

# Employer Application For Administrative Services

Administered by:



## Alternate Funded Benefit plans offered by Georgia Chamber Federation Benefit Plan (GCF) or Georgia Farm Bureau Member Health Program (GFB)

Please complete this form. Use extra sheets of paper if necessary.

**Note:** Anthem Blue Cross and Blue Shield provides administrative claims payment services only, for medical plans, and does not assume any financial risk or obligation with respect to claims. Anthem Blue Cross and Blue Shield provides fully-insured specialty plan coverage is provided under Anthem Blue Cross and Blue Shield and Anthem Life.

### Section 1: Effective date

Requested effective date: <input type="text"/> (MMDDYYYY)
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### Section 2: Employer information

Applicant (legal name of group)	Doing business as	Name of chamber (required for GCF only)	
Group contact name	Title	Email	
Name of administrative contact (authorized signer)	Title	Email	
Name of additional authorized signer	Title	Email	
Type of business	Standard industry code (SIC) code	Date business established	
Type of organization: <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Labor Union <input type="checkbox"/> Trust <input type="checkbox"/> Government Unit <input type="checkbox"/> Other: _____			
Home office address	City	State	ZIP code
County	Phone no. (include area code)	Tax ID/FEIN (required)	
Business address (if different from above)	City	State	ZIP code
Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give the legal names, federal tax ID no. and number of employees employed by each.			
Legal name	Federal tax ID no.	No. of employees	
In the past 36 months, has the company or any affiliate entity filed for protection or operated under federal/state bankruptcy law (Chapter 11 or 7) or state receivership? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity to be placed voluntarily into bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your group have a cafeteria plan under IRS Section 125? <input type="checkbox"/> Yes <input type="checkbox"/> No			
For 24 hour coverage, list eligible owners and officers (additional premium required)			
Name	Name	Name	

### Section 3: Medical plan(s) – The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

Plan selected	Contract code

**Section 3: Medical plan(s) – Continued**Is this plan intended to replace any existing group medical coverage? ☐ Yes ☐ No

If yes, complete the information below for each group medical insurance plan you now have.

Insurer	Type of plan (HMO, EPO, PPO)	Effective date (MMDDYYYY)	Proposed termination date

**Section 4: Specialty plan(s) – The benefits you have selected are outlined on the proposal, herein incorporated by reference.****Dental coverage**

Plan selected: \_\_\_\_\_ Contract code: \_\_\_\_\_

Plan selected: \_\_\_\_\_ Contract code: \_\_\_\_\_

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No

If yes, complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, EPO, PPO)	Effective date (MMDDYYYY)	Proposed termination date

**Vision coverage**

Plan selected: \_\_\_\_\_ Contract code: \_\_\_\_\_

Plan selected: \_\_\_\_\_ Contract code: \_\_\_\_\_

**Life coverage – Please check all that apply and attach your quote/proposal with the application.****A minimum of two employees must enroll.****Life/AD&D products****Choose life product:**

- ☐ None
 ☐ Basic Life & AD&D
 ☐ Optional Supplemental/Voluntary Life and AD&D  
☐ Basic Dependent Life
 ☐ Optional Supplemental/Voluntary Dependent Life

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible employees is 30 hours per week unless otherwise indicated.

**Prior life coverage**Do you have any existing life insurance with this or any other company? ☐ Yes ☐ No

Do you intend with the purchase of this insurance to replace, terminate or change the value of any existing life insurance with this or any other company?

☐ Yes ☐ No

If yes, provide information below for each policy or contract being replaced and attach any applicable replacement forms:

Insurance company name	Policy/contract no.	Termination date (MMDDYYYY)

**Disability coverage – Please check all that apply and attach your quote/proposal with the application.****A minimum of two employees must enroll.****Disability products****Choose disability product:**

- ☐ None
 ☐ Short Term Disability
 ☐ Voluntary Short Term Disability  
☐ Long Term Disability
 ☐ Voluntary Long Term Disability

If disability benefits are selected, indicate whether the employee pays disability premiums on a pre- or post-tax basis. If it varies by class, attach additional page with class-level information.

Short Term Disability: ☐ Pre tax ☐ Post taxVoluntary Short Term Disability: ☐ Pre tax ☐ Post taxLong Term Disability: ☐ Pre tax ☐ Post taxVoluntary Long Term Disability: ☐ Pre tax ☐ Post tax

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible employees is 30 hours per week unless otherwise indicated.

