

Do you have union negotiated benefits?  Yes  No If Yes, next scheduled negotiation date: \_\_\_\_\_

Will this coverage be offered to employees as the sole health insurance option?  Yes  No

If No, what other carriers will be offered and how many employees are enrolled with each?

Carrier	No. of Employees	Carrier	No. of Employees

Is any active employee or dependent or COBRA-eligible person or dependent now pregnant?  Yes  No

Are you aware of any active employee or dependent or COBRA-eligible person or dependent with current health problems?

Yes  No

If Yes, explain: \_\_\_\_\_

Describe large or unusual claims: \_\_\_\_\_

Are any of your employees and/or dependents unable to perform the usual, ordinary duties of his/her occupation or normal activities due to a medical or mental condition?  Yes  No

Do you currently have an employee(s) who, by court order (QMCSO), must provide medical insurance for a dependent(s)?

Yes  No

If Yes, please attach a copy of the court order and provide the employee's name and Social Security number and the dependent's name and address.

Employee Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Dependent Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Custodial Parent(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If Support Order:**

Support Agency Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

Support Agency Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

***We certify that the benefits outlined above are the benefits the group has agreed to purchase. (If purchasing Essential Blue<sup>SM</sup> for Chambers, please note that the Essential Blue policy provides limited benefits. Review your policy carefully.)***

Authorized Group Representative ( <i>print name</i> ):	Title
Authorized Group Representative's Signature:	Date:
Independent Producer ( <i>print name</i> ):	BC #:
Independent Producer's Signature:	Date:
District Manager's Signature:	Date:

Sales Representative #: \_\_\_\_\_ UW Initials: \_\_\_\_\_ Date: \_\_\_\_\_



**GROUP QUESTIONNAIRE FOR NEW GROUPS 2-50 EMPLOYEES**  
**(THIS FORM TO BE COMPLETED WHEN SALE IS FINAL)**

Independent Producer Name: \_\_\_\_\_  
(please print)

Premium Enclosed: \$ \_\_\_\_\_

**GROUP INFORMATION:**

Group Number: \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_

Name of Person Interviewed: \_\_\_\_\_ Title: \_\_\_\_\_

Legal Name of Business: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(no PO box)

Tax ID Number (TIN) \_\_\_\_\_

Nature of Business: \_\_\_\_\_ NAICS Code \_\_\_\_\_

Type of Business:  Sole Proprietor  Partnership  Corporation  Other (please identify) \_\_\_\_\_

Is the business affiliated with any other business?  Yes  No If yes, who? \_\_\_\_\_

Do you file a separate or joint state tax return?  Separate  Joint In which state is the corporate office located? \_\_\_\_\_

**Contact Information**

	(Mr/Mrs/Ms) Name <small>(please print)</small>	Title	Email Address	Phone Number	Fax Number
<b>Executive Contact*</b>					
Management Contact					
<b>Group Administrator*</b>					
Primary Billing Contact					
Alternate Billing Contact					

\* must be filled in

**Current Carrier Information**

Name of medical carrier: \_\_\_\_\_ Group number: \_\_\_\_\_

Length of time enrolled: \_\_\_\_\_ Date of last rate change: \_\_\_\_\_

Current Employer Contribution: \_\_\_\_\_ % OR \$ \_\_\_\_\_  
**Employee** **Dependent**

Current Deductible \$ \_\_\_\_\_ Current Copay \$ \_\_\_\_\_ Current Coinsurance \$ \_\_\_\_\_ Current Out-of-Pocket \$ \_\_\_\_\_ Current Pharmacy \$ \_\_\_\_\_

Do you currently have maternity benefits?  Yes  No If Yes, describe benefits: \_\_\_\_\_

Do you currently have dental benefits?  Yes  No If Yes, for how long: \_\_\_\_\_

Name of dental carrier: \_\_\_\_\_

Current medical and/or dental rates: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Employee Employee & Spouse Employee & 1 Child Employee & 2+ Children Family

**Program(s) Applying For**

- BlueWorks<sup>sm</sup>  Preferred Blue<sup>®</sup> PPO  Access Blue<sup>sm</sup> PPO  HSA Blue<sup>sm</sup> PPO  Chamber Blue<sup>sm</sup> PPO  
 Essential Blue<sup>sm</sup> for Chambers (a limited benefit plan)  Basic  Standard  Catastrophic  Dental  Vision  
(If applying for Basic, Standard or Catastrophic, go directly to the COBRA administration option.)

