



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association



Companion Life is a separate life insurance company that does not provide BlueCross BlueShield of South Carolina products or services. Companion Life is solely responsible.

MEMBERSHIP APPLICATION

SM Service Mark of the Blue Cross and Blue Shield Association.

*Registered Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI) 2. Birthdate 3. Male Female
4. Address: (Street) (City) (State) (ZIP)
5. Employee Social Security Number: 6. Home Phone: () - E-mail:
7. Name of Employer: 8. Group No.:
9. Dept. No.: 10. Effective Date of Action Requested: / /

REASON FOR APPLICATION

11. New Member - I am a full-time employee working at least 30 hours per week, 48 weeks per year? Yes No Full-time Date of Hire: / /
Coverage Change - Reason for Change: Date of Occurrence:
Late Enrollee Address Change Beneficiary Change Cancellation - Date Left Employment: / /
Reinstatement - Reason: Return from Layoff Return from Leave Cancellation Error
COBRA Qualifying Event: Start Date: / /
State Continuation - Start Date: / /
Sponsored Membership - Sponsored Member's Social Security Number: - -

COVERAGE INFORMATION Plan Offered by Employer: Business BlueSM Complete (Preferred Blue) Business BlueSM Secure Business BlueSM Basic
PPO HDHP HDHRA

12. MEDICAL ELECTION
Employee Only Employee/Spouse
Employee/Child(ren) Family
No Medical Coverage due to: (Check one)
Other BlueCross BlueShield of SC Coverage (01)
Covered by Military (03)
Insurance with Another Company (02)
Covered by Medicare (12)
Covered by Spouse with this Employer (07)
Other (05) (Explain)

13. DENTAL ELECTION Business Blue Complete (Preferred Blue, HDHP and HDHRA) Only
Employee Only Employee/Spouse Employee/Child(ren) Family No Dental Coverage
14. LIFE COVERAGE (underwritten by Companion Life)
Life Only (No Medical) Life and AD&D Dependent Life STD LTD
Life Amount \$ Life Class
Earnings \$ Hourly Weekly Biweekly Monthly Annually
Beneficiary Designation (All Plans - applicable only if Life Coverage is available and selected)
Primary: Relationship:
Contingent: Relationship:

ENROLLMENT INFORMATION (List all individuals to be covered.)

Table with 7 columns: 15., Last Name, First Name, Birthdate (mm/dd/yyyy), Male or Female, Social Security Number, Full-Time Student* (Yes/No)

(*Age 19 through 22 Only) Please attach Registrar's letter or tuition receipt showing credit hours. This is required before coverage can become effective for this dependent.)

OTHER COVERAGE INFORMATION

16. Other than your coverage with this employer, do you or any of your family members have other health (including Medicare), dental or drug coverage? Yes No
If yes and the policy is with Blue Cross and Blue Shield of South Carolina, please indicate the Policyholder's ID Number:
17. Did you or any of your family members have health or dental coverage in effect prior to your coverage under this policy? Yes No
If yes, please attach a copy of the applicable Certificate of Coverage or other proof so that we can determine if you are eligible for credit toward your waiting period for pre-existing conditions.

EMPLOYEE CERTIFICATION Authorization to Release Information and Statement of Understanding

I hereby authorize the release of any medical or non-medical information about myself or eligible or enrolled dependents by any insurance company, medical professional, medical institution or other healthcare provider concerning the diagnosis, the treatment, and prognosis of any health condition, including drug or alcohol abuse. This authorization for release of my (our) past, present and future information, to include Medicare Parts A and B claims, is for eligibility determination for coverage or review or investigation of a claim. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and my employer. I also understand that my coverage may be voided or terminated or claims denied if material misstatements or misrepresentations have been made on this application subject to the Time Limit on Certain Defenses provisions. The statements made herein are complete and true to the best of my knowledge.

If I do not elect to receive coverage under the group plan offered by my employer and currently do not have other health insurance coverage, I understand that if I wish to enroll later, I will be excluded from coverage for twelve months, then subject to pre-existing conditions for six months.

