

REQUESTED EFFECTIVE DATE (MM/DD/YYYY)
 (NO RETROACTIVE CHANGES)

**2-99 EMPLOYER APPLICATION
 Exhibit B**



An Independent Licensee of the Blue Cross and Blue Shield Association

CIRCLE SECTIONS TO BE CHANGED: I II III

NEW
 Change to existing group: GROUP #

**PLEASE FULLY COMPLETE ALL SECTIONS OF THIS APPLICATION
 EVEN WHERE SPECIFIC PROVISIONS REMAIN UNCHANGED.**

SECTION I - EMPLOYER GROUP INFORMATION											
LEGAL COMPANY NAME					DBA						
ARIZONA LOCATION STREET ADDRESS					CITY		STATE ZIP CODE AZ				
ARIZONA BILLING ADDRESS					CITY		STATE ZIP CODE AZ				
COUNTY					FEDERAL ID NUMBER / TAX ID NUMBER		ARIZONA STATE TAX ID NUMBER				
HEADQUARTERS LOCATION - STREET ADDRESS (IF DIFFERENT THAN ABOVE)					CITY		STATE ZIP CODE				
TYPE OF BUSINESS					CONTACT PHONE NUMBER		FAX				
EXECUTIVE NAME			TITLE		E-MAIL						
GROUP ADMINISTRATOR			TITLE		E-MAIL						
LEGAL ENTITY <input type="radio"/> CORP. <input type="radio"/> LLC <input type="radio"/> PARTNERSHIP <input type="radio"/> SOLE PROPRIETORSHIP <input type="radio"/> POLITICAL SUBDIVISION/MUNICIPALITY <input type="radio"/> NON ARIZONA BASED ENTITY WHICH MEETS BCBSAZ UNDERWRITING GUIDELINES <input type="radio"/> OTHER											
SECTION II - PLAN INFORMATION - INDICATE HEALTH / DENTAL PLAN SELECTED											
BLUE PREFERRED STAND ALONE (PPO) <input type="radio"/> PLAN 100 90/70 <input type="radio"/> PLAN 100 90/70 COPAY <input type="radio"/> PLAN 250 90/70 COPAY <input type="radio"/> PLAN 250 80/60 COPAY <input type="radio"/> PLAN 500 80/60 COPAY <input type="radio"/> PLAN 1000 80/50 COPAY <input type="radio"/> PLAN 2000 80/50 COPAY		BLUE PREFERRED SAVER <input type="radio"/> PLAN 1000 80/50 <input type="radio"/> PLAN 2600 80/50 <input type="radio"/> PLAN 2600 100/50 <input type="radio"/> PLAN 5000 100/50		BLUE PREFERRED BASIC <input type="radio"/> PLAN 250 BASIC <input type="radio"/> PLAN 500 BASIC <input type="radio"/> PLAN 1000 BASIC		BLUE SELECT STAND ALONE (HMO) <input type="radio"/> SELECT 10 <input type="radio"/> SELECT 20 DUAL OPTION <input type="radio"/> SELECT 10 AND PREFERRED 250 90/70 COPAY		DENTAL / CHIROPRACTIC / LIFE, ANCILLARY PRODUCTS <input type="radio"/> DENTAL CHOICE <input type="radio"/> DENTAL CHOICE with ortho <input type="radio"/> CHIROPRACTIC OTHER <input type="radio"/>		<input type="radio"/> LIFE <input type="radio"/> DEPENDENT LIFE <input type="radio"/> STD <input type="radio"/> LTD GROUPS ARE UNDERWRITTEN BY MEDICAL LIFE INSURANCE COMPANY, OR FORT DEARBORN LIFE INSURANCE COMPANY	
SECTION III - UNDERWRITING, ENROLLMENT, ELIGIBILITY, MANAGEMENT CONTINUATION AND PARTICIPATION											
1) FOR ALL ELIGIBLE EMPLOYEES, THE EMPLOYER AGREES TO CONTRIBUTE AN AMOUNT EQUAL TO 50-100% OF THE EMPLOYEE'S PREMIUM. PLEASE REFER TO UNDERWRITING GUIDELINES FOR COMPLETE ELIGIBILITY, CONTRIBUTION AND PARTICIPATION REQUIREMENTS. (IF ELIGIBLE FOR RETIREE COVERAGE, SEE SECTION VI.)											
DEFINE EMPLOYEE CLASSIFICATION AND INDICATE EMPLOYER CONTRIBUTION BY DOLLAR AMOUNT OR PERCENTAGE		CLASS 1 DEFINITION			HEALTH CONTRIBUTION		EMPLOYEE		DEPENDENT		
		CLASS 2 DEFINITION			→		EMPLOYEE		DEPENDENT		
