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℠ for Chambers, please note that the Essential Blue policy provides limited benefits. Review your policy carefully.)

Authorized Group Representative *(print name)*:	Title
Authorized Group Representative's Signature:	Date:
Independent Producer *(print name)*:	BC #:
Independent Producer's Signature:	Date:
District Manager's Signature:	Date:

Sales Representative #: _____ UW Initials: _____ Date: _____

Blue Cross of Idaho

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 *(please print)*	Title	Email Address	Phone Number	Fax Number
Executive Contact*					
Management Contact					
Group Administrator*					
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 $ _____ _____% 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℠ ❑ Preferred Blue® PPO ❑ Access Blue℠ PPO ❑ HSA Blue℠ PPO ❑ Chamber Blue℠ PPO
❑ Essential Blue℠ 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℠/HSA Blue℠ PPO ❑ Preferred Blue® PPO/HSA Blue℠ PPO ❑ Access Blue℠ PPO/HSA Blue℠ PPO

An Independent Licensee of the Blue Cross and Blue Shield Association

Benefit Options

BlueWorks℠ Program *(Please check one deductible and one coinsurance, with one corresponding out-of-pocket amount, where applicable.)*

Deductible	Coinsurance	Out-of-Pocket
❑ $ 250 ❑ $ 500 ❑ $ 750 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $3,000 ❑ $5,000	❑ 80% / 20% ❑ 70% / 30%	❑ $1,000 ❑ $2,000 ❑ $3,000
❑ $ 0 ❑ $ 250 ❑ $ 500	50% / 50%	❑ $1,000 ❑ $3,000 ❑ $2,000 ❑ $5,000
❑ $2,000 ❑ $3,000 ❑ $5,000	100%	N/A

Access Blue℠ PPO or Chamber Blue℠ PPO *(Please check one deductible, one out-of-pocket limit, one annual maximum and one prescription drug option.)*

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

Essential Blue℠ for Chambers – a limited benefit plan *(Please check one deductible option and one prescription drug option.)*

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

HSA Blue℠ 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	
❑ $2,000	$4,000	$ 4,000	$ 8,000	❑ 90%	70%	***Major Medical Options***
❑ $3,000	$5,000	$ 6,000	$10,000	❑ 80%	60%	❑ 60% coinsurance after deductible
❑ $5,000	$5,000	$10,000	$10,000	❑ 100% *($5,000/$10,000 deductible only)*		❑ 100% coinsurance after deductible *($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 In-Network / Out-of-Network	Prescription Drugs
❑ $3,000 / $ 6,000	$5,000 / $10,000	❑ 90% 70%	***Major Medical Options***
❑ $5,000 / $10,000	$5,000 / $10,000	❑ 80% 60%	❑ 60% coinsurance after deductible
		❑ 100% *($5,000/$10,000 deductible only)*	❑ 100% coinsurance after deductible *($5,000/$10,000 deductible only)*

Benefit Options *(continued)*

Preferred Blue® PPO Program *(Please check one deductible, one copay amount, one coinsurance, and one out-of-pocket amount, where applicable.)*

Deductible	Copay	Coinsurance	Out-of-Pocket*
		In-Network / Out-of-Network	In-Network / Out-of-Network
❑ $ 250 ❑ $ 500 ❑ $ 750 ❑ $1,000 ❑ $1,500 ❑ $2,000	❑ $20 ❑ $30	❑ 90% ..... 70% ❑ 80% ..... 60% ❑ 70% 50%	$1,500 ..... $3,000
❑ $ 250 ❑ $ 500 ❑ $ 750 ❑ $1,000 ❑ $1,500 ❑ $2,000	❑ $20 ❑ $30	❑ 80% ..... 60% ❑ 70% 50%	$3,000 ..... $5,000
❑ $3,000 ❑ $5,000	❑ $30 ❑ $40	❑ 90% ..... 70% ❑ 80% ..... 60% ❑ 70% 50%	$1,500 ..... $3,000
❑ $3,000 ❑ $5,000	❑ $30 ❑ $40	❑ 80% ..... 60% ❑ 70% 50%	$3,000 ..... $5,000
❑ $3,000 ❑ $5,000	❑ $30 ❑ $40	70% 50%	❑ $1,500 ..... $3,000 ❑ $4,500 ..... $6,000

Dental *(issued separately for HSA Blue℠ PPO)*

❑ Yes ❑ No If YES, indicate desired program below.

