Blue Cross and Blue Shield of New Mexico

# Group Master Application

| PPO Group #: | HMO Group #: | Dental Group #: | Requested Effective Date: | Approved Effective Date: |
|---|---|---|---|---|

☐ **BluePPO Evolution** _____ Deductible

☐ **Blue PPO Options** _____ Copay

☐ **BlueNet EPO** _____ Ded. _____ Out-of-Pocket

☐ Option A | ☐ Option B | ☐ Option C | ☐ Option D

☐ **BlueNet "H" EPO**

☐ Plan 1 | ☐ Plan 2 | ☐ Plan 3 | ☐ Plan 4

☐ **Prescription Drug Plan** _____

☐ **Custom Plan (51+ Only)** _____

☐ **HMO Blue**

_____ OV Copay _____ Hospital Copay

☐ **HMO Blue Alternatives**

_____ OV Copay _____ Hospital Copay

☐ **HMO Blue Options**

_____ OV Copay _____ Hospital Copay

☐ **Prescription Drug Plan** _____

☐ **Custom Plan (51+ Only)** _____

☐ **BlueCare Dental Freedom Plan #** _____

☐ **BlueCare Dental Choice Plan #** _____

☐ **Custom Plan (51+ Only) Plan #** _____

☐ Preferred Vision

☐ Premier Vision

**BlueEdge HSA** (Integrated 25/50 Rx): ☐ Basic ☐ Enhanced ☐ Premier

(Integrated Rx): ☐ HSA 100 Option 1 ☐ HSA 100 Option 2

Banking Option _____

**BlueEdge HCA (Non-Integrated Rx):**

☐ Basic ☐ Enhanced ☐ Premier

Banking Option _____

NOTE: Your prior coverage should NOT be cancelled until you have been notified that your application for group insurance has been accepted. No agent can bind coverage, set an effective date, or waive or alter any provision of this application. Insurance is not in effect until the date established by BLUE CROSS AND BLUE SHIELD OF NEW MEXICO.

**Exact Legal Name of Company** _____

**Federal Tax ID/EIN** _____ **Telephone Number** _____ **Fax Number** _____

**Physical Address of Business** (required)

**Nature of Business** (full description)

**City, State, Zip**

**Prior Carrier Name**

**Name of Subsidiary or Affiliated Companies**

**Mailing/Billing Address** (if different than above)

**Group Administrator Name and Email Address:**

**Type of Organization**

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC

☐ Other

**Is your group subject to?** ☐ COBRA ☐ TEFRA/DEFRA

**Regularly Scheduled Hours Worked Per Week**

(Enter number of hours, minimum 20 hours/week)

**COBRA Administrator** (only applies to groups subject to COBRA)

☐ BCBSNM-designated ☐ Group Administers

☐ Other Administrator ☐ N/A

**Senior Programs**

☐ N/A ☐ BlueSecure

**Employee Retirement Income Security Act (ERISA):**

☐ Applies (e.g., private employer) ☐ Exempt (e.g. church, gov't. entity)

**Does your group have a Section 125 plan?**

☐ Yes ☐ No

Employer Contribution – Medical (Employer must contribute at least 50% toward single tier premium)

Employer contributes _____% of employee-only premium

Employer Contribution – Dental (Employer must contribute at least 50% toward single membership)

Employer contributes _____% of employee-only premium

Probationary Period is defined as the number of days of continuous, uninterrupted employment beginning at the employee's most recent date of hire and ending on the date employee becomes eligible to apply for coverage under the employer's group. The length of the probationary period for new employees or rehires for small groups (2-50) is limited to 30, 60, 90, 120, or 180 calendar days. Employees will become effective on the first billing date following completion of the probationary period.

☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ Negotiable for large groups with 51 or more employees. *If negotiable, please explain:*

_____

Is the company waiving the probationary period at initial enrollment? ☐ Yes ☐ No

Is the group plan limited to a certain classification of employees? ☐ Yes ☐ No If yes, specify how your classification of employees will be determined.

_____

Retirees may be eligible if there are 51 or more active employees under this group health plan. Does your company intend to enroll retirees under this plan? ☐ Yes ☐ No If yes, please give details: _____

Is there any other health coverage in force or coverage currently being applied for in addition to this group coverage for some or all employees?

