$15,600	$7,000	$11,000	$11,000	$15,000	$11,000	$15,000	$10,000	$20,000

Options for High Deductible Health Plans: ☐ Chiropractic ☐ Sustained Health

☐ We will open HSA accounts through BlueCross BlueShield of South Carolina.

☐ **Business Blue** ***High Deductible for HRA***
(Not HSA Qualified)

	☐ HDHRA1		☐ HDHRA2		☐ HDHRA3		☐ HDHRA4		☐ HDHRA5	
	IN	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**	**IN**	**OUT**
Deductible – single	$2,000	$2,000	$3,000	$3,000	$5,000	$5,000	$7,500	$7,500	$10,000	$10,000
Deductible – family	$4,000	$4,000	$6,000	$6,000	$10,000	$10,000	$15,000	$15,000	$20,000	$20,000
Coinsurance	100%	60%	100%	60%	100%	60%	100%	60%	100%	60%
Out-of-Pocket – single	$2,000	$4,000	$3,000	$6,000	$5,000	$10,000	$7,500	$15,000	$10,000	$20,000
Out-of-Pocket – family	$4,000	$8,000	$6,000	$12,000	$10,000	$20,000	$15,000	$30,000	$20,000	$40,000

Options for HDHRA:

☐ $20/$40 Office Visit Copayment
☐ $35/$60 Office Visit Copayment
☐ Chiropractic
☐ Sustained Health

Prescription Drug Options: **(Must choose one)**

☐ Drug Card
☐ Secure Card
☐ Secure Generic Card
☐ Blue Rx

Options for all Business Blue Plans:

☐ Dental High Option ☐ Dental Standard Option ☐ Orthodontics (13-50 Enrolled)

Note: Information provided on this form may be verified by phone, personal interview or other means prior to or after requested effective date.

The statements furnished herein are true and correct to the best of my knowledge and belief, and they are offered to Blue Cross and Blue Shield of South Carolina, an independent licensee of the Blue Cross and Blue Shield Association, and/or Companion Life Insurance Company as part of an application for group insurance covering the employees or members of the firm or organization I represent. I understand that any misstatements or omission of information may be the basis for cancellation of any coverage granted.

Coverage is not effective unless and until approved in writing by the Underwriting department at the home office of Blue Cross and Blue Shield of South Carolina and/or Companion Life Insurance Company. Any existing coverage should not be terminated before receipt of approval.

Signed: _____ Title: _____ Date: _____ / _____ / _____
(Principal or Executive Correspondent)

Signed: _____ Date: _____ / _____ / _____
(Agent)

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