2) EMPLOYEES ARE ELIGIBLE UPON COMPLETION OF THE FOLLOWING SPECIFIED EMPLOYEE'S ENROLLMENT WAITING PERIOD:		CLASS 1 <input type="text"/> DAYS MONTHS		CLASS 2 <input type="text"/> DAYS MONTHS		3) NEW GROUP ENROLLMENT REGULATIONS EMPLOYER'S ENROLLMENT WAITING PERIODS WILL BE WAIVED AT THE NEW GROUP'S INITIAL ENROLLMENT <input type="radio"/> YES <input type="radio"/> NO					
4) EMPLOYEE EFFECTIVE / TERMINATION DATE <input type="radio"/> FIRST DAY OF THE BILLING MONTH FOLLOWING COMPLETION OF ENROLLMENT WAITING PERIOD / <input type="radio"/> LAST DAY OF THE BILLING MONTH FOLLOWING LOSS OF ELIGIBILITY					OTHER <input type="radio"/>						
5) FULL TIME EMPLOYEES ARE DEFINED AS THOSE WORKING: <input type="radio"/> A MINIMUM OF 25 HOURS PER WEEK <input type="radio"/> OTHER					6) TOTAL NUMBER OF EMPLOYEES (INCLUDING THOSE IN ENROLLMENT WAITING PERIOD) TOTAL FULL TIME EMPLOYEES: <input type="text"/> TOTAL PART TIME EMPLOYEES: <input type="text"/> TOTAL NUMBER OF EMPLOYEES: <input type="text"/>						
7) TOTAL NUMBER OF EMPLOYEES ELIGIBLE FOR COVERAGE		8) TOTAL NUMBER OF ARIZONA EMPLOYEES ENROLLED FOR COVERAGE		9) TOTAL NUMBER OF OUT OF STATE EMPLOYEES ENROLLED FOR COVERAGE		10) NUMBER OF EMPLOYEES TERMINATED IN THE LAST 12 MONTHS		11) IS THE GROUP ELIGIBLE FOR COBRA? <input type="radio"/> YES <input type="radio"/> NO		IF YES, NUMBER OF COBRA CONSTITUENTS <input type="text"/>	
12) BANKRUPTCY A) IN THE PAST 36 MONTHS, HAS THE COMPANY OR ANY AFFILIATED ENTITY FILED FOR PROTECTION OR OPERATED UNDER FEDERAL / STATE BANKRUPTCY LAWS? <input type="radio"/> YES <input type="radio"/> NO B) IN THE PAST 36 MONTHS, HAS ANY CREDITOR FILED OR THREATENED TO FILE A PETITION REQUESTING THE COMPANY OR ANY AFFILIATED ENTITY TO BE PUT INTO BANKRUPTCY? <input type="radio"/> YES <input type="radio"/> NO											
13) WORKER'S COMPENSATION A) DOES THE EMPLOYER PROVIDE WORKER'S COMPENSATION FOR ALL EMPLOYEES INCLUDING THE OWNER? <input type="radio"/> YES <input type="radio"/> NO			B) IF NO, LIST THE EMPLOYEES NOT COVERED AND INDICATE REASON FOR NO COVERAGE BELOW			14) HOW MANY PREVIOUS GROUP HEALTH CARRIERS HAS THE GROUP HAD IN THE LAST FIVE YEARS?		15) LIST OTHER CO-EXISTING CARRIERS			
1 NAME OF PERSON NOT COVERED: REASON NOT COVERED:					2 NAME OF PERSON NOT COVERED: REASON NOT COVERED:						
SECTION IV - BROKER INFORMATION											
LAST NAME					FIRST NAME						
AGENCY NAME Assurance Benefits											
SUITE NO.		STREET ADDRESS PO Box 41454									
CITY Phoenix							STATE AZ	ZIP + FOUR 85080			
PHONE NUMBER (INCLUDE AREA CODE) 623 322 4608		FAX NUMBER (INCLUDE AREA CODE) 623 322 4607		E-MAIL							
BROKER TAX ID NUMBER			BCBS BROKER NUMBER			ARIZONA DEPARTMENT OF INSURANCE LICENSE NUMBER					
ON FILE											

SECTION V - THIS SECTION APPLIES ONLY TO GROUPS OF 26 OR MORE ELIGIBLE EMPLOYEES

PLEASE COMPLETE THE FOLLOWING QUESTIONS WHEN APPLYING FOR NEW GROUP COVERAGE TO THE BEST OF YOUR KNOWLEDGE. THIS INFORMATION IS NECESSARY TO EVALUATE YOUR GROUPS APPLICATION BY BLUE CROSS BLUE SHIELD OF ARIZONA. IN ORDER TO PROTECT THE INDIVIDUALS INVOLVED, DO NOT DISCLOSE THE NAME OF ANY EMPLOYEE OR DEPENDENT.

