Note: Please complete this application in its entirety. Questions left blank will be assumed no.

New Business Small Employer Application

Group Information

Group Name *(full and complete legal name is required)*

Doing Business As: (if applicable)

Nature of Business: / SIC Code:

Employer Classification

☐ Corporation ☐ Partnership ☐ Sole Proprietor

☐ Other:

Group's Physical Address

City State Zip

Decision Maker Name and Title:

Group's Mailing Address: *(if different from above)*

Email address to be used for Echosign Documents
(must be an authorized group representative who is actively employed)

City State Zip

Phone Fax

Workers' Compensation Carrier:

Writing Agent Name and Florida Blue AOR Code:

Prior Health Insurance Carrier:

GROUP Tax ID#

The original effective date of this Policy shall be:

/ / 2024

Waiting Period Days (see notes below)

☐ 0 ☐ 60

☐ 30 ☐ 90

Waive Waiting Period for Initial Enrollment? ___Yes ___No

The Benefit Period of this Policy shall be:

☐ Calendar Year (1/1 - 12/31)

☐ Non-Calendar/Policy Year

Add New Eligible Employees on:

☐ 1st day of billing cycle **(For 0-60 day waiting period)**

☐ Date of hire **(For 0-90 day waiting period)**

Term Eligible Employees on:

☐ Last day of billing cycle ☐ Termination Date

Eligibility Information

Employer Contribution:

Employee %

Dependent %

Important note regarding Waiting Periods:

0, 30 , 60 days will be counted by a CALENDAR MONTH

90 days will be counted by ACTUAL DAYS

What was the average total number of all employees (full-time, part-time, and seasonal) in the previous calendar year?

☐

What is the total number of employees, (including owners and partners, etc.), currently employed by your business?

☐

# of new Full-time Employees still in waiting period? ☐

Total # of Part-time /Seasonal Employees. ☐

# of COBRA / FHICCA Continuants ☐

# of employees waiving FL Blue health benefits but are covered on another health benefit plan? ☐

# of employees waiving FL Blue health benefits without coverage elsewhere? ☐

Is your company a member of a Controlled Group of Corporations as referenced in section 414 of Internal Revenue Code of 1986 (26 U.S.C. §414(b), (c), (m), or (o))? ☐ Yes ☐ No
If yes, complete and attach Small Employer Common Ownership Form 24284 0613.

Under Federal Law, if your group had 20 or more full and part-time employees, including owners and partners on at least 50% of the employer's work days of the preceding calendar year, you must provide employees with COBRA Continuation. If your group had less than 20 employees, your employees are eligible for coverage under the Florida Health Insurance Coverage Continuation Act ("FHICCA"). All full time employees are counted as one employee and each part-time employee is counted as a fraction of an employee. Owners, partners and others paid by the employer(s) are included. Self-employed / independent contractors and non-employee directors are not counted.

☐ COBRA Continuation

OR

☐ FHICCA

Waive FL Blue COBRA Admin services?

☐ Yes* ☐ No

*If yes, please submit the appropriate Cobra waiver forms

Please answer all of the following questions:

We are a ☐ Single Employer Plan OR a ☐ Multiple or Multi-Employer Plan

A Multiple Employer Plan is a plan sponsored by more than one employer. A Multi-Employer Plan is a plan jointly sponsored by employers and unions.

One or more employers in our group employed 20 or more full and/or part-time employees during the current or preceding calendar year. ☐ Yes ☐ No

Our group employed 100 or more full and/or part-time employees on 50 percent or more of the work days during the preceding calendar year. ☐ Yes ☐ No

It is recommended that the Employer retain a copy of all applications/waivers for all eligible employees.

At least 70% of the eligible employees for applicants with 4-50 employees, and 100% of the eligible employees for applicants with 1-3 employees must be enrolled under the Policy on the original Effective Date and throughout the term of the Policy. FL Blue shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage; applicant agrees to furnish any such request.

If a small employer fails to meet the participation and contribution requirements, FL Blue will only accept the application from 11/15 to 12/15 for a January 1 effective date in accordance with 45 C.F.R. § 147.104.