Signature: Date:

HEALTH STATEMENT 2 - 24 Enrolled Employees

www.SouthCarolinaBlues.com

Name: _____ Employee Social Security #: _____ - _____ - _____

Name of Employer: _____

Employee: Height: _____ ft. _____ in. / Weight: _____ lbs. Spouse: Height: _____ ft. _____ in. / Weight _____ lbs.
(if coverage is to include spouse)

The following questions apply to **ALL** persons, including dependents, applying for coverage. Please provide details of any "yes" answers in the space provided or in an attached and signed document. In the past ten (10) years, have you or any persons listed on the application been diagnosed, treated or advised to seek treatment or testing, or had symptoms related to any of the following:

1. Blood Disorders/ Circulatory System
 Yes No

Anemia Aneurysm Angina/Chest Pain Angioplasty/By-Pass Blood Clot Carotid Artery Disease
 Congestive Heart Disease Coronary Artery Disease Elevated Cholesterol/Triglycerides Heart Attack Heart Murmur
 Hemophilia Irregular Heartbeat Phlebitis Polycythemia Vera Sickle Cell Stroke Varicose Veins
 High Blood Pressure (Last three readings/date (Ex. 120 / 80 03 / 13 / 04))
 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
 Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

2. Bones/Injuries/ Muscles and Tissues
 Yes No

Rheumatoid Arthritis Arthritis (Other) Broken/Fractured Bones Bulging/Herniated Disc Fibromyalgia
 Lupus Necrosis Back/Neck Disorder (specify) _____ Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

3. Congenital Anomalies/ Birth Defects
 Yes No

Cleft Lip Cleft Palate Polycystic Kidney Spina Bifida Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

4. Digestive System
 Yes No

Cirrhosis of Liver Hepatitis (specify type) _____ Other Liver Disorder (specify) _____
 Crohn's/Ulcerative Colitis Colon Disorders (specify) _____ Gallbladder
 Hernia (specify type) _____ Pancreatitis Reflux Ulcer (specify) _____ Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

5. Endocrine System
 Yes No

Diabetes: Oral Medication _____ Dosage _____
 Daily Insulin Dosage AM Units _____ PM Units _____
 Last three Blood Sugar Readings (Ex. 140 03 / 13 / 04)
 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
 Cystic Fibrosis Goiter Gout Pituitary Dwarfism Thyroid Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

6. Infectious/Parasitic Conditions
 Yes No

HIV/AIDS Sarcoidosis Tuberculosis Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

7. Mental Health Conditions/Substance Abuse
 Yes No

Alcohol Abuse Anxiety/Depression Bipolar Drug Abuse Anorexia Bulimia
 Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**8. Nervous System/
Sense Organs**
 Yes No

Alzheimer's Disease Cataract Cerebral Palsy Deviated Nasal Septum Chronic Ear Infection
 Epilepsy/Seizures Glaucoma Headaches/Migraines Multiple Sclerosis Muscular Dystrophy
 Paralysis Parkinson's Disease Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**9. Reproductive System/
Urinary System**
 Yes No

Abnormal Pap Smear (Last three Pap Readings (Ex. normal 03 / 13 / 04))
 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
 Bladder Disorder (specify) _____ Breast Disorder (specify) _____
 Endometriosis/Adhesions Infertility Kidney Stones Kidney Disorder (specify) _____
 Pregnant (due date ____/____/____) Current Pregnancy Complications
 Prostate Disorder (specify) _____ Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

10. Respiratory System
 Yes No

Allergies Asthma Chronic Sinusitis Emphysema Chronic Bronchitis Pneumonia
 Shortness of Breath Sleep Apnea Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

11. Transplant
 Yes No

Organ (type(s)) _____ Bone Marrow
 Surgery Advised or Pending Yes No Surgery Completed Yes No Date Completed _____
 Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**12. Tumor/Cancer/Polyps/
Cyst**
 Yes No

Brain Breast Colon Hodgkin's Disease Leukemia/Lymphoma Lung Melanoma
 Pancreatic Polyps (specify type) _____ Prostate Sarcoma Testicular Other (specify) _____
 Patient Name's _____ Date Diagnosed _____
 Stage/Level _____ Malignant Benign
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**13. Symptoms, Conditions
or Treatment not listed
above**
 Yes No

Abnormal Lab, Test or Physical Exam Results Pain, Discomfort or Abnormality Not Yet Seen by a Physician
 Treatment or Surgery Advised But Not Yet Done Condition _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

14. Current Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication _____	Medication _____	Medication _____
	Patient's Name _____	Patient's Name _____	Patient's Name _____
	Diagnosis _____	Diagnosis _____	Diagnosis _____

I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form part of my application for group insurance, and that such insurance will not become effective until such application has been approved by Blue Cross and Blue Shield of South Carolina and/or Companion Life Insurance Company.