☐ Yes ☐ No If yes, please give details: _____

**Participation Requirements:**

To apply for group coverage and rates, a minimum of two employees must enroll and at least one must be under age 65. To retain group coverage and rates, the Employer agrees to maintain the following enrollment percentage requirements, based on NET ELIGIBLE EMPLOYEES under age 65, or age 65 or older if eligible due to TEFRA/DEFRA/COBRA.

Total eligible employees are calculated by total number of employees minus ineligible employees. See descriptions of each category below. Net eligible employees are calculated by subtracting employees with other coverage and/or excludable employees from total eligible employees.

If the number of eligible employees enrolled does not comply with the required percentage, we reserve the right to cancel the contract upon 30 days advance written notice.

| Groups 2-50 Enrolling | Groups 51+ Enrolling |
|---|---|
| **Groups with 2-4 net eligible employees:** 100% of net eligible employees must enroll<br>**Groups with 5-50 net eligible employees:** 75% of net eligible employees must enroll | 75% of net eligible employees and no fewer than 50% of total eligible employees must enroll |

**The employer hereby certifies the following number of employees in each category below:**

Total number of employees _____

Total number of ineligible employees (part-time, temporary, seasonal, ineligible class [carve-outs], probationary employees) _____

Total number of eligible employees _____

Total number of excludable employees (BCBSNM Group or BCBSNM Individual coverage, other group insurance coverage, Indian Health Services [IHS], Medicare, Medicaid, State Coverage Insurance [SCI], Military) _____

Total number of net eligible employees _____

Total number of COBRA or 6-month continuation participants _____

Other (please explain) _____

Total number of employees enrolling _____

The Employer agrees and warrants that no person who is not an eligible member under this provision will be listed, named, or otherwise represented by it in any way to be an eligible member, and that the employer will not remit membership premiums for any such person or participant or assist in obtaining or maintaining a Membership Certificate for such ineligible person. The employer agrees to maintain complete records and to furnish to us, upon request, such information as may be requested by us for our underwriting review. The employer further agrees to permit a payroll audit by us or by a representative appointed by us.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

**GENERAL INFORMATION**

The undersigned Employer applies for the health care coverage as set out in this Group Master Application and agrees to pay the required premium and to be bound by the terms and conditions of the contract. It is understood that group health coverage is issued with no guarantee of renewability. It is understood that the benefits and rates quoted may change based on the actual enrollment of the group. The Employer agrees that an employer participation level must be maintained according to Blue Cross and Blue Shield of New Mexico (BCBSNM) underwriting regulations and policies.

Employer acknowledges that if BCBSNM accepts this application and issues a Group Policy, BCBSNM may pay the broker/producer a commission and/or other compensation in connection with the issuance of such Group Policy. The undersigned further acknowledges that if additional information is needed regarding any commissions or other compensation paid the broker/producer by BCBSNM in connection with the issuance of the Group Policy, they should contact the broker/producer.

Employer represents, agrees, and warrants the information contained in this Application is true and correct and forms an essential basis for our issuance of the Contract. Even though this Application is submitted with proposed premiums or other funds, there will be no coverage until this application is approved by us. Employer agrees and understands that the amount tendered with this application is based upon a proposal rate, which is subject to change. If we approve this application, we will notify you and specify the effective date of group coverage. If we do not approve this Application, the submitted funds will be returned to the Employer.

NOTE: If you have employees in Massachusetts – Any fully-insured health care benefits indicated above are being offered to all of my full-time employees living in Massachusetts (if any). For purposes of the previous statement, a full-time employee is one who is scheduled or expected to work at least 35 hours per week (or as otherwise defined by Massachusetts law). Also, for full-time MA employees enrolling in the insured health care benefit program(s) indicated above, I will not make a smaller premium contribution percentage than I do for full-time MA employees who receive equal or greater total hourly or annual salaries.

Employer signature _____ Date _____

_____ Date _____

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

Agent or Broker Name (please print) & Tax ID or Broker Number: _____

Agent or Broker Signature: _____