Integrated *(enrollee/dependents enrolled in medical will automatically be enrolled in dental)*

Dual: ❑ Yes ❑ No **Dental Carryover:** ❑ Yes ❑ No *(Not available with Voluntary Dental)*

Traditional Dental
❑ Incentive ❑ $25 Deductible ❑ $50 Deductible

Preferred Blue Dental
❑ Option I ❑ Option II ❑ Option III
❑ $25 Deductible ❑ $50 Deductible

Annual Maximum
❑ $1,000
❑ $1,250
❑ $1,500

Waiting Periods
❑ Yes
❑ No

Orthodontia *(24-month waiting period for groups of 20+)*
❑ None
❑ $1,000 lifetime maximum
❑ $1,250 lifetime maximum
❑ $1,500 lifetime maximum
❑ No waiting period
❑ 12 month waiting period
❑ 24 month waiting period

Basic Blue Dental *(No choice of closed list or waiting periods)* ❑ $25 Deductible ❑ $50 Deductible

Other

Voluntary Dental *(No choice of closed list or waiting periods)*
❑ Plan A ❑ Plan B ❑ Plan C
❑ $25 Deductible ❑ $50 Deductible

Annual Maximum
❑ $1,000
❑ $1,250
❑ $1,500

Orthodontia *(24-month waiting period for groups of 20+)*
❑ None ❑ $1,250 lifetime maximum
❑ $1,000 lifetime maximum ❑ $1,500 lifetime maximum

Vision (VSP) *(Issued separately for HSA Blue℠ PPO)*

Standard	Exam + Materials	Voluntary
❑ Plan CI ❑ Exam Only – VSX0 $0 Copay	❑ VSX2 $100 (12/12)	❑ Plan V1 $10/$25 (12/12)
❑ Plan CII ❑ Exam Only – VSX1 $10 Copay	❑ VSX3 $125 (12/12)	❑ Plan V2 $20/$25 (12/12)
❑ Plan CIII ❑ Exam Only – VSX8 $20 Copay	❑ VSX4 $150 (12/12)	❑ Plan V3 $10/$25 (12/24)
❑ Exam Only – VSX9 $25 Copay	❑ VSX5 $100 (12/24)	❑ Plan V4 $20/$25 (12/24)
	❑ VSX6 $125 (12/24)	
	❑ VSX7 $150 (12/24)	

Prescription Drug Coverage *(Not available with Access Blue℠ PPO, Chamber Blue,℠ Essential Blue℠ for Chambers or HSA Blue℠ PPO)*

❑ None
❑ $10 Generic/$20 Brand Name
❑ $10 Generic/$20 Brand Name w/$3000 calendar year maximum benefit payment
❑ 60%/40%
❑ 50%/50%
❑ $10/$25/$40, 100%
❑ $15/$30/$45, 100%
❑ $250 deductible Brand Only $10/$30/$50
❑ $500 deductible Brand Only $10/$30/$50
❑ $750 deductible Brand Only $10/$30/$50

Supplemental Accident *(Not available with Chamber Blue,℠ Essential Blue℠ for Chambers or HSA Blue℠ PPO)*

❑ Yes ❑ No *(PPO has a $300 calendar year maximum per insured. BlueWorks℠ has a $500 calendar year maximum per insured).*

Maternity Benefit

❑ Yes ❑ No

Optional Life and Accidental Death and Dismemberment *(Administered and underwritten by selected life insurance companies)*

❑ None
❑ $20,000 minimum ❑ Greater flat amount $_____ ❑ By employment class
(If group elects life insurance, please obtain LifeWise Assurance Company forms)

COBRA Administration *(Only groups with 20 or more employees are eligible for COBRA)*

Administered by Blue Cross of Idaho? ❑ Yes ❑ No

Employee Assistance Program (EAP) with Business Psychology Associates

❑ Yes ❑ No If Yes, number of visits _____