PRINT NAME _____

SIGNATURE _____ DATE _____



ENROLLMENT CHECKLIST FOR NEW GROUPS SIZE 2 – 50 AND FOR CHAMBER GROUPS WITH 51-99 LIVES

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Group Name: _____ Requested Effective Date: _____

Agent Name: _____ Agent Number: _____ / _____

REQUIRED INFORMATION

Please Note: Missing information will delay case submission and could result in a change of the requested effective date.

AGENT

- Group Request for Coverage
- Application for Group Health Insurance
- Companion Life Master Application
- Current Proposal with Census – must match membership applications and benefits selected on Group Request for Coverage.

EMPLOYER

- *Premium Binder Check – The check should be made payable to BlueCross BlueShield in the amount of \$_____.
- *Name of Workers Compensation Carrier
- *SC Employer Quarterly Contribution & Wage Report UCE-101 & UCE-120
Note: Please indicate current employment status for each employee listed. If Quarterly Wage Statement is not available, see reverse for documentation needed to establish business eligibility.
- *Current Carrier Bill – to give credit for prior coverage, we need current carrier's billing statement for most recent month. If the bill has no original effective date of health coverage, we will need current carrier's bill for the 12th month prior to your requested effective date or **Certificates of Creditable Coverage to include beginning and ending date.

EMPLOYEE

- **Membership Applications – must be completed by all full-time eligible employees to include COBRA and State Continuation. Waivers and refusals must complete a Membership Application in its entirety, including dates of hire, date of birth and other health insurance information. Sponsored Members (**dependents previously covered by Blue Cross and Blue Shield of South Carolina under the employee's social security number**) must complete a separate Membership Application for continuation of coverage. To ensure credit to the dependent for prior coverage, the dependent's social security number should be placed in the **Sponsored Member Social Security Number** field and the employee's social security number should be placed in the **Employee Social Security Number** field on the Membership Application.
- **Personal Health Statements – must be completed for groups with less than 25 enrolled full-time employees or if life insurance is greater than \$50,000.
- **Full-time Student Dependent ages 19 through 22 – letter from school registrar's office or tuition receipt with number of credit hours is required before coverage can become effective for this dependent.

- * **GROUP ADMINISTRATOR SHOULD HAVE THESE ITEMS AVAILABLE.**
- ** **REMINDEMPLOYEES TO BRING APPROPRIATE INFORMATION ON ENROLLMENT DATE.**

COMMENTS: _____

THANK YOU FOR YOUR BUSINESS!

BUSINESS DOCUMENTATION FORMS

The information below explains the type of documentation needed to determine group eligibility for our most common types of business.

Most groups will file a Quarterly Wage report (QW) (forms UCE – 101 & UCE – 120). The most current QW report must be provided. The QW report must indicate the current employment status of each employee listed – for example, full-time, part-time, terminated (provide termination date), seasonal or in probationary period (provide date of hire).

The following documents are accepted if the owner(s) are not included on the QW.

Corporation

QW

S Corporation

QW **or**

K-1 **or** form 1065 for each owner.

Partnership

QW **or**

K-1 **or** form 1065 for each owner.

Sole Partnership

QW **or**

Schedule C

If employing only a spouse, Schedule C **or** copy of the W-2.

Limited Liability Corporation

QW **or**

If only one owner Schedule C;

If multiple owners K-1 **or** form 1065 for each owner.

Agricultural Workers/Farms

QW **or**

Federal form 943 **and** payroll records.

For Profit (Churches, Daycare and/or Nursery)

QW

Not For Profit (Churches, Youth Clubs, Charity Organizations)

Federal form 941 **and** payroll records.

New Business

The effective date of group coverage cannot be prior to the official day the business begins operations. Appropriate tax forms, as outlined above, must be submitted within 30 days of the tax-filing deadline. If the group has not filed required tax forms because the business is new, please provide a copy of the group's payroll records, copy of Business License or Secretary of State form. The group must provide us with a copy of their first filed QW report.

For a husband and wife only business, a copy of their Business License or Secretary of State form. The group must provide us with a copy of their first filed QW report.

1099 Employees

Since there is no true employee/employer relationship, these individuals are not eligible.

New Group
Administered By:
 BlueCross TCC
 Renewal
 Change (Reason): _____

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Independent Blue Cross and Blue Shield Plans.

