CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT APPLICATION

If this Application is being completed for a new Group, or an existing Group selecting a new product or making a jurisdictional change, the Group is required to complete this Application in its entirety, in black ink, and sign, date and return it to the Group's Sales Representative. The attached rate sheet describes the benefits and corresponding rates for the coverage selected by the Group.

If this Application is being completed for an existing Group amending the Group's current coverage, or changing general information, the Group is required to complete, in black ink, *only* the sections in which the information is changing, sign, date and return this Application to the Group's Sales Representative.

Do not alter this document except to fill in the blanks and check the boxes provided. This Application will not be accepted if any other changes are made.

GENERAL INFORMATION

Group Number (if available): _____

Name of Organization: _____

Physical Location:

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Billing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Group Administrator (Person to Contact):

Name: _____ Telephone Number: _____

Title: _____

Email Address: _____

Chief Executive Officer/President

Name: _____ Telephone Number: _____

Title: _____

Email Address: _____

Type of Organization ☐ Sole Proprietorship ☐ Partnership
☐ Corporation ☐ Other _____

Nature of Business: _____

Federal Tax Identification Number: _____

EMPLOYER CONTRIBUTION

To be eligible for CareFirst BlueChoice Group dental coverage, the employer must identify the contribution level that applies to the dental coverage in the checkboxes below. If the employer's contribution for enrolled employees is an amount equal to at least 50% of the cost of the Individual Coverage for enrolled employees, then the employer should select employer-sponsored below. If the employer's contribution is less than 50% of the cost of the Individual Coverage, the plan will be considered Voluntary, and the employer should select Voluntary below. If the employee or participant in the Group agrees to pay the entire premium for the coverage to the Group, then the employer should select Voluntary below.

The Group must specify if the coverage will be:

☐ Employer-sponsored or
☐ Voluntary

GROUP ELIGIBILITY REQUIREMENTS

It is understood and agreed that in order to be eligible for coverage and maintain such eligibility, the Group must meet the following requirements.

Annual Enrollment Certification: CareFirst BlueChoice reserves the right to inspect the records of the Group after sixty (60) days from the effective date of the Group coverage in order to verify the eligibility of employees and their dependents. In addition, the Group may be required to complete and return to CareFirst BlueChoice an eligibility audit and/or census report annually.

Minimum Enrollment Requirements:

The Group must enroll and maintain enrollment (unless otherwise approved by CareFirst BlueChoice) as stated below:

At least two common law employees must be employed full-time and enrolled under the Group's coverage at all times. (Note: The sole proprietor or spouse of the sole proprietor and those employees with complementary to Medicare coverage do not count toward the two employee minimum enrollment requirement.) Enrolled Groups that drop to less than two full-time employees should contact their CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

CareFirst BlueChoice will notify the Group for any rate adjustments allowed under the terms of this Group Contract no later than 45 days prior to the effective date of the rate change.

EMPLOYEE ELIGIBILITY REQUIREMENTS

The following employees (and their dependents) are eligible for coverage, as long as they meet the additional eligibility requirements stated in the Evidence of Coverage and any attachments thereto.

All employees (including owners and partners) who are regularly employed on a full-time basis working at least 30 hours a week. Seasonal employees and independent contractors, such as subcontractors, who received a 1099, may be counted as employees under the law. The IRS has issued guidance on when individuals could be treated as either an employee or independent contractor. Employers are encouraged to review this guidance and consult with an attorney or accountant, if needed.

All former employees and their dependents whose eligibility for group coverage has been extended due to COBRA requirements.

Note: No individual is eligible to enroll under the Group's coverage both as a Subscriber and as a Dependent. If the Group employs both Spouses of a family (or both Domestic Partners, if applicable), they may not both select a Type of Coverage that is Individual and Adult Coverage or Family Coverage.

Specify as many of the following additional categories of employees or retirees as the Group wishes to cover, even if the Group does not currently have such individuals in the Group. NOTE: These individuals cannot be included in the total number of eligible employees for the Group.

☐ YES ☐ NO Part time employees working at least 17.5 hours a week for more than six months each year. (Those working less than these required time periods are not eligible).

☐ YES ☐ NO Retirees in accordance with the provisions of the Group's retirement program, as amended from time to time.

☐ YES ☐ NO Retirees who have retired prior to the effective date of this coverage. (Available only if covered under the Group's prior health coverage.)

☐ YES ☐ NO All employees who terminated employment due to disability prior to the effective date of this coverage for a period of not more than two years. If for a shorter period of time, state here _____.
(Available only if covered under the Group's prior health coverage.)

☐ YES ☐ NO All employees who terminate employment due to disability after the effective date of this coverage for a period of not more than two years. If for a shorter period of time, state here _____.

☐ YES ☐ NO (Specify) _____
(Approval required)
CareFirst BlueChoice Approval: Initials _____ Date _____

DOMESTIC PARTNER ELIGIBILITY

Specify below whether Domestic Partners of Subscribers will be eligible to enroll as Dependents:

☐ YES ☐ NO Domestic Partners of Subscribers are eligible.

