REQUESTED EFFECTIVE DATE (MM/DD/YYYY)

(NO RETROACTIVE CHANGES)

An Independent Licensee of the Blue Cross and Blue Shield Association

2-99 EMPLOYER APPLICATION
Exhibit B

CHECK SECTIONS TO BE CHANGED: ☐ I ☐ II ☐ III

PLEASE FULLY COMPLETE ALL SECTIONS OF THIS APPLICATION EVEN WHERE SPECIFIC PROVISIONS REMAIN UNCHANGED.

◯ NEW
◯ Change to existing group: GROUP #

SECTION I - EMPLOYER GROUP INFORMATION

LEGAL COMPANY NAME				
DBA				
ARIZONA LOCATION STREET ADDRESS	CITY		STATE A Z	ZIP CODE
ARIZONA BILLING ADDRESS	CITY		STATE A Z	ZIP CODE
COUNTY	FEDERAL TAX ID NUMBER		ARIZONA STATE TAX ID NUMBER	
HEADQUARTERS LOCATION - STREET ADDRESS (IF DIFFERENT THAN ABOVE)	CITY		STATE	ZIP CODE
TYPE OF BUSINESS	STATE INCORPORATED IN	CONTACT PHONE NUMBER	FAX	
EXECUTIVE NAME	TITLE	E-MAIL		
GROUP ADMINISTRATOR	TITLE	E-MAIL		

LEGAL ENTITY
◯ CORP. ◯ LLC ◯ PARTNERSHIP ◯ SOLE PROPRIETORSHIP ◯ POLITICAL SUBDIVISION/ MUNICIPALITY ◯ NON ARIZONA BASED ENTITY WHICH MEETS BCBSAZ UNDERWRITING GUIDELINES ◯ OTHER

SECTION II - PLAN INFORMATION - INDICATE HEALTH / DENTAL PLAN SELECTED

◯ **BLUEPREFERRED (PPO)**
COPAY PLAN OPTION:__________
NON-COPAY PLAN OPTION: ◯ 100 ◯ 2000 ◯ 5000
◯ **BLUEPREFERRED SAVER (PPO)** PLAN OPTION:__________
◯ **BLUEPREFERRED BASIC (PPO)** PLAN OPTION:__________
◯ **BLUESOLUTIONS (PPO)** PLAN OPTION:__________
◯ **BLUESELECT (HMO)** PLAN OPTION:__________

DENTAL
◯ DENTALCHOICE
◯ DENTALCHOICE with ortho
} OPTION:____

OTHER
◯

SECTION III - UNDERWRITING, ENROLLMENT, ELIGIBILITY, MANAGEMENT CONTINUATION AND PARTICIPATION

DOES THE EMPLOYER OFFER AN ENROLLMENT PERIOD OF AT LEAST 31 DAYS? ◯ YES ◯ NO (STANDARD RATES APPLY ONLY IF "YES")

1) EMPLOYER AGREES TO CONTRIBUTE TO PREMIUM COST FOR ELIGIBLE EMPLOYEES AS SPECIFIED IN BCBSAZ UNDERWRITING GUIDELINES. PLEASE REFER TO UNDERWRITING GUIDELINES FOR COMPLETE ELIGIBILITY, CONTRIBUTION AND PARTICIPATION REQUIREMENTS. (IF ELIGIBLE FOR RETIREE COVERAGE, SEE SECTION VI.)