**Dual Option** (Not available for Chamber Blue or Essential Blue for Chambers)

- BlueWorks<sup>sm</sup>/HSA Blue<sup>sm</sup> PPO  Preferred Blue<sup>®</sup> PPO/HSA Blue<sup>sm</sup> PPO  Access Blue<sup>sm</sup> PPO/HSA Blue<sup>sm</sup> PPO

## Benefit Options

### BlueWorks<sup>sm</sup> Program *(Please check one deductible and one coinsurance, with one corresponding out-of-pocket amount, where applicable.)*

Deductible				Coinsurance		Out-of-Pocket		
<input type="checkbox"/> \$ 250	<input type="checkbox"/> \$ 500	<input type="checkbox"/> \$ 750	<input type="checkbox"/> \$1,000	<input type="checkbox"/> 80% / 20%		<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000
<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> 70% / 30%				
<input type="checkbox"/> \$ 0	<input type="checkbox"/> \$ 250	<input type="checkbox"/> \$ 500			50% / 50%		<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$3,000
					100%		<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$5,000					N/A	

### Access Blue<sup>sm</sup> PPO or Chamber Blue<sup>sm</sup> PPO *(Please check one deductible, one out-of-pocket limit, one annual maximum and one prescription drug option.)*

Copayment	Deductible	Coinsurance		Out-of-Pocket Limit	Annual Maximum	Prescription Drug
		In-Network	Out-of-Network			
\$25	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	80% .....	60%	<input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000	<input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000	<input type="checkbox"/> None <input type="checkbox"/> \$10/\$25/\$40, with \$3,000 annual maximum <input type="checkbox"/> \$15/\$30/\$45, with \$3,000 annual maximum <input type="checkbox"/> \$5 copay for <b>generic</b> drugs only. <b>Member</b> pays 100% for brand name drugs. MAC N <input type="checkbox"/> \$250 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$500 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$750 deductible Brand Only \$10/\$30/\$50

### Essential Blue<sup>sm</sup> for Chambers - a limited benefit plan *(Please check one deductible option and one prescription drug option.)*

Copayment	Deductible	Coinsurance		Out-of-Pocket Limit (Does not include deductible)	Prescription Drug
		In-Network	Out-of-Network		
\$30	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	80% .....	60%	\$2,000	<input type="checkbox"/> None <input type="checkbox"/> \$15/\$30/\$45 with \$3,000 annual maximum <input type="checkbox"/> \$5 copay for <b>generic</b> drugs only. <b>Member</b> pays 100% for brand name drugs. MAC N <input type="checkbox"/> \$250 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$500 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$750 deductible Brand Only \$10/\$30/\$50

### HSA Blue<sup>sm</sup> PPO *(Please check one deductible, one coinsurance and one prescription drug option.)*

- UMBRELLA** (\*The claims of all family members accumulate toward the same family deductible and out-of-pocket maximum. Benefits for all family members begin after the family deductible is met.)

Single		Family*		Coinsurance		Prescription Drugs
Deductible	Out-of-Pocket (Includes deductible and coinsurance)	Deductible	Out-of-Pocket (Includes deductible and coinsurance)	In-Network	Out-of-Network	
<input type="checkbox"/> \$2,000	\$4,000	\$ 4,000	\$ 8,000	<input type="checkbox"/> 90% .....	70%	<b>Major Medical Options</b> <input type="checkbox"/> 60% coinsurance after deductible <input type="checkbox"/> 100% coinsurance after deductible (\$5,000/\$10,000 deductible only)
<input type="checkbox"/> \$3,000	\$5,000	\$ 6,000	\$10,000	<input type="checkbox"/> 80% .....	60%	
<input type="checkbox"/> \$5,000	\$5,000	\$10,000	\$10,000	<input type="checkbox"/> 100% (\$5,000/\$10,000 deductible only)		

- AGGREGATE** (One family member will not accumulate more than the individual deductible or out-of-pocket maximum toward the family deductible or out-of-pocket maximum. After one family member has met the individual deductible, benefits begin for that person. After the family deductible has been met, benefits begin for all family members.)

