



Independence Blue Cross  
1901 Market Street  
Philadelphia, PA 19103

**Application for New Small Employer Health Benefits – 2-50**

This form and the Blue Solution suite of plan designs can only be used when a group has between 2 and 50 total employees. Total employees represents all active full-time, part-time, and seasonal employees on the payroll as of the requested effective date.

**Section I. Company Information**

<b>Full Legal Name of Company:</b>		
<b>Tax ID#:</b>	<b>CID/Group #(internal use only):</b>	
<b>Customer Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Customer Contact:</b>	<b>Phone: ( )</b>	<b>Fax: ( )</b>
<b>Nature of Business:</b>	<b>Year in Business:</b>	<b>Customer Email Address:</b>
<b>Is there any Group Health Plan now in force and to be continued: Yes ( ) No ( ) Name of Carrier:</b>		
<b>Total number of eligibles:</b>	<b>Total number of employees:</b>	
<b>Amount of Premium paid by employer:</b> <input type="checkbox"/> 100% <input type="checkbox"/> Partial _____% <input type="checkbox"/> Other		
<b>Number of Hours Worked per Week for Eligibility:</b> _____		

**Section II: Third Party Representation**

<b>Marketing Representative Name/Code:</b>	
<b>Producing Agent:</b>	
<b>Primary Broker/Association:</b>	<b>Broker/Association ID#:</b>

**Section III: Quote Conditions Signature**

**Available Benefits**

- Groups with 2-50 employees (including active full-time, part-time, and seasonal workers) must select Blue Solutions® for small employers options, which includes prescription drug and vision benefits. Groups may not offer the same medical plan with different drug, dental and/or vision options. Groups may also choose from the benefits listed on the rate sheet.

**Dual-option offerings**

- Groups of 2-4 enrolled (active subscribers) contracts can select a maximum of one medical plan for all enrollees. A second option may be added to HMO/POS only if a PPO is needed for an out-of-area employee.
- Groups of 5-50 enrolled (active subscribers) contracts can select a maximum of two medical plans. A third option may be added to HMO/POS only if a PPO is needed for an out-of-area employee.

**Participation Requirements**

- Groups of 2-19 eligible lives (employees that qualify for benefits) must have 100 percent participation in combined or separate HMO/POS/PPO offerings. IBC requires a minimum of two enrolled lives.
- Groups with 20-50 eligible lives (employees that qualify for benefits) must have 75 percent participation, which includes all product lines. HMO/POS-only groups must also have 75 percent participation.
- IBC will count waivers in the eligibility calculations.
- Credit is given for those eligible employees who opt out because they have coverage through a spouse, as an eligible dependent to 26, or are enrolled in Medicare or Medicaid. Only these types of opt-outs, or waivers, are excluded from the calculation to determine if a group meets the 100 percent participation requirement.
- Retiree-only groups will not be accepted. For groups covering retirees, 100 percent participation will be required for active and retired employees. The group must consist of a minimum of 75 percent active employees.

**Employer contribution requirement**

- For contributory plan offerings, you must contribute a minimum of 25 percent of the calculated gross monthly premium or 75 percent of the single-tier rate for each plan offered.
- For fully-insured accounts that offer a high deductible health plan (HDHP), the employer cannot fund more than 50 percent of the annual employee/family deductible; provide a secondary/supplemental benefit plan that augments the core health insurance plan; pay more than 50 percent of employee/family deductible costs through an allowance or claims payment; or provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible.

**Rate tiers**

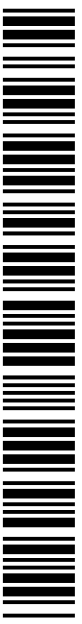
- All rates will be offered on a standard four-tier basis effective January 1, 2011.

**Submission guidelines**

- All offerings are subject to final underwriting review and acceptance. Additional guidelines and policies may apply.

Additionally, I have appointed (Broker Agency / Association) to represent our employment group. I understand that, if eligible, commissions on the account will be paid by the carrier and additional compensation known as "override commissions" may be earned from the carrier for meeting overall sales and retention goals.

