



South Carolina

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

BlueMeasureSM Benefit Selection

<input type="checkbox"/> New Group <input type="checkbox"/> Change (Reason): _____

Requested Effective Date: _____ / _____ / _____

1. Company /Employer Data (information required) Group Number _____ - _____ - _____

Company Name: _____					
Physical Address: _____					
(Street)	(City)	(County)	(State)	(ZIP)	
Mailing Address: _____					
(if different from physical address) (Street) (City) (County) (State) (ZIP)					
Billing Address: _____					
(if different from mailing address) (Street) (City) (County) (State) (ZIP)					
Group Located Within City Limits: <input type="checkbox"/> Yes <input type="checkbox"/> No SIC Code: _____					
Nature of Business: _____					
Identify How Taxes are Filed: <input type="checkbox"/> Corp <input type="checkbox"/> S Corp <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship					
<input type="checkbox"/> Agricultural/Farm <input type="checkbox"/> Non-Profit <input type="checkbox"/> For Profit <input type="checkbox"/> New Business, not yet filed					
List Each Owner(s)/Partner(s) and the Percent of Ownership: 1. _____ / _____%					
2. _____ / _____% 3. _____ / _____%					
Employer Identification No. (EIN): _____					
Prior Carrier: _____					

2. ERISA Status (information required)

ERISA <input type="checkbox"/>	Non-ERISA <input type="checkbox"/>	Government or Municipality <input type="checkbox"/>	Church Plan <input type="checkbox"/>
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3. Contact Information for Group Plan (information required)

Benefit Coordinator #1 _____	
Telephone: _____ - _____ - _____	Email: _____
Benefit Coordinator #2 _____	
Email: _____	
Agency Name: _____	Agent: _____ Agent Code _____ - _____
Agency Administrator: _____	Telephone: _____ - _____ - _____
Agent Email: _____	

4. Participation Requirements: The group must meet at least 70 percent participation of the eligible employees enrolling in the employer sponsored group health plan. Participation is determined by dividing the total enrolled employees by the total eligible employees. All eligible employees that waive coverage count against the participation threshold.

If employer contribution is 100% of the premium for employee only coverage, then all eligible employees must enroll in coverage making the participation requirement 100%.

Eligible Employees	Minimum Enrollment	Participation Percent
20	14	70%
50	35	70%

5. Participation (information required)

Eligible employees must be actively at work an average of 30 hours per week.

- A. Total Employees, including Part-Time..... _____
- B. Full-Time Eligible Employees..... _____
- C. Employees in Waiting Period..... _____
- D. Eligible Employees..... _____

Eligible employees must be actively at work an average of 30 hours per week.

- E. Waivers/Refusals..... _____
- F. Enrolled Employees..... _____
- G. Waiting Period for new employees One month* Two months* 90 days Exact

(*1st of the month following end of waiting period/ full-time date of hire)

6. Additional Information (if applicable)

Please complete **ALL** of these questions: (these questions will help to determine if you are eligible for COBRA or State Continuation)

A. Please list all out-of-state locations covered by this plan and their number of employees:

Employees	City	State	ZIP Code	Percentage of Ownership
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. Do you own any other company under "common control" that should be considered with this group for group size purposes? "Common control" is defined in the Internal Revenue Code, § 414 (b) and (c).

- Yes No **If yes, please list below:**

7. Benefit Information (information required)

Benefit Period: Calendar Year Contract Year

8. Benefit Selection (required for health benefits)

	Product	Coinsurance	Single Deductible	Single Out of Pocket	Family Deductible	Family Out of Pocket
<input type="checkbox"/>	BlueMeasure HD 1	0%	\$2,000	\$2,000	\$4,000	\$4,000
<input type="checkbox"/>	BlueMeasure HD 2	0%	\$3,000	\$3,000	\$6,000	\$6,000
<input type="checkbox"/>	BlueMeasure HD 3	0%	\$4,000	\$4,000	\$8,000	\$8,000
<input type="checkbox"/>	BlueMeasure HD 4	0%	\$6,900	\$6,900	\$13,800	\$13,800
<input type="checkbox"/>	BlueMeasure 5	20%	\$1,000	\$2,500	\$2,000	\$5,000
<input type="checkbox"/>	BlueMeasure 6	20%	\$1,500	\$3,500	\$3,000	\$7,000
<input type="checkbox"/>	BlueMeasure 7	25%	\$2,500	\$4,000	\$5,000	\$8,000
<input type="checkbox"/>	BlueMeasure 8	30%	\$2,000	\$5,000	\$4,000	\$10,000
<input type="checkbox"/>	BlueMeasure 9	40%	\$3,000	\$5,500	\$6,000	\$11,000
<input type="checkbox"/>	BlueMeasure 10	30%	\$3,500	\$6,000	\$7,000	\$12,000
<input type="checkbox"/>	BlueMeasure 11	40%	\$4,000	\$7,000	\$8,000	\$14,000
<input type="checkbox"/>	BlueMeasure 12	40%	\$5,000	\$8,000	\$10,000	\$16,000
<input type="checkbox"/>	BlueMeasure 13	10%	\$7,000	\$8,000	\$14,000	\$16,000
<input type="checkbox"/>	BlueMeasure 14	40%	\$6,500	\$8,150	\$13,000	\$16,300
<input type="checkbox"/>	BlueMeasure 15	0%	\$8,150	\$8,150	\$16,300	\$16,300

The information above is provided to ensure this group is administered in accordance with all federal and state laws. The group understands and agrees it is required to provide updated information in the event significant changes occur in the group status or group member eligibility and is fully responsible for assuring eligibility of group members. If any information is found to be inconsistent with these responses, BlueCross reserves the right to update the Payment Terms as outlined in Article V of the Administrative Services Agreement.

Authorized Group Signature: _____

Date: _____