1. Company Information Group Number: _____ - _____ - _____

Company Name: _____ Requested Eff. Date: ____ / ____ / ____

Physical Address: _____
(Street) (City) (County) (State) (ZIP)

Mailing Address: _____
(Street) (City) (County) (State) (ZIP)

Billing Address (if different from mailing address): _____
(Street) (City) (County) (State) (ZIP)

Group Located Within City Limits: Yes No SIC Code: _____ Nature of Business: _____

Identify How Taxes are Filed: Corp S Corp LLC Partnership Sole Proprietorship Agricultural/Farm
 Non-Profit For Profit New Business (not yet filed)

List Each Owner(s)/Partner(s) and the Percent of Ownership: 1. _____ / ____% 2. _____ / ____% 3. _____ / ____%

Mail ID Cards: (check one) Agent Group

Mail the New Group Package: (check one) Agent Group

2. Contact Information

Group Administrator: _____ Title: _____

Telephone: _____ - _____ - _____ Fax: _____ - _____ - _____ E-mail: _____

Agency Name: _____ Agent: _____ Agent Code: _____ - _____

Agency Administrator: _____ Telephone: _____ - _____ - _____ E-mail: _____

3. Participation Information

Eligible employees must be actively at work a minimum of 30 hours per week, 48 weeks a year.

- A. Total Employees, including Part-Time** _____
(Employers with 51 or more Employees are eligible for enhanced mental health benefits.)
- B. Full-Time Employees** _____
- C. Not Eligible**
Employees in Waiting Period _____
Husband/Wife employed with the Same Employer _____
Total _____
- D. Eligible Employees** _____
(Subtract C from B)
- E. Employees Not Electing Coverage** _____
(Employees not covered by this plan.)
- F. Enrolled Employees** _____

Total Full-Time Eligible Employees	Allowed Number of Employee(s) Not Electing Coverage
Less than 4	None
4 to 7	1
8 to 11	3
12 to 14	4
15 or more	A minimum of 60% of the total full-time eligible employees.

- Group Dental participation = 75% of those enrolled in Business BlueSM Complete plans must take dental except:
2 - 6 size groups = 100% of those enrolled in health must enroll in dental. Enrollment status must be the same for health and dental.
7 - 50 size groups with dental only coverage must have a minimum of 7 enrolled employees, with at least 75% of all full-time eligible employees enrolled.
- Health & Dental/Vision status must be the same for all members of Business BlueSM Secure.
- G. Employer Contribution** (*Minimum 25% contribution required for health. If 100%, then all full-time employees must enroll.*)
Employee Health: _____% Employee Dental: _____% Employee Life: _____%
- H. Waiting Period for New Employees** (*1st or 15th day of the month following full-time date of hire*):
Groups with 7 or more enrolled employees: 30 days 60 days 90 days 180 days
Groups with 2 - 6 enrolled employees: 90 days (*mandatory*)

I. Group Life Insurance: Participation Requirement = Same as Health (Underwritten by Companion Life)

4. Underwriting Information

Please complete ALL of the following questions:

A. Do you currently have Workers' Compensation coverage? NO YES, name of carrier: _____

B. Are there any out-of-state locations to be covered by this plan? NO YES, please list the City, State, ZIP Code and the number of Employees: _____

C. Are there any Employees who are not actively at work or disabled? NO YES, please list the Employee's name, reason not at work, nature of disability and prognosis: _____

4. Underwriting Information (continued)

D. Are there any individuals, including any dependents covered by or eligible for, State Continuation or COBRA coverage? NO YES, please list the name, qualifying date, coverage end date and the current status/prognosis.

E. List present and prior carriers for past 3 years: _____ From: _____ To: _____

_____ From: _____ To: _____

_____ From: _____ To: _____

- F. Please provide details of any of the following questions answered "yes" in the space provided below:
1. Have any employees or dependents to be covered incurred claims in excess of \$2,500 in the last 12 months? Yes No
 2. In the past 10 years, have any employees or dependents to be covered been treated for any of the following conditions or health problems: heart or circulatory disease, diabetes, organ or tissue transplant (pending or completed) kidney failure or disease, emphysema, cystic fibrosis, cirrhosis of the liver, sickle cell anemia, AIDS, cancer of any kind, including Hodgkin's disease, leukemia, malignant melanoma, sarcoma, lymphoma or brain tumors? Yes No
 3. Are any employees or spouses now pregnant? Yes No
If yes, when is the expected due date? _____
Are multiple births expected or is there a history of pregnancy complications? Yes No
 4. In this section or in an attached signed document, please provide details of any "yes" answers to questions 1 and 2:

First Name:	Diagnosis:	Diagnosis Date(s):	Treatment:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Benefit Information

All Contracts will be issued as:

- Calendar Year Deductible
- Benefit Period Deductible

Dual Option: Yes No

If yes, choose your Dual Option combination:

Dual Options may consist of the following combinations:

- Business Blue Complete (Preferred Blue®) with HDHP
- Business Blue Complete (Preferred Blue) with Business Blue Secure
- Business Blue Secure with HDHP

- Dual options are only available to groups with seven or more employees enrolled and *may not* include a Business Blue Complete (Preferred Blue) with 90/70 coinsurance or with deductibles of \$250 or \$500.

<input type="checkbox"/> Business Blue Complete (Preferred Blue)	Coinurance:	Deductible:	Out-of-Pocket: (In/Out)	Options for Business Blue Complete (Preferred Blue): <input type="checkbox"/> \$20/\$40 Office Visit Copayment <input type="checkbox"/> Enhanced Preventive <input type="checkbox"/> \$35 /\$60 Office Visit Copayment <input type="checkbox"/> Prescription Drug Card <input type="checkbox"/> Chiropractic <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Dental Standard Option <input type="checkbox"/> Dental High Option <input type="checkbox"/> Orthodontics (13-50 enrolled)
	(pick one)	(pick one)	(pick one)	
	<input type="checkbox"/> 90/70	<input type="checkbox"/> \$250	<input type="checkbox"/> \$1,500/3,000	
	<input type="checkbox"/> 80/60	<input type="checkbox"/> \$500	<input type="checkbox"/> \$2,000/4,000	
	<input type="checkbox"/> 70/50	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$3,000/6,000	
<input type="checkbox"/> 60/40	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$5,000/10,000		
	<input type="checkbox"/> \$2,000			
	<input type="checkbox"/> \$3,000			

<input type="checkbox"/> Business Blue Secure	Coinurance:	Deductible: (In/Out)	Out-of-Pocket: (In/Out)	Options for Business Blue Secure: <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Dental/Vision
	(pick one)	(pick one)	(pick one)	
	<input type="checkbox"/> 80/60	<input type="checkbox"/> \$1,250/2,500	<input type="checkbox"/> \$1,750/3,500	Prescription Drug Options: (Must choose one) <input type="checkbox"/> Drug Card <input type="checkbox"/> Secure Card <input type="checkbox"/> Secure Card 100 <input type="checkbox"/> Secure Generic Card <input type="checkbox"/> Blue Rx SM
	<input type="checkbox"/> 70/50	<input type="checkbox"/> \$1,750/3,500	<input type="checkbox"/> \$2,250/4,500	
	<input type="checkbox"/> 60/40	<input type="checkbox"/> \$2,250/4,500	<input type="checkbox"/> \$3,750/7,500	
<input type="checkbox"/> 50/50	<input type="checkbox"/> \$3,250/6,500	<input type="checkbox"/> \$5,250/10,500		
	<input type="checkbox"/> \$4,250/8,500			
	<input type="checkbox"/> \$5,250/10,500			

APPLICATION FOR GROUP HEALTH INSURANCE GROUP AND INDIVIDUAL DIVISION

BLUE CROSS[®] AND BLUE SHIELD[®] OF SOUTH CAROLINA

An Independent Licensee of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

COLUMBIA, SOUTH CAROLINA

www.SouthCarolinaBlues.com

Application is hereby made for group health insurance for the eligible Employees and Dependents or Members of the Group (herein referred to as the Applicant.) _____ (Product Name(s)).

Name of Applicant: _____
(Company correct legal name)

Address of Applicant: _____
(Physical)

Upon approval, the Effective Date of the Contract under this application shall be 12:01 a.m., standard time on the _____ day of _____, _____, and such coverage will continue until terminated in accordance with the provisions of the Contract between the Applicant and Blue Cross and Blue Shield of South Carolina.

Classification of Eligible Employees: All full-time, active Employees working at least 30 hours a week at least 48 weeks a year for the Applicant. To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor other than substance abuse or chemical dependency; and 2) be performing the normal duties of his or her occupation at one of the Employer's normal places of business or at a location to which the Employee must travel to do his or her job.