DEFINE EMPLOYEE CLASSIFICATION AND INDICATE EMPLOYER CONTRIBUTION BY DOLLAR AMOUNT OR PERCENTAGE		ER HEALTH CONTRI-BUTION →			ER DENTAL CONTRI-BUTION →		
	CLASS 1 DEFINITION		EMPLOYEE	DEPENDENT		EMPLOYEE	DEPENDENT
	CLASS 2 DEFINITION		EMPLOYEE	DEPENDENT		EMPLOYEE	DEPENDENT

2) EMPLOYEES ARE ELIGIBLE UPON COMPLETION OF THE FOLLOWING SPECIFIED EMPLOYEE'S ENROLLMENT WAITING PERIOD:	CLASS 1 ◯ DAYS ◯ MONTHS	CLASS 2 ◯ DAYS ◯ MONTHS	**3) NEW GROUP ENROLLMENT REGULATIONS** EMPLOYER'S ENROLLMENT WAITING PERIODS WILL BE WAIVED AT THE NEW GROUP'S INITIAL ENROLLMENT ◯ YES ◯ NO

4) EMPLOYEE EFFECTIVE / TERMINATION DATE
◯ FIRST DAY OF THE BILLING MONTH FOLLOWING COMPLETION OF ENROLLMENT WAITING PERIOD / LAST DAY OF THE BILLING MONTH FOLLOWING LOSS OF ELIGIBILITY
OTHER ◯

5) DOMESTIC PARTNERS TO BE COVERED? ◯ YES ◯ NO
IF YES, GROUP ACCEPTS BCBSAZ DOMESTIC PARTNER CRITERIA AS DEFINED IN THE DECLARATION OF DOMESTIC PARTNERSHIP.

6) ELIGIBLE EMPLOYEES ARE DEFINED AS THOSE WORKING:
◯ A MINIMUM OF 25 HOURS PER WEEK ◯ OTHER

7) TOTAL NUMBER OF EMPLOYEES

TOTAL ELIGIBLE EMPLOYEES:	TOTAL NON-ELIGIBLE EMPLOYEES:	TOTAL NUMBER OF EMPLOYEES:

8) BANKRUPTCY
A) IN THE PAST 36 MONTHS, HAS THE COMPANY OR ANY AFFILIATED ENTITY FILED FOR PROTECTION OR OPERATED UNDER FEDERAL / STATE BANKRUPTCY LAWS? ◯ YES ◯ NO
B) IN THE PAST 36 MONTHS, HAS ANY CREDITOR FILED OR THREATENED TO FILE A PETITION REQUESTING THE COMPANY OR ANY AFFILIATED ENTITY TO BE PUT INTO BANKRUPTCY? ◯ YES ◯ NO

9) WORKER'S COMPENSATION	**A)** DOES THE EMPLOYER PROVIDE WORKER'S COMPENSATION FOR ALL EMPLOYEES INCLUDING THE OWNER ◯ YES ◯ NO	**B)** IF NO, LIST THE EMPLOYEES NOT COVERED AND INDICATE REASON FOR NO COVERAGE BELOW	**10)** HOW MANY PREVIOUS GROUP HEALTH CARRIERS HAS THE GROUP HAD IN THE LAST FIVE YEARS?	**11) LIST OTHER CO-EXISTING CARRIERS**

1 NAME OF PERSON NOT COVERED:	2 NAME OF PERSON NOT COVERED:
REASON NOT COVERED:	REASON NOT COVERED:

SECTION IV - BROKER INFORMATION

LAST NAME		FIRST NAME		MI
AGENCY NAME				
SUITE NO.	STREET ADDRESS			
CITY			STATE	ZIP + FOUR
PHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL		
BROKER TAX ID NUMBER	BCBS BROKER NUMBER	ARIZONA DEPARTMENT OF INSURANCE LICENSE NUMBER		

SECTION V - THIS SECTION APPLIES ONLY TO GROUPS OF 26 OR MORE ELIGIBLE EMPLOYEES

PLEASE COMPLETE THE FOLLOWING QUESTIONS WHEN APPLYING FOR NEW GROUP COVERAGE TO THE BEST OF YOUR KNOWLEDGE. THIS INFORMATION IS NECESSARY TO EVALUATE YOUR GROUPS APPLICATION BY BLUE CROSS BLUE SHIELD OF ARIZONA. IN ORDER TO PROTECT THE INDIVIDUALS INVOLVED, DO NOT DISCLOSE THE NAME OF ANY EMPLOYEE OR DEPENDENT.