EMPLOYEE EFFECTIVE DATES

Coverage for current employees, other individuals currently covered if selected above, and former employees whose eligibility for group coverage has been extended due to COBRA requirements, and their eligible dependents becomes effective on the date that the Group Contract becomes effective.

Coverage for new employees is effective as stated below (if different for different classes of employees, state all in "Other" section):

- ☐ On the date of employment
- ☐ On the first day of the month following the date of employment
- ☐ On the first of the month following ____ months of employment (cannot exceed a total of ninety (90) days)
- ☐ On the first of the month following ____ days of employment (cannot exceed a total of ninety (90) days)
- ☐ Other _____
  (Specify. Date cannot exceed a total of ninety (90) days. This date must comply with federal and state law and regulation.)
  (Approval required)
  CareFirst BlueChoice Approval: Initials _____ Date _____

TERMINATION OF COVERAGE

Coverage for enrolled Subscribers and their enrolled Dependents terminates on the date stated below:

- ☐ On the date on which the Subscriber's employment or eligibility terminates
- ☐ On the last day of the month in which the Subscriber's employment or eligibility terminates

AGE LIMITS FOR DEPENDENT CHILDREN

Dependent children are covered until:

Select One

- ☐ End of the month of their 26th birthday.
- ☐ End of the calendar year of their 26th birthday.
- ☐ On the date of their 26th birthday.
- ☐ End of the month of their ____ birthday (must be over 26).
- ☐ End of the calendar year of their ____ birthday (must be over 26).
- ☐ On the date of their ____ birthday (must be over 26).
- ☐ Other _____
  (Specify. Age must be over 26).
  (Approval required)
  CareFirst BlueChoice Approval: Initials _____ Date _____

Dependent students may remain eligible after the age selected above as long as they are enrolled as full-time students in an institution and students age 26 and over must have a student certification on file with CareFirst BlueChoice until:

Select One if applicable

- ☐ End of the month of their graduation or the end of the month of their ____ birthday, whichever occurs last (must be over 26).
- ☐ End of the month of their ____ birthday (must be over 26).
- ☐ End of the calendar year of their ____ birthday (must be over 26).
- ☐ On the date of their ____ birthday (must be over 26).
- ☐ On the date of their graduation or on their ___ birthday, whichever occurs last (must be over 26).
- ☐ End of the calendar year of their graduation or on their ___ birthday, whichever occurs first (must be over 26).

☐ Other _____
(Specify. Age must be over 26).
(Approval required)
CareFirst BlueChoice Approval: Initials _____ Date _____

Note: Dependent eligibility must end in the same manner for dependent children and dependent students, i.e., at the end of the year, or the end of the month, or on the birthday. For example, the Group may not select end of the month for dependent children and end of the year for dependent students.

GROUP'S RESPONSIBILITY TO EMPLOYEES

In any case in which the employee is responsible for a portion of the monthly premiums, the Group must:

1. Advise the employee of his/her eligibility for coverage under the Group Contract;

2. Advise the employee when s/he may enroll for such coverage in accordance with the provisions stipulated in this Application and the Group Contract, including the Evidence of Coverage;

3. Advise the employee when coverage will commence based on the aforementioned provisions and the date of completion of the enrollment form;

4. Advise the employee of the cost of such coverage to the employee and the method in which payment is to be made; and

5. Obtain from the employee a completed enrollment form and a signed agreement by the employee to pay the applicable portion of the monthly rates.

GROUP STATEMENTS

The Group agrees that in the making of this Application, it is acting for and on behalf of itself and as the agent representative of its employees and COBRA participants, and their dependents; and it is agreed and understood that the Group is not the agent or representative of CareFirst BlueChoice for any purpose of this Application or any Group Contract issued pursuant to this Application.

The Group agrees to receive on behalf of its eligible employees and their dependents and COBRA participants the Evidence of Coverage, including all attachments, and all relevant notices furnished by CareFirst BlueChoice, and to forward such materials to these individuals.

The Group agrees that in the making of this Application, it has provided CareFirst BlueChoice with information regarding the eligibility of employees (and their dependents) that is accurate and consistent with the requirements and provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of the Internal Revenue Code and 42 U.S.C).

This Group Contract Application is part of the Agreement between the Group and CareFirst BlueChoice.

IMPORTANT NOTE: The Group's rate sheet which describes the benefits and corresponding rates for the coverage selected must be signed by the Group before coverage can be made effective. CareFirst BlueChoice reserves the right to revise the rates if the actual enrollment varies substantially from that used in the original rating or if applicable law or regulatory authority requires such revisions.

Warning: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia state law.

If the Group has any questions concerning the benefits and services that are provided by or excluded under the coverage for which the Group is applying, please contact a customer services representative before signing this Application.

ACCEPTED FOR:

_____
(Name of Organization)

BY: _____
(Printed Name of Authorized Officer)

_____
(Signature of Authorized Officer)

Title: _____ Date: _____

Broker (if applicable)

_____
(Printed Name of Broker)

_____
(Signature of Broker)

Email Address: _____

Date: _____

Effective Date of Group Contract: _____