

Group Contract Application



651 Perimeter Drive, Suite 300, Lexington, KY 40517
Phone: 800-787-2680

1 COMPANY INFORMATION			
Company Name		Provide company name and address of any affiliates or subsidiaries to be covered (if applicable) Company Name _____ _____ <input type="checkbox"/> Subsidiary <input type="checkbox"/> Affiliate	
Mailing Address			
Street			
City/State/Zip			
County	Federal Tax Identification Number		
Authorized Representative		Title	Phone Number
Benefit Administrator		Title	Phone Number
Type of Business	SIC Code	Fax Number	Email Address

2 CONTRACT INFORMATION																		
Effective Date	Anniversary Date	<input type="checkbox"/> Total Replacement <input type="checkbox"/> Choice Basis	<input type="checkbox"/> New Group <input type="checkbox"/> Renewal															
Will this plan replace any existing or previously in force coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, provide Insurer's Name	Termination Date															
Benefit Description Product: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> Other _____ Plan Code _____ Pharmacy Rider _____ Other Rider(s) _____ Other Program(s) _____		Composite Premium Rate Structure (If matrix rates are used the Company Officer must attach a signed rate sheet) <table border="1"> <thead> <tr> <th>Tier</th> <th>Total Premium</th> <th>Amount or Percentage of Employer Contribution</th> </tr> </thead> <tbody> <tr> <td>Single</td> <td>\$</td> <td></td> </tr> <tr> <td>Employee + Spouse</td> <td>\$</td> <td></td> </tr> <tr> <td>Employee + Child(ren)</td> <td>\$</td> <td></td> </tr> <tr> <td>Family</td> <td>\$</td> <td></td> </tr> </tbody> </table>		Tier	Total Premium	Amount or Percentage of Employer Contribution	Single	\$		Employee + Spouse	\$		Employee + Child(ren)	\$		Family	\$	
Tier	Total Premium	Amount or Percentage of Employer Contribution																
Single	\$																	
Employee + Spouse	\$																	
Employee + Child(ren)	\$																	
Family	\$																	
Waiting Period for Eligible Employees:			Minimum hours per week required for eligibility:															

3 EMPLOYEE INFORMATION	
Employee Count Full-Time Employees _____ Part-Time Employees _____ Disabled Employees _____ Family Leave Employees _____ Employees on COBRA _____ Total Number of Employees _____ Employees Eligible for Coverage _____ Name of person(s) in COBRA Eligibility Period _____ _____ _____	Are all employees applying for coverage actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain _____ Are any classes of employees being excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain _____ To the best of your knowledge, are any employees or dependents currently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give name, condition, prognosis and date of first treatment (attach separate page if necessary) _____ Is your Company subject to COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a COBRA Administrator? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your Company employ 20 or more employees under the terms of the Medicare Secondary Payer Statute? <input type="checkbox"/> Yes <input type="checkbox"/> No Company is required to inform Bluegrass Family Health should this information change.

4 AGREEMENT		
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. IC § 35-43-5-3.4; TCA § 56-53-111. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. KRS § 304.47-030 Group Contract Application must be signed by Company Officer and Bluegrass Family Health Marketing Director		
Company Officer	Title	Date
Broker/Agent	Broker Code	Date
Bluegrass Family Health Account Executive		Date
Bluegrass Family Health Marketing Director		Date