Are you aware of any employee, dependent, or COBRA employee who:

- a) is currently disabled? _____ YES NO
- b) incurred expenses of \$5,000 or more in the last 18 months? _____ YES NO
- c) has been advised that necessary surgery or hospitalization is required (including pregnancy)? _____ YES NO
- d) has had an organ transplant such as kidney, liver, heart or lung? _____ YES NO
- e) is currently being treated or diagnosed as having cancer, heart/lung disease, high blood pressure, diabetes, muscular skeletal condition? _____ YES NO
- f) is currently taking medication? _____ YES NO
- g) has been diagnosed or is being treated for any other known medical condition? _____ YES NO
- h) has any other known medical conditions? _____ YES NO

If yes to any of the questions above, please explain: _____

SECTION VI - RETIREE COVERAGE AND DOMESTIC PARTNER COVERAGE IS ONLY AVAILABLE FOR GROUPS OF 51 OR MORE ENROLLED EMPLOYEES

RETIREMENT ELIGIBILITY	RETIREEES TO BE COVERED? <input type="radio"/> YES <input type="radio"/> NO	IF YES: <input type="radio"/> UNDER 65 <input type="radio"/> 65 AND OLDER	RETIREEES DEPENDENTS TO BE COVERED? <input type="radio"/> YES <input type="radio"/> NO	OTHER THAN NEWBORNS, ETC. FOR WHICH COVERAGE MAY BE MANDATED UNDER APPLICABLE ARIZONA LAW
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RETIREMENT PARTICIPATION REQUIREMENTS

A) RETIREE MUST COMPLETE _____ YEARS OF SERVICE PRIOR TO RETIREMENT | B) RETIREE IS ELIGIBLE FOR COVERAGE ONLY THROUGH END OF BILLING PERIOD IN WHICH RETIREE REACHES AGE _____

C) OTHER: _____

DOMESTIC PARTNERS TO BE COVERED? <input type="radio"/> YES <input type="radio"/> NO	IF YES, GROUP ACCEPTS BCBSAZ DOMESTIC PARTNER CRITERIA AS DEFINED IN THE DECLARATION OF DOMESTIC PARTNERSHIP.
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SECTION VII - IMPORTANT - READ CAREFULLY

I certify the Company is the sole employer of the employees to be enrolled under this contract and the information provided on this 2-99 Employer Application and all other applicable documents provided is complete and accurate. The Company shall notify Blue Cross Blue Shield of Arizona (BCBSAZ) promptly of any changes in this information that may effect the eligibility of employees or their dependents, including the addition of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the employer. I understand any and all Health/Medical and other information may be verified by outside sources, or other investigative firms, which BCBSAZ deems appropriate for finalizing its approval. BCBSAZ reserves the right to retroactively adjust the rates provided if information, including medical information, subsequently received, regardless of how BCBSAZ learns of the information, indicates this information was incomplete or inaccurate or that a material misrepresentation was made in the application, and such information would have affected the rate calculation. Further, the proposal quotation may be invalidated, withdrawn or an enrolled group may be terminated.

Acceptance of this Application is subject to final approval by BCBSAZ and shall be based upon information supplied by the group, the requested benefits, and any other information obtained from outside sources which BCBSAZ deems appropriate. Such acceptance shall be evidenced by the execution of this Application by an authorized representative of BCBSAZ, at which time this Application shall become binding upon BCBSAZ. Upon acceptance, this Application shall be attached to and shall become a part of the Group Master Contract (the "Contract"). The Contract may be terminated by BCBSAZ for the Group's failure to meet certain obligations under the contract, including, but not limited to, maintaining the agreed-upon Group contribution and employee and/or dependent participation levels as set forth in the Contract, in accordance with A.R.S. Sec. 20-2301 et seq., as applicable.

I understand by including my e-mail address on the reverse side, I am authorizing BCBSAZ to send me information via e-mail. I also understand I may change my e-mail address or rescind this permission at any time by contacting BCBSAZ through www.azblue.com.

Company Authorized Officer / Owner / Partner

X _____
SIGNATURE DATE

_____ TITLE LOCATION (CITY, STATE)

X _____
BCBSAZ Authorized Signature: DATE TITLE

To be completed by BCBSAZ
Team Code _____
GROUP # _____