Group name

### Prior disability coverage

Do you have any existing disability insurance with this or any other company? ☐ Yes ☐ No

Do you intend with the purchase of this insurance to replace, terminate or change the value of any existing disability insurance with this or any other company?  
☐ Yes ☐ No

If yes, provide information below for each policy or contract being replaced and attach any applicable replacement forms:

Insurance company name	Policy/contract no.	Termination date (MMDDYYYY)

### Participation requirements

Refer to the Life and Disability Proposal for life and disability participation requirements.

## Section 5: Eligibility

No. of eligible full-time employees (minimum 30 hours per week including those within their waiting period): \_\_\_\_\_

Total no. of employees (including part-time): \_\_\_\_\_

Total no. of employees residing/working outside of home office state: \_\_\_\_\_

Eligible enrollees as of this plan's effective date will have coverage (Only one waiting period is allowed per group and will impact all full-time employees.)

☐ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on

The day after: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days of employment

OR

First of the month after: ☐ 0 days ☐ 30 days ☐ 60 days

Do you wish to offer coverage for Domestic Partner? ☐ Yes ☐ No

## Section 6: Contribution requirements

### Contribution and minimum participation requirements

Employer must have at least one employee enrolled in GFB to maintain benefits and two employees enrolled in GCF to maintain benefits under this plan. Group minimum participation for health: 50% of Net Eligible Employees. Net Eligible Employees = total number of eligible employees less those employees with other valid health coverage. Flat contribution amounts are not allowed. There is no minimum contribution percentage required for dental and/or vision.

Choose your group contribution level for each month:

Medical: \_\_\_\_\_ % per employee \_\_\_\_\_ % per dependent (optional)

Dental: \_\_\_\_\_ % per employee \_\_\_\_\_ % per dependent (optional)

Vision: \_\_\_\_\_ % per employee \_\_\_\_\_ % per dependent (optional)

Basic Life & AD&D: \_\_\_\_\_ %

Basic Dependent Life: \_\_\_\_\_ %

Optional Supplemental/Voluntary Life and AD&D: 0%

Optional Supplemental/Voluntary Dependent Life: 0%

Short Term Disability: \_\_\_\_\_ % Voluntary Short Term Disability: 0%

Long Term Disability: \_\_\_\_\_ % Voluntary Long Term Disability: 0%

For Health Savings Account (HSA) plans:

Do you want Anthem Blue Cross and Blue Shield to facilitate opening a HSA Financial Custodian (bank) account? ☐ Yes (requires completion of questionnaire) ☐ No

HSA administrator name	Phone no. (include area code)	Email address

## Section 7: Electronic Access of Group Information by Agent/Producer/Broker/General Agent

### Contribution and minimum participation requirements

We, the employer, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem Blue Cross and Blue Shield or Anthem Life to access the group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/producer/broker/general agent is also hereby authorized to use the EmployerAccess system of Anthem Blue Cross and Blue Shield and/or Anthem Life to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker/general agent changes. The agent/producer/broker/general agent must maintain original employee/member enrollment documentation, and shall make them available upon Anthem's request.

Select this box ☐ ONLY if the employer DOES NOT want to authorize the agent/producer/broker/general agent to access and change the group's information on behalf of the group. **Do not select this box if you consent.**

**Section 8: Read this section carefully before signing. Please review your application for errors or omissions.**

With respect to your medical plan, the employer and/or authorized representative hereby requests that Anthem Blue Cross and Blue Shield administer certain health care benefits of employer's self-insured group health plan pursuant to the terms of Anthem Blue Cross and Blue Shield's administrative services agreement with GCF Benefit Plan or GFB Member Health Program. With respect to your vision, dental and/or life plans, the employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield and Anthem Life and agrees to be bound by the governing rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premium or premium equivalent rates; and the authorized representative certifies:

1. To comply with all terms and provisions of the participation agreement between the employer and the GCF Benefit Plan or the GFB Member Health Program, as applicable.
2. To make the health care benefits available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as agreed.
3. To maintain records and furnish to Anthem Blue Cross and Blue Shield or their designated agent(s), any information required in connection with administration of the health care benefits.
4. To provide notice of any applicable rights to continue health care benefits under COBRA/State Continuation and life insurance conversion to eligible employees and eligible dependents.
5. That acceptance of this application may cancel any prior contract(s) or administrative services agreement with Anthem Blue Cross and Blue Shield effective immediately preceding the effective date of the administration of health care benefits.
6. To pay Anthem Blue Cross and Blue Shield by the invoice due date, the applicable premium and/or premium equivalent rate on behalf of each member enrolled for health care benefits, to submit applications of employees prior to their date of eligibility to keep all necessary records regarding membership, to assume responsibility for handling the COBRA/State Continuation process, if applicable.
7. That claims filed by or on behalf of members may, at Anthem Blue Cross and Blue Shield's option, be suspended if applicable premium and/or premium equivalent rates are not timely received.
8. If applicable, employer will receive on behalf of the members, all notices delivered by Anthem Blue Cross and Blue Shield, and immediately forward such notices to persons involved, at their last known address.
9. That in order to accept or decline this application, all the information requested on this application must be completed. In the event the application is not completed, Anthem Blue Cross and Blue Shield, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The applicable premium and/or premium equivalent rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents by the employer. Anthem Blue Cross and Blue Shield, on behalf of GCF and GFB, reserves the right to review such applicable premium and/or premium equivalent rates upon receipt of all individual applications for employers' employees and to modify the applicable premium and/or premium equivalent rates, if the enrollment information so warrants.
10. This entire application has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
11. All employees applying for benefits are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. With respect to vision, dental and/or life coverage, eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligible waiting period.
12. The agreement for employer is not in effect unless and until this application is accepted by Anthem Blue Cross and Blue Shield or by Anthem Blue Cross and Blue Shield on behalf of GFC Benefit Plan or GFB Member Health Program as applicable and an employee's health care benefits are not in effect unless and until the employee enrolls.
13. The authorized representative of the employer acknowledges and understands the following:  
The Plan ("Arrangement") is a multiple employer self-insured health plan, and benefits are not guaranteed by a licensed insurer.
  - a) The Arrangement is not covered by the Georgia Life and Health Guaranty Association.
  - b) This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan Arrangement is unable to pay its obligations, Participating Employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations, subject to the terminal liability provisions of the governing Participation Agreement.
  - c) If the Arrangement fails to make up the deficiency or make the required assessment within thirty (30) days after the Commissioner orders it to do so or if the deficiency is not fully made up within sixty (60) days after the date on which any such assessment is made or within such longer period as may be specified by the Commissioner, the plan shall be deemed to be insolvent.
  - d) A terminal liability provision in the excess loss policy requires the reinsurer of the Arrangement to pay any unpaid liabilities of the Arrangement should the Arrangement be terminated. The Participating Employers will be notified if this provision is removed, thus allowing the Participating Employer to terminate their participation without further liability.
  - e) Certain other major protections offered to Georgia residents under the Georgia Insurance Code and Rules and Regulations, such as conversion rights and certain mandated or required benefits, may not be available through the Arrangement.
14. The broker(s) listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem Blue Cross and Blue Shield if this authorization is revoked.
15. With respect to vision, dental, and/or life coverage, Employer agrees to the following:
  - a) All terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, govern and Employer will enrollment under the Anthem Life trust policy(ies), if applicable.
  - b) Statements of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem Life.
  - c) The advance premium payment does not create temporary or interim coverage, and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem Life's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem Life except to refund the payment. The employer will be responsible for returning to individual.
  - d) STD benefits for employees eligible for state disability plans in CA, HI, NJ, NY, PR or RI will be integrated with the state mandated program in that state. The volume calculated for monthly premium will be based on the total benefit amount, and not reduced by the state mandated benefit.

Authorized signer signature

X

Title

Date (MMDDYYYY)

**Section 9: Broker certification**

I hereby certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
3. I have not signed any of the applications for the employer or any of its eligible employees.
4. I have advised the group that failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date or re-rating of the group's premium equivalent rate retroactive to the effective date. Health care benefits shall not be effective until Anthem Blue Cross and Blue Shield reviews and accepts the application.

Broker signature <b>X</b>			Broker name			Date (MMDDYYYY)		
<b>Writing payable/sub-agent/producer/broker</b>			_____ %			<b>Second writing payable/sub-agent/producer/broker (if applicable)</b>		
Agency name			Agency tax ID no.			Agency name		
Agent/producer/broker name			Broker license no.			Agent/producer/broker name		
Agent/producer/broker ID no.			Broker encrypted TIN			Agent/producer/broker ID no.		
Payable/sub-agent/producer/broker ID no. if different						Payable/sub-agent/producer/broker ID no. if different		
Street address						Street address		
City			State ZIP code			City		
Phone no.			Fax no.			Phone no.		
Email address						Email address		
Signature <b>X</b>			Date (MMDDYYYY)			Signature <b>X</b>		
<b>For general agent/producer/broker use only</b>								
General agent/producer/broker name			Agent/producer/broker ID no.					
Street address			City			State ZIP code		