Periods of Continuous Employment as Prerequisite to Eligibility: Coverage for new Employees hired following the Effective Date of the contract will begin: on the first monthly Effective Date following _____ days of employment
 on the first day following _____ days of employment

PARTICIPATION Requirements:

1. When the Employer pays 100% of the single coverage premium, all eligible Employees must enroll with at least single coverage.
2. When the Employer pays less than 100% of the single coverage premium:

Employee may elect not to receive coverage:

The number of Employees not electing coverage is determined by group size:

Total Full-time Eligible Employees	Allowed number of Employee(s) Not Electing Coverage
Less than 4	none
4 to 7	1
8 to 11	3
12 to 14	4
More than 15	Minimum of 60% of Total full-time must enroll.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in the group health plan or the first day of the Waiting Period for the enrollment, whichever is earlier.

Late Enrollee: An eligible Employee or Dependent who enrolls under this Contract other than during:

1. The first period in which the Employee or Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
2. A Special Enrollment period.

Late Enrollees will be excluded from coverage for 12 months then have a 6-month Pre-existing Condition Limitation.

Special Enrollment: If the Employee is eligible and not already enrolled, or if a Dependent is eligible and not already enrolled, the Corporation will allow the Employee or Dependent to enroll if each of the following is met:

1. The Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage was previously offered to the Employee or Dependent; and
2. The Employee stated in writing at the time that coverage under a Group Health Plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at the time. The plan sponsor or issuer must have given the Employee a notice of the requirement and the consequences of the requirement at the time; and
3. The Employee's or Dependent's coverage described in paragraph 1 above:
 - a. Was under a COBRA or state continuation provision and the coverage under the provision was exhausted; or
 - b. Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage or employer contribution toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, termination of employment or reduction in the number of hours of employment;
 - c. Was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.
4. The Employee requests the enrollment not later than 31 days after the date prior coverage ended due to loss of eligibility or Employer contribution stopped as described above.

If the Employee is eligible under the plan but is not enrolled, and he or she marries, the Employee and the new spouse may enroll in the plan if enrollment is requested within 31 days of the marriage.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child or a child is placed with the Employee or Employee's spouse for adoption, the new Dependent(s) may receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse may also receive coverage. However, the Employee and Employee's spouse may be subject to the Pre-existing Condition Limitation period up to 12 months. Coverage must be requested within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees other than a newborn, adopted child or child placed for adoption may be subject to the Pre-existing Condition Limitation period up to 12 months.

PRE-EXISTING CONDITION LIMITATIONS

Any services or charges for services for Pre-existing Conditions are not covered under this Contract when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to the Enrollment Date.

The Pre-existing Condition Exclusion period ends at the earliest of:

- a. The date on which the member has not received medical care, treatment or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends on or after the Effective Date of coverage; or
- b. 12 months after the Enrollment Date. In the case of a Late Enrollee, 18 months after the date the Member completes the application for coverage (See Late Enrollee).

Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.

A period of Creditable Coverage does not count if there is at least a 63-day period where the Employee or eligible Dependent was not covered under any Creditable Coverage.

Any period that an Employee or Dependent is in a Waiting Period under a Group Health Plan may not be taken into account in determining the 63-day period.

The Corporation shall count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

The Pre-existing Condition Limitations do not apply to Maternity Services or to Genetic Information in the absence of a diagnosis of the condition related to the information.

The Pre-existing Condition Limitations do not apply to a newborn child, a child who is adopted or placed with the Employee or Employee's spouse for the purpose of adoption before he or she reaches 18 years of age if the Employee applied for coverage and the premium was paid within 31 days from the birth, adoption or placement for adoption. If, however, the Employee or Dependent does not have Creditable Coverage after the end of the first 63-day period, the above newborn and adopted provisions do not apply.

If an Employee has single coverage and adds Dependents, the Pre-existing Condition Limitations apply to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.

Creditable Coverage: Benefits or coverage provided under:

1. A group health plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulation;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

This term does not include coverage for Excepted Benefits. Excepted Benefits is defined in the Contract.

The Corporation will count a period of Creditable Coverage without regard to specific health benefits covered during the period.

The period of any Pre-existing Condition exclusion is reduced or eliminated by the total periods of Creditable Coverage listed above.

It is understood and agreed that the Applicant shall pay Blue Cross and Blue Shield of South Carolina, in advance, the premiums specified in Schedule A of the Master Contract on behalf of the Applicant's Employees who meet the eligibility requirements as specified in this application and that this application when received by the Applicant, shall form a part of the Contract between Blue Cross and Blue Shield of South Carolina and the Applicant. Coverage is not effective unless and until approved by the Underwriting department at Blue Cross and Blue Shield of South Carolina's home office. The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from policyholder's funds or from funds contributed by the insured persons, or from both.