Individual and Family Deductible		Individual and Family Out-of-Pocket (Includes deductible and coinsurance)		Coinsurance		Prescription Drugs
				In-Network	Out-of-Network	
<input type="checkbox"/> \$3,000 / \$ 6,000		\$5,000 / \$10,000		<input type="checkbox"/> 90% .....	70%	<b>Major Medical Options</b> <input type="checkbox"/> 60% coinsurance after deductible <input type="checkbox"/> 100% coinsurance after deductible (\$5,000/\$10,000 deductible only)
<input type="checkbox"/> \$5,000 / \$10,000		\$5,000 / \$10,000		<input type="checkbox"/> 80% .....	60%	
				<input type="checkbox"/> 100% (\$5,000/\$10,000 deductible only)		

**Benefit Options** (continued)

<b>Preferred Blue® PPO Program</b> (Please check one deductible, one copay amount, one coinsurance, and one out-of-pocket amount, where applicable.)							
<b>Deductible</b>			<b>Copay</b>	<b>Coinsurance</b>		<b>Out-of-Pocket*</b>	
				In-Network	Out-of-Network	In-Network	Out-of-Network
<input type="checkbox"/> \$ 250	<input type="checkbox"/> \$ 500	<input type="checkbox"/> \$ 750	<input type="checkbox"/> \$20	<input type="checkbox"/> 90% .....70%		\$1,500.....	\$3,000
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$30	<input type="checkbox"/> 80% .....60%			
				<input type="checkbox"/> 70% .....50%			
<input type="checkbox"/> \$ 250	<input type="checkbox"/> \$ 500	<input type="checkbox"/> \$ 750	<input type="checkbox"/> \$20	<input type="checkbox"/> 80% .....60%		\$3,000.....	\$5,000
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$30	<input type="checkbox"/> 70% .....50%			
<input type="checkbox"/> \$3,000			<input type="checkbox"/> \$30	<input type="checkbox"/> 90% .....70%		\$1,500.....	\$3,000
<input type="checkbox"/> \$5,000			<input type="checkbox"/> \$40	<input type="checkbox"/> 80% .....60%			
				<input type="checkbox"/> 70% .....50%			
<input type="checkbox"/> \$3,000			<input type="checkbox"/> \$30	<input type="checkbox"/> 80% .....60%		\$3,000.....	\$5,000
<input type="checkbox"/> \$5,000			<input type="checkbox"/> \$40	<input type="checkbox"/> 70% .....50%			
<input type="checkbox"/> \$3,000			<input type="checkbox"/> \$30	70%.....50%		<input type="checkbox"/> \$1,500.....	\$3,000
<input type="checkbox"/> \$5,000			<input type="checkbox"/> \$40			<input type="checkbox"/> \$4,500.....	\$6,000

<b>Dental</b> (issued separately for HSA Blue <sup>sm</sup> PPO)		Integrated (enrollee/dependents enrolled in medical will automatically be enrolled in dental)			
<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, indicate desired program below.		Dual: <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental Carryover: <input type="checkbox"/> Yes <input type="checkbox"/> No (Not available with Voluntary Dental)	
<b>Traditional Dental</b>		<b>Annual Maximum</b>	<b>Waiting Periods</b>	<b>Orthodontia</b> (24-month waiting period for groups of 20+)	
<input type="checkbox"/> Incentive <input type="checkbox"/> \$25 Deductible <input type="checkbox"/> \$50 Deductible				<input type="checkbox"/> None	
<b>Preferred Blue Dental</b>		<input type="checkbox"/> \$1,000	<input type="checkbox"/> Yes	<input type="checkbox"/> \$1,000 lifetime maximum	
<input type="checkbox"/> Option I <input type="checkbox"/> Option II <input type="checkbox"/> Option III		<input type="checkbox"/> \$1,250	<input type="checkbox"/> No	<input type="checkbox"/> \$1,250 lifetime maximum	
<input type="checkbox"/> \$25 Deductible <input type="checkbox"/> \$50 Deductible		<input type="checkbox"/> \$1,500		<input type="checkbox"/> \$1,500 lifetime maximum	
<b>Basic Blue Dental</b> (No choice of closed list or waiting periods) <input type="checkbox"/> \$25 Deductible <input type="checkbox"/> \$50 Deductible				<input type="checkbox"/> No waiting period	
<b>Voluntary Dental</b> (No choice of closed list or waiting periods)		<b>Annual Maximum</b>		<input type="checkbox"/> 12 month waiting period	
<input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C		<input type="checkbox"/> \$1,000		<input type="checkbox"/> 24 month waiting period	
<input type="checkbox"/> \$25 Deductible <input type="checkbox"/> \$50 Deductible		<input type="checkbox"/> \$1,250		<b>Other</b>	
		<input type="checkbox"/> \$1,500		<input type="checkbox"/> None	
				<input type="checkbox"/> \$1,250 lifetime maximum	
				<input type="checkbox"/> \$1,000 lifetime maximum	
				<input type="checkbox"/> \$1,500 lifetime maximum	