The following information is required for access to Florida Blue's Employer Point tool

Decision Maker Information (required)

****Must be an authorized representative of the group who is actively employed****

Contracts, Final Rates & EmployerPoint registration will be sent to the Decision Maker's email address listed below

Legal First Name: ____________________
Middle Initial (optional): ____________________
Legal Last Name: ____________________
DOB: ____________________
Work Email (**cannot be agent**): ____________________
Work Phone: ____________________

Please select contact roles for Decision Maker:

Primary Benefit Administrator?	Yes	No
Employer Point Access?	**Yes (default)**	
Manage Group BA	**Yes (default)**	
Group Enrollment	**Yes (default)**	
View and Pay Invoices	**Yes (default)**	
Manage COBRA	**Yes (default)**	
Invoice Notification Email	**Yes (default)**	

Primary Benefit Administrator (if applicable)

Legal First Name: ____________________
Middle Initial (optional): ____________________
Legal Last Name: ____________________
DOB: ____________________
Work Email: ____________________
Work Phone: ____________________

Please select contact roles for Primary Benefit Admin:

Employer Point Access?	**Yes (default)**	
Manage Group BA	Yes	No
Group Enrollment	Yes	No
View and Pay Invoices	Yes	No
Manage COBRA	Yes	No
Invoice Notification Email	Yes	No

Additional Benefit Administrator (if applicable)

Legal First Name: ____________________
Middle Initial (optional): ____________________
Legal Last Name: ____________________
DOB: ____________________
Work Email: ____________________
Work Phone: ____________________

Please select contact roles for Additional Benefit Admin:

Employer Point Access?	Yes	No
Manage Group BA	Yes	No
Group Enrollment	Yes	No
View and Pay Invoices	Yes	No
Manage COBRA	Yes	No
Invoice Notification Email	Yes	No

Groups with 10+ Eligible, please select:
Final Rates are to be ___Composite ___Age-Banded

Health Plan Selections *(complete one section for each plan selected)*

Health Plan Name

Deductible:

Per Person ______ Per Family ______

Refer to rate sheet(s)

See the Group Master Policy for a complete description of benefits.

Rx Option *(indicate copayments)*

Coinsurance

In-Network/Participating

Out of Network/Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Health Plan Name

Deductible:

Per Person ______ Per Family ______

Refer to rate sheet(s)

See the Group Master Policy for a complete description of benefits.

Rx Option *(indicate copayments)*

Coinsurance

In-Network/Participating

Out of Network/Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Health Plan Name

Deductible:

Per Person ______ Per Family ______

Refer to rate sheet(s)

See the Group Master Policy for a complete description of benefits.

Rx Option *(indicate copayments)*

Coinsurance

In-Network/Participating

Out of Network/Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Health Plan Name

Deductible:

Per Person ______ Per Family ______

Refer to rate sheet(s)

See the Group Master Policy for a complete description of benefits.

Rx Option *(indicate copayments)*

Coinsurance

In-Network/Participating

Out of Network/Non-Participating

Office Visit Copay:

Family Phy.

All Other Providers

Are you choosing BCBSF's integrated HSA, HRA or FSA preferred administrator arrangement? ☐ Yes ☐ No

If yes, which type of accounts are you choosing? ☐ HSA ☐ HRA ☐ FSA

NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

Dental, Vision & Life Plan Selections

Dental Plan Name

Vision Plan Name

Dental Plan 2 Name (if applicable)

Prior Carrier (dental/vision)

Employer Contribution (Dental):

Employee %

Dependent %

Employer Contribution (Vision):

Employee %

Dependent %

Life Benefit Class	Description of Class (e.g.; All Members)	Benefit Amount (e.g.; 50k)
1		
2		
3		
4		

If electing Dependent Life and/or Voluntary Life benefits,
please include a copy of the sold quote with the paperwork.

Rate Information

Premiums/Prepayment fee are payable on or before the due date. Regular Billing – Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination. The Rates established for this Policy will not be changed for the first twelve (12) months following the original Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, FL Blue may change the Rates that are to be effective after this initial twelve (12)month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to theirEffective date.

Note to the Writing Agent and Group Decision Maker:

This document is used for data collection purposes only. The final contract/application and rate sheet(s) will be emailed to you for electronic signature via the EchoSign process. Please review the information thoroughly for accuracy before electronically signing and submitting to Florida Blue.

Final premiums, benefits and effective date are subject to approval by Florida Blue.