The Applicant hereby expressly acknowledges its understanding that this application constitutes a Contract solely between the Applicant and the Corporation. The Corporation is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The "Association" permits the Corporation to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and that the Corporation is not contracting as the agent of the Association.


The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Corporation and that no person, entity or organization other than the Corporation shall be held accountable or liable to the Applicant for any of the Corporation's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Corporation other than those obligations created under other provisions of this Contract.

Dated at (City) _____, South Carolina, this _____ day of _____, _____

Name of Applicant (Company Name)

**BLUE CROSS AND BLUE SHIELD
OF SOUTH CAROLINA**

By: _____
(Authorized Signature)

By: 

(Authorized Signature)



COMPANION LIFE INSURANCE COMPANY
PO Box 100102, Columbia, SC 29202-3102

COMPANION LIFE MASTER APPLICATION

New Group Application Coverage Change

Effective Date ___ / ___ / _____

Group Number _____

EMPLOYER INFORMATION

1. Company Name _____ 2. Contact _____
 3. Address _____ City _____ State _____ Zip _____
 4. Telephone (____) ____ - _____ Fax (____) ____ - _____ E-mail _____
 5. Tax ID Number _____ - _____ 6. SIC/Nature of Business _____

ELIGIBILITY All Groups

7. Normal work week for full-time employees is _____ hours. (Minimum of 30 hours per week required.)
 8. Waiting period for initial enrollment: Immediate 30 days 60 days 90 days 180 days
 Waiting period for future employees: 30 days 60 days 90 days 180 days
 Following completion of the probationary period, coverage will be effective the 1st or 15th of the month.
 9. Number of Eligible Employees: _____ 10. Number of Enrolled Employees: _____
 11. Are there any classes of ineligible employees: Yes No Explain _____
 12. Are any persons to be covered retired, currently hospitalized, disabled, or on extension of benefits?
 Yes No If yes, give details _____
 13. Are all employees to be insured covered by Workers Compensation? Yes No
 14. Current Life Insurance Carrier _____ Will this insurance replace existing insurance? Yes No
 15. Percentage of premium paid by employer: Life & AD&D _____% STD _____% LTD _____% Dep. Life _____%

COVERAGE INFORMATION Groups with 2 – 9 Lives Only

16. **Life and AD&D**
 Flat Amount Plan: \$10,000 \$15,000 \$20,000 \$30,000 \$40,000 \$50,000
 Class Plan: Class 1. _____ Amount \$ _____
 Class 2. _____ Amount \$ _____
 Class 3. _____ Amount \$ _____
 17. **Dependent Life** No Yes (Spouse \$2,000; Children \$1,000; 14 days - 6 months \$200)
 18. **Short Term Disability** No Yes
 Flat Amount Plan: \$200/week Benefit Period: 13 weeks 26 weeks
 Percent of Earnings: 60% to a maximum of \$600/week Benefits Begin: 1st day Accident; 8th day illness

Participation Agreement (administered and underwritten by Companion Life Insurance Company)

The Participant does hereby apply for Group Insurance Benefits as set forth in the above application.
 Name of Trust: Joint Employer Group Insurance Trust. It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does he or she have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy. **The undersigned employer agrees that coverage shall not commence until this application has been approved by Companion Life Insurance Company and notice of approval has been transmitted to us.** As named employer, I understand that I should not cancel any existing coverage until notified that this application has been accepted by Companion Life.

Signature of Applicant/Title _____ Date _____ / _____ / _____

Signature of Agent Broker _____ Agent Code _____ - _____ Date _____ / _____ / _____

LIFE SPECIFICATIONS *Groups of 10 and Above Only*

19. Life Insurance and Accidental Death & Dismemberment

Class Definitions (describe below)	Basic Life/AD&D	Dependent Life Insurance
Class 1. _____	\$ _____	_____ Yes _____ No
Class 2. _____	\$ _____	(\$5000)
Class 3. _____	\$ _____	
Class 4. _____	\$ _____	

- Notes: A. Basic Life & AD&D Benefits reduce 35% at age 65, and then to 50% at age 70. Benefits terminate at retirement.
 B. Waiver of Premium is provided as a continuation of Life Benefits in the event of total disability
 C. An Accelerated Death Benefit is included.