<b>Vision (VSP)</b> (Issued separately for HSA Blue <sup>sm</sup> PPO)		
<b>Standard</b>	<b>Exam + Materials</b>	<b>Voluntary</b>
<input type="checkbox"/> Plan CI <input type="checkbox"/> Exam Only – VSX0 \$0 Copay	<input type="checkbox"/> VSX2 \$100 (12/12)	<input type="checkbox"/> Plan V1 \$10/\$25 (12/12)
<input type="checkbox"/> Plan CII <input type="checkbox"/> Exam Only – VSX1 \$10 Copay	<input type="checkbox"/> VSX3 \$125 (12/12)	<input type="checkbox"/> Plan V2 \$20/\$25 (12/12)
<input type="checkbox"/> Plan CIII <input type="checkbox"/> Exam Only – VSX8 \$20 Copay	<input type="checkbox"/> VSX4 \$150 (12/12)	<input type="checkbox"/> Plan V3 \$10/\$25 (12/24)
<input type="checkbox"/> Exam Only – VSX9 \$25 Copay	<input type="checkbox"/> VSX5 \$100 (12/24)	<input type="checkbox"/> Plan V4 \$20/\$25 (12/24)
	<input type="checkbox"/> VSX6 \$125 (12/24)	
	<input type="checkbox"/> VSX7 \$150 (12/24)	

<b>Prescription Drug Coverage</b> (Not available with Access Blue <sup>sm</sup> PPO, Chamber Blue <sup>sm</sup> , Essential Blue <sup>sm</sup> for Chambers or HSA Blue <sup>sm</sup> PPO)	
<input type="checkbox"/> None	<input type="checkbox"/> 50%/50%
<input type="checkbox"/> \$10 Generic/\$20 Brand Name	<input type="checkbox"/> \$10/\$25/\$40, 100%
<input type="checkbox"/> \$10 Generic/\$20 Brand Name w/\$3000 calendar year maximum benefit payment	<input type="checkbox"/> \$15/\$30/\$45, 100%
<input type="checkbox"/> 60%/40%	<input type="checkbox"/> \$250 deductible Brand Only \$10/\$30/\$50
	<input type="checkbox"/> \$500 deductible Brand Only \$10/\$30/\$50
	<input type="checkbox"/> \$750 deductible Brand Only \$10/\$30/\$50

<b>Supplemental Accident</b> (Not available with Chamber Blue <sup>sm</sup> , Essential Blue <sup>sm</sup> for Chambers or HSA Blue <sup>sm</sup> PPO)
<input type="checkbox"/> Yes <input type="checkbox"/> No (PPO has a \$300 calendar year maximum per insured. BlueWorks <sup>sm</sup> has a \$500 calendar year maximum per insured).

<b>Maternity Benefit</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Optional Life and Accidental Death and Dismemberment</b> (Administered and underwritten by selected life insurance companies)
<input type="checkbox"/> None
<input type="checkbox"/> \$20,000 minimum <input type="checkbox"/> Greater flat amount \$_____ <input type="checkbox"/> By employment class
(If group elects life insurance, please obtain LifeWise Assurance Company forms)

<b>COBRA Administration</b> (Only groups with 20 or more employees are eligible for COBRA)
Administered by Blue Cross of Idaho? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Employee Assistance Program (EAP) with Business Psychology Associates</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of visits _____