Are you aware of any employee, dependent, or COBRA employee who:

a) is currently disabled? ____ ⬭ YES ⬭ NO

b) incurred expenses of $5,000 or more in the last 18 months? ____ ⬭ YES ⬭ NO

c) has been advised that necessary surgery or hospitalization is required (including pregnancy)? ____ ⬭ YES ⬭ NO

d) has had an organ transplant such as kidney, liver, heart or lung? ____ ⬭ YES ⬭ NO

e) is currently being treated or diagnosed as having cancer, heart/lung disease, high blood pressure, diabetes, muscular skeletal condition? ____ ⬭ YES ⬭ NO

f) is currently taking medication? ____ ⬭ YES ⬭ NO

g) has been diagnosed or is being treated for any other known medical condition? ____ ⬭ YES ⬭ NO

h) has any other known medical conditions? ____ ⬭ YES ⬭ NO

If yes to any of the questions above, please explain: ____

____

SECTION VI - RETIREE COVERAGE IS ONLY AVAILABLE AS SPECIFIED IN THE BCBSAZ UNDERWRITING GUIDELINES.

RETIREMENT ELIGIBILITY	RETIREES TO BE COVERED? ⬭ YES ⬭ NO	IF YES: ⬭ UNDER 65 ⬭ 65 AND OLDER	RETIREES DEPENDENTS TO BE COVERED? ⬭ YES ⬭ NO	OTHER THAN NEWBORNS, ETC. FOR WHICH COVERAGE MAY BE MANDATED UNDER APPLICABLE ARIZONA LAW

RETIREMENT PARTICIPATION REQUIREMENTS

A) RETIREE MUST COMPLETE ____ YEARS OF SERVICE PRIOR TO RETIREMENT

B) RETIREE IS ELIGIBLE FOR COVERAGE ONLY THROUGH END OF BILLING PERIOD IN WHICH RETIREE REACHES AGE ____

C) OTHER:

SECTION VII - IMPORTANT - READ CAREFULLY

I certify the Company is the sole employer of the employees to be enrolled under this contract and the information provided on this 2-99 Employer Application and all other applicable documents provided is complete and accurate. The Company shall notify Blue Cross Blue Shield of Arizona (BCBSAZ) promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the employer. I understand any and all Health/Medical and other information may be verified by outside sources, or other investigative firms, which BCBSAZ deems appropriate for finalizing its approval. BCBSAZ reserves the right to retroactively adjust the rates provided if information, including medical information, subsequently received, regardless of how BCBSAZ learns of the information, indicates this information was incomplete or inaccurate or that a material misrepresentation was made in the application, and such information would have affected the rate calculation. Further, the proposal quotation may be invalidated, withdrawn or an enrolled group may be terminated.

Acceptance of this Application is subject to final approval by BCBSAZ and shall be based upon information supplied by the group, the requested benefits, and any other information obtained from outside sources which BCBSAZ deems appropriate. Such acceptance shall be evidenced by the execution of this Application by an authorized representative of BCBSAZ, at which time this Application shall become binding upon BCBSAZ. Upon acceptance, this Application shall be attached to and shall become a part of the Group Master Contract (the "Contract"). The Contract may be terminated by BCBSAZ for the Group's failure to meet certain obligations under the Contract, including, but not limited to, maintaining the agreed-upon Group contribution and employee and/or dependent participation levels as set forth in the Contract, in accordance with A.R.S. Sec. 20-2301 et seq., as applicable.

I understand by including my e-mail address on the reverse side, I am authorizing BCBSAZ to send me information via e-mail. I also understand I may change my e-mail address or rescind this permission at any time by contacting BCBSAZ through www.azblue.com.

Company Authorized Officer / Owner / Partner

X ____

SIGNATURE DATE

____

TITLE LOCATION (CITY, STATE)

X ____

BCBSAZ Authorized Signature: DATE TITLE

To be completed by BCBSAZ

Team Code ____

GROUP # ____