**Print Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Independence Blue Cross/Keystone Health Plan East Benefit Plans  
Application for New Small Employer Health Benefits – 2-50**

**Company Name:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

<u>OPTION 1</u>		<u>OPTION 2</u>	
<b>Product:</b> <input type="checkbox"/> HMO <input type="checkbox"/> Direct POS		<b>Product:</b> <input type="checkbox"/> HMO <input type="checkbox"/> Direct POS	
<b>Plan:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5		<b>Plan:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5	
<input type="checkbox"/> 1.1 <input type="checkbox"/> 2.1 <input type="checkbox"/> 3.1 <input type="checkbox"/> 5.1		<input type="checkbox"/> 1.1 <input type="checkbox"/> 2.1 <input type="checkbox"/> 3.1 <input type="checkbox"/> 5.1	
<b>Product:</b> <input type="checkbox"/> PPO		<b>Product:</b> <input type="checkbox"/> PPO	
<b>Plan:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		<b>Plan:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	
<input type="checkbox"/> 1.1 <input type="checkbox"/> 2.1 <input type="checkbox"/> 3.1 <input type="checkbox"/> 4.1 <input type="checkbox"/> 5.1 <input type="checkbox"/> 6.1		<input type="checkbox"/> 1.1 <input type="checkbox"/> 2.1 <input type="checkbox"/> 3.1 <input type="checkbox"/> 4.1 <input type="checkbox"/> 5.1 <input type="checkbox"/> 6.1	

<u>OPTION 1</u>		<u>OPTION 2</u>	
<b>Product:</b> <input type="checkbox"/> HMO <input type="checkbox"/> Direct POS		<b>Product:</b> <input type="checkbox"/> HMO <input type="checkbox"/> Direct POS	
<b>Plan:</b> <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<b>Plan:</b> <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
<input type="checkbox"/> 4.1 <input type="checkbox"/> 6.1 <input type="checkbox"/> 7.1		<input type="checkbox"/> 4.1 <input type="checkbox"/> 6.1 <input type="checkbox"/> 7.1	
<b>Product:</b> <input type="checkbox"/> PPO		<b>Product:</b> <input type="checkbox"/> PPO	
<input type="checkbox"/> 7 <input type="checkbox"/> 8		<input type="checkbox"/> 7 <input type="checkbox"/> 8	
<input type="checkbox"/> 7.1 <input type="checkbox"/> 8.1		<input type="checkbox"/> 7.1 <input type="checkbox"/> 8.1	

<u>OPTION 1</u>		<u>OPTION 2</u>	
<b>Product:</b> <input type="checkbox"/> PPO HDHP (contract year)		<b>Product:</b> <input type="checkbox"/> PPO HDHP (contract year)	
<b>Plan:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		<b>Plan:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	

<b>BlueSaver<sup>SM</sup> Health Reimbursement Account (HRA)</b>	
Medical Package Code: _____	Annual Fund Rollover: <input type="checkbox"/> None <input type="checkbox"/> All
IRS 213(d) Eligible Expenses Ind: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cap on the Total Balance in the HRA? <input type="checkbox"/> Yes <input type="checkbox"/> No
Claims Rollover: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Cap Amount: _____
Employer Contribution: <input type="checkbox"/> 25% of Deductible	Funding Method: _____
<input type="checkbox"/> 50% of Deductible	

**Total Number of Personal Choice Applications Attached:** \_\_\_\_\_

**Total Number of Keystone Applications Attached:** \_\_\_\_\_

<p align="center"><b>IBC Dental Riders (HMO/DPOS)</b></p> <p><input type="checkbox"/> Basic</p> <p><input type="checkbox"/> Value</p> <p><input type="checkbox"/> Pediatric</p>	<p align="center"><b>United Concordia Dental</b></p> <p><input type="checkbox"/> Concordia Flex                    <input type="checkbox"/> Concordia Preferred</p> <p><input type="checkbox"/> Concordia Plus                    <input type="checkbox"/> Concordia Choice</p> <p>  <input type="checkbox"/> Option: _____</p>
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**Dependent / Student Age: 26 / 26**

