



**BlueCross BlueShield  
of Georgia**  
**BlueCross BlueShield  
Healthcare Plan of Georgia**

Independent Licensees of the Blue Cross and Blue Shield Association

# GROUP MASTER APPLICATION

The purpose of this form is for Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) and Blue Cross and Blue Shield of Georgia, Inc. (BCBSGA) to evaluate rating for the company's request for group insurance coverage. Please answer all questions. This form must be signed and dated by an officer of the company.

<b>SECTION I - EMPLOYER INFORMATION</b>				
Legal Name of Employer		Group's Telephone Number		
Street Address		County	What is the nature of the business?	
City	State	Zip Code	Number of years in business	
Are there other locations to be included? Yes ___ No ___ If yes, please provide the name and number of employees at each location. The Employer certifies that (enter specific number) _____ employees are eligible to make application for coverage on the date of this Group Application, and agrees that _____ or more of all eligible employees will have made application for membership before the Effective Date of Coverage. Otherwise this Group Application will be deemed to have been withdrawn.				
<b>SECTION II - GROUP HEALTH PROFILE</b>				
Has anyone incurred health claims in excess of \$7,500 in the past 12 months and is the condition ongoing? Yes ___ No ___				
Specify: Employee, Dependent or COBRA	Age	Dollar amount of Claim	Diagnosis/Prognosis	Date of Last Treatment
<b>SECTION III - CURRENT COVERAGE INFORMATION</b>				
Carrier		Effective Date	Type Coverage	Type of Funding
RATES	Current Rates	Renewal Rates		Current Rates
	Medical	Medical		Dental
EE				
EE & SP				
EE & Child(ren)				
Family				
Total Number of Employees?		Total Number of Eligible Employees?		
Number of Employees Currently Enrolled in the Health Plan?		Number of Employees in Employee Waiting Period		
Number of COBRA Participants				

**IV - REQUESTED COVERAGE INFORMATION**

1A. Coverages Requested: (Enter appropriate coverage plan number and attach benefit summary) Indicate Local Sales Office \_\_\_\_\_

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. HMO Plan _____	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. POS Plan _____	BlueCross BlueShield of Georgia, Inc. PPO Plan _____	BlueCross BlueShield of Georgia, Inc. Traditional Health Plan (THP) _____	BlueCross BlueShield of Georgia, Inc. Dental Plan _____ Replacement? _____	BlueCross BlueShield of Georgia, Inc. Vision Plan _____
RX Copay Generic \$ _____ Brand \$ _____ In Formulary \$ _____ Not In Formulary \$ _____ PTD \$ _____	Generic \$ _____ Bm \$ _____ In Formulary \$ _____ Not In Formulary \$ _____ PTD \$ _____	Generic \$ _____ Brand \$ _____ In Formulary \$ _____ Not In Formulary \$ _____ PTD \$ _____	Generic \$ _____ Brand \$ _____ In Formulary \$ _____ Not In Formulary \$ _____ PTD \$ _____	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Blue Choice Platinum Plan _____	

1 B. Comments

2. Maternity coverage is included with HMO and POS plans, and with PPO and THP plans for groups with 15 or more employees. Maternity coverage is optional for groups with less than 15 employees for PPO and THP plans. If you have less than 15 employees, do you wish to select maternity coverage? (If rejected, it cannot be added at a later date.)	Yes ____	No ____
3. Mental health/substance abuse options are listed on your group proposal or other supplemental forms. Please indicate the Lifetime Maximum. (\$10,000 and \$25,000 choices are only available for PPO and THP groups 2-50. HMO and POS are unlimited automatically.)	\$Unlimited _____	\$10,000 _____ \$25,000 _____
4. Indicate the percentage of the premium to be paid by the employer	Employee Health _____%	Dependent Health _____%
	Employee Dental _____%	Dependent Dental _____%
5. What period of continuous service (employee waiting period) on a full-time basis must be completed by an employee before becoming eligible for coverage? Will coverage be effective date of hire? Yes ____ No ____	Health	Dental
6A. Will the coverage be effective on the first day following the employee waiting period?	Yes ____	No ____
6B. Or will the coverage be effective on the first day of the month following the employee waiting period?	Yes ____	No ____
6C. Do you wish to waive the employee waiting period at initial enrollment?	Yes ____	No ____

**EFFECTIVE DATE OF COVERAGE**

The proposed Effective Date of the Group Master Contract, if issued, is 12:01 a.m. (Eastern Standard time) on the \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year)

The first Contract anniversary date shall be \_\_\_\_\_ (month), \_\_\_\_\_ (year) whether or not the two dates are separated by twelve (12) months. The Group Master Contract, if issued, shall remain in force unless terminated in accordance with the terms of the Group Master Contract. The due date shall be the first of each month.

Signed at \_\_\_\_\_ on \_\_\_\_\_ (month, date), \_\_\_\_\_ (year)

\_\_\_\_\_  
Agent, Broker or Consultant of record

\_\_\_\_\_  
Name of the Employer (Company Name)

\_\_\_\_\_  
Representative of BCBSHPGA BCBSGA

\_\_\_\_\_  
Employer's Authorized Representative and Title