SMALL GROUP WORKSHEET

Rep Information

Representative Name Jim Edwards

Representative Number

Telephone Number 406-443-1060

E-Mail Address

Fax Number 406-442-1913

Requested Effective Date:
(Subject to BCBSMT Approval)

BELOW: Indicate either/both Community and/or which Association and the plan types to be quoted. ↓

Group Information

Preferred Association Eligible? ___Yes ___No
(Preferred = industry specific)

If Yes, which Association? ____________________

Is a Preferred Association quote requested? ___Yes ___No

Plan Preference
(Indicate the plan type(s) for which you would like to receive a quote)

- ❑ ____________________
- ❑ ____________________
- ❑ ____________________

Group Tax ID Number ____________________

Group Legal Name ____________________

DBA (If Applicable) ____________________

Address (Physical)

City, State, ZIP Code

Group Leader

Title

Telephone Number

Additional Authorized signers:

E – Mail Address **(Group Leader)**

Firm's Web Address **(if applicable)**

Is your firm a subsidiary of another entity or does your firm have any subsidiaries? (common ownerships/affiliate) Can this business file a consolidated tax return with another business for either Federal or State? (if yes, they are affiliated) Do any owners of this firm have 80% or greater interest in another firm or does another firm have 80% or greater interest in this firm? If yes, they are affiliated.
❑ Yes ❑ No If yes, list the name(s), location(s), and relationship.

	Name	Location (Physical Location)	Relationship
1.			
2.			

Organizational Structure (Please indicate how your business is organized)

- ❑ **Sole Proprietorship**
- ❑ **Incorporated**
- ❑ **Partnership**
- ❑ **Other** (Specify) ____________________

Type of Business

If incorporated or a partnership, please list the name(s) and title(s) of all officers or partners. If they are not eligible employees, what is their status (silent owners, part time employees, board members, …)

	Name of Officer or Partner: Status	Title
1.		
2.		
3.		
4.		

Eligibility	
	Based on the criteria outlined above in the affiliate section of this form, including all other subsidiaries with which there is common ownership or control, is this a Small Employer (including affiliates)? ❑ Yes ❑ No **Is this business registered with the Montana Secretary of State? ❑ Yes ❑ No** **Does this Business have other group coverage? ❑ Yes ❑ No** **If yes, carrier name: ________________________________**
	1. What are the work hour requirements for employees to be considered eligible for coverage? (Must be between 20 and 40 hours per week) ______________
	2. What is the current probationary period required before an employee is eligible for coverage under the health benefit Plan? (Maximum 330 days): _______________
	3. What is the firm's employer contribution? (If there are different criteria by class of employee, identify what constitutes a "class" and how contribution is determined.) **Employees** _______________ (% of premium or $ of premium contributed.) **Dependents** _______________ (% of premium or $ of premium contributed.) Community: Contribution must be a minimum of 60% on Employee only, or 50/50 split between employee and dependents MCC: Minimum of 50% employee only
	4. List any employees or dependents who are under age 65 and eligible for Medicare due to disability and/or end stage renal disease. (Include SSN and Medicare-assigned number) ____

Disclaimer	
	If the enrolled demographics of the group change, the quoted rates and/or qualifications for coverage may be impacted.

Conditions/Signature

As an individual duly authorized to act on behalf of _________________ (group name), I certify that the above information and any attachments are completed to the best of my knowledge and belief. I also certify the following to the best of my knowledge and belief:

1. Eligible employees will be notified of their access to coverage under the health benefit plan within their probationary period and will be required to complete either an application for coverage or a waiver of coverage for themselves and their dependents.

2. Only eligible employees, their eligible dependents, and eligible retirees will be covered or offered coverage under the health benefit plan.

3. I understand that continued coverage is subject to meeting specific percentages of enrollment (participation requirements) and timely payment of the premium due and that we have been advised of those requirements.

____

Signature Date

____

Printed or typed name

____

Title

BlueCross BlueShield of Montana

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