DISABILITY SPECIFICATIONS *Groups of 13 and Above Only*

20. Short Term Disability

Class Definitions (describe below)	Benefits	Accident (Days)	Illness (Days)	Duration (Weeks)
Class 1. _____	_____	_____	_____	_____
Class 2. _____	_____	_____	_____	_____
Class 3. _____	_____	_____	_____	_____
Class 4. _____	_____	_____	_____	_____

21. Long Term Disability (MINIMUM OF 6 EMPLOYEES TO BE ELIGIBLE)

Class Definitions (describe below)	Benefits	Maximum Benefit (monthly)	Minimum Benefit (monthly)	Elimination Period (days)	Maximum Duration (years)
Class 1. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 2. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 3. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 4. _____	_____ %	\$ _____	\$ _____	_____	_____

22. Benefit Integration will be as follows:

- Primary & Family Social Security (standard)
- Primary Social Security
- Primary & Family Social Security with 70% all Sources

23. Pre-existing Conditions Exclusion:

- 12/12 (Groups 6 - 24)
- 3/6/12 (Groups 25 and greater)

24. Optional policy features to be included are: _____

APPLICANT'S SIGNATURE

Quotations were based upon proposal data submitted to Companion Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Companion Life's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. Only Companion Life's Home Office has the authority to guarantee the acceptability of the requested insurance.

Signature of Applicant/Title _____ Date ____ / ____ / ____

Signature of Agent _____ Agent Code _____ - _____ Date ____ / ____ / ____



Voluntary Authorization to Disclose Protected Health Information to a Third Party

RETURN THIS FORM TO:

BlueCross BlueShield of South Carolina, Group and Individual Privacy Official, I-20 at Alpine Road (AX-E05), Columbia, SC 29219-0001 Fax Number: 803-264-0174

SECTION A – MEMBER INFORMATION (INDIVIDUAL WHOSE INFORMATION WILL BE RELEASED):

Name: (Last, First, Middle Initial) Date of Birth: Telephone Number: (including area code) Address: (Including Zip Code) Member's ID Number (as shown on the Member's identification card) or Social Security Number: Spouse's Name* (if included in this authorization): Date of Birth: Dependent's Name* age 16 or older to be included in this authorization: Date of Birth: *That person must sign this authorization below agreeing to the release of his or her protected health information.

List Dependents under age 16 to be included in this authorization:

Name: Date of Birth: Name: Date of Birth:

SECTION B – AUTHORIZED PERSON (PERSON OR ORGANIZATION RECEIVING YOUR INFORMATION):

I authorize BlueCross BlueShield of South Carolina to disclose protected health information on the above individuals to: Name: Address: Phone Number: Relationship to Member: Agent/Agency Name: David A. Crotts & Associates Address: 422 Montague Ave. - Suite #7, Greenwood, SC 29649 Phone Number: 800-803-7873 or 864-223-8788 Agency/Agent Number: 150

SECTION C – DESCRIPTION OF INFORMATION TO BE RELEASED: (TYPE OF INFORMATION THAT WILL BE USED OR DISCLOSED).

1. Please check only one: [X] I authorize BlueCross BlueShield of South Carolina to disclose any protected health information (except psychotherapy notes) that the above-name individual/entity may request. [] I authorize BlueCross BlueShield of South Carolina to disclose ONLY the following protected health information to the above-named individual/entity. 2. This authorization is made: [] At my request [] For the following purpose(s):

SECTION D – EXPIRATION AND REVOCATION: (WHEN THIS AUTHORIZATION WILL END).

Expiration: This authorization will expire 12 months after termination of coverage under BlueCross BlueShield of South Carolina policy or upon my written revocation, whichever occurs first. Revocation: I understand that I may revoke this authorization at any time by sending written notice of my revocation to the address shown above. Please note: Your revocation will not affect any action taken before receipt of your notice of revocation.

SECTION E – SIGNATURE*/DATE

I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described in Section C is not subject to federal health information privacy laws, that person or entity may further disclose the protected health information and federal privacy laws may no longer protect it. Signature: Spouse's Signature: Dependent age 16 or older Signature: Date: SIGN HERE

*If the individual's personal representative signs this authorization, the personal representative must attach legal documentation showing the authority to act as the individual's personal representative.

You should keep a signed copy of this authorization for your records; however, a copy will be provided upon your request.