BlueCross BlueShield of North Carolina

P.O. Box 2291, Durham, NC 27702-2291

Blue20/20℠ Employer Application

Number of Eligible Employees:	Number of Participating Employees:
Requested Effective Date: ________ (month) ________ (year)	First Renewal Date: ________ (month) ________ (year)

Internal Use Only **Group Number**:

EMPLOYER INFORMATION

1. Legal Name of Employer:

2. Physical Address:	City:	State:	Zip Code:
3. Billing Address: (**if different from above**)	City:	State:	Zip Code:

4. Name of Group Administrator:	Telephone Number:	Fax Number:
E-mail Address	Alternate E-mail Address	

5. Divisions / Subsidiaries / Affiliates to be Covered (**attach list, if necessary**): ☐ Yes ☐ No

Name: ________ Relationship: ________

Address: ________ E-mail Address: ________

City: ________ State: ________ Zip Code: ________

Nature of Business: ________

Note: Eligibility must be received in a manner that will identify the location or group in which the individual is to be enrolled.

6. (a) Will the Employer pay any amount towards the vision premium? ☐ Yes ☐ No	(b) Employer (group) paid premium contribution percentage: For Employee: ____ % For Dependents: ____ %

EMPLOYEE ELIGIBILITY

7. Eligibility Requirements to be Applicable to Newly Hired Employees:
   - ☐ 0 day probationary period, effective 1st of month following the date of hire
   - ☐ 1st of the month following 30 days
   - ☐ 1st of the month following 60 days
   - ☐ 1st of the month following 90 days

8. Coverage will terminate end of the contract month following employment termination.

An Independent licensee of the Blue Cross and Blue Shield Association ®, SM Marks of the Blue Cross and Blue Shield Association.

BENEFIT DESIGN OPTIONS

9. **PLAN OPTIONS:** (select) **Note: Premiums are based on a Per Employee Per Month fee**

Plan	Options	Premiums
Blue 20/20 Exam Only	Exam copay ☐ $0 ☐ $10 ☐ $20 ☐ $25	Employee Only $______ Employee + Spouse $______ Employee + Children $______ Employee + Family $______
Blue 20/20 Exam Plus	Exam copay ☐ $0 ☐ $10 ☐ $20 ☐ $25 Lens copay ☐ $10 ☐ $25 Frame allowance ☐ $100 ☐ $130 ☐ $150 Frame frequency ☐ 1 per 12 months ☐ 1 per 24 months	Employee Only $______ Employee + Spouse $______ Employee + Children $______ Employee + Family $______
Blue 20/20 Lens & Frame Only	Material allowance ☐ $200 ☐ $250 ☐ $300	Employee Only $______ Employee + Spouse $______ Employee + Children $______ Employee + Family $______

Non-Voluntary: at least 25% employer contribution and 75% employee participation
Voluntary: less than 25% employer contribution and at least 20% employee participation

10. Is your group vision plan exempt from COBRA? ☐ Yes ☐ No

11. Under federal law, the Plan Administrator may be required to provide a notice to Plan Participants who do not read English but are literate in another language, advising them of where they can get information and assistance concerning their benefits and member rights. The notice must be in their primary language and appear in the summary plan description (member booklet). The following information is being requested to determine if such a notice will be necessary. It may also assist BCBSNC in meeting special customer service needs.

    For Groups of 51+: Do 10% or 500 of the persons covered by your plan, whichever is less, meet the following criteria:
    Literate only in a foreign (non-English) language? ☐ Yes ☐ No

PAYMENT OPTIONS

12. **Initial / First Month's Premium (a check for the entire first month's premium payable to BCBSNC must accompany this application).** The amount of the check is calculated, based upon the plan selected, by multiplying the number of employees times the fee for the type of coverage (tier) elected, and then by totaling all subtotals for each type of coverage (tier) elected.

    Would you like Subsequent premiums drafted from your bank account? ☐ Yes ☐ No
    If yes, complete Question 13 (Authorization for Bank Draft).

13. **Authorization for Bank Draft**

    By signing below, I certify that I am an authorized user of the bank account designated below. I hereby request and authorize BCBSNC to charge subsequent premium(s) for Group Insurance described by this document to the bank account payable to the order of BCBSNC. I agree that BCBSNC's rights in respect to the bank draft shall be the same as if it were a check drawn on the bank account, and signed by me or another authorized user. I also authorize the financial institution to reduce the balance of the bank account by the amount of the bank draft. This authorization will remain in effect until it is revoked by an authorized user in writing at least 10 days prior to the date the bank account is scheduled to be charged. I agree that if such charges were dishonored, whether with or without cause and whether intentionally or inadvertently, BCBSNC shall have no liability whatsoever even though dishonor results in forfeiture of insurance.

    Type of Account: ☐ Checking ☐ Savings

Name of Bank Account Holder: ______________________ Name of Bank: ______________________

Bank Routing Transit Number: ______________________ Bank Account Number: ______________________

This number appears in the lower left-hand corner of your check. This number appears to the right of the transit number and is separated from the transit number by symbols/spaces.

Signature of Account Holder: X ______________________ Date: __________ MM / DD / YYYY

Please attach a VOIDED Check or Deposit Slip

14. Subject to the acceptance of this application by BCBSNC, the effective date of coverage pursuant to this application shall be 12:01 AM Eastern Time on the First day of ______________ (month), __________ (year), provided that the initial monthly fees are paid, and coverage under the Group Contract will be for a period of 12 months, and that, unless terminated in accordance with the Group Contract, the Group Contract will be renewable for subsequent 12 month periods.

CERTIFICATIONS

STATEMENT OF UNDERSTANDING:

Insured Groups Only (all sizes):

By signing below, I certify that I am the authorized signer on behalf of the Group and that all information provided is complete and accurate. I further understand that submission of this application and requisite fees constitutes an offer and a binding contract upon acceptance, as applicable, by BCBSNC. Acceptance of the offer by BCBSNC shall be signified by the earlier of the following events: BCBSNC's issuance of the Group Contract, or issuance of identification cards to the Group's members. The Contracts issued by BCBSNC shall set out the terms of the agreement between the parties, and this application shall be incorporated therein by reference. Group agrees that the Contracts shall be binding upon the parties as issued, without the necessity of signature by the Group. A representative sample of the Contracts are available upon request.

Authorized Signature (for the Group): ______________________ Date: __________ MM / DD / YYYY

Print Name: ______________________ Title: ______________________ **Elected Official Coverage:** ☐ Yes ☐ No

AGENT'S REPORT - Complete, If Applicable

Agent/Broker Name (Please Print):	Agent's E-mail Address:
Agent Code (BCBSNC Producer Number): P ___ ___ ___ ___ ___ ___ ___	Agent Tax ID# or SSN:
Agency Name:	Agency Number: A ___ ___ ___ ___ ___ ___ ___
Telephone Number:	Agency Tax ID#/EIN:
Agency Mailing Address:	

City:	State:	Zip Code:	County:

Is Agent or Broker licensed and appointed by BCBSNC for the types of insurance solicited where this group is located? ☐ Yes ☐ No

Signature of Agent/Broker:	State License:

Questions? Call Blue Cross and Blue Shield of North Carolina at 1-888-723-4476