BlueCross BlueShield of North Carolina

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Small Employer Quote Profile

PLEASE PRINT. DO NOT WRITE IN SHADED AREAS.
COMPLETE BOTH SIDES, IN INK.

1. This questionnaire is designed to provide information specific to your group.
2. The information will be used in evaluating the characteristics of your group and confirming eligibility requirements as part of your application for coverage.
3. Please answer all questions to the best of your knowledge.

Employer's Tax Identification Number:	Agent Name and P Number:

1. BUSINESS PROFILE

Business Name:	Telephone Number:

Business Address (Must be a Physical Street Address):	City:	State:	Zip Code:

County:	County Code:	Is your company headquartered in North Carolina? ☐ Yes ☐ No	**If no**, Business Headquarters Location (City, State):

Type of Business:	NAICS Code:

Group certifies that it meets the definition of a Small Employer as defined by the North Carolina Small Employer Group Health Insurance Reform Act. ☐ Yes ☐ No

North Carolina General Statute § 58-50-110(22b): a "Small employer" means, in connection with a nongrandfathered, nontransitional group health plan with respect to a calendar year and a plan year, an employer who meets the definition of small employer under 42 U.S.C. §18024(b)(2): An employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. The number of employees shall be determined using the method set forth in section 4980H(c)(2) of the Internal Revenue Code.

Please Read Carefully: This question is designed to restrict plan choices offered by Blue Cross NC related to the Patient Protection and Affordable Care Act, 45 C.F.R. §147.131, 45 C.F.R. §147.132 and 45 C.F.R. §147.133. — exemptions for coverage of certain preventive benefits related to contraceptive services (also includes contraceptive drugs and devices). Use 'None of the Above' for a Group Employer NOT wishing to restrict plan choices. If you have questions, contact your Agent or Blue Cross NC representative.

- ☐ By checking this box, the group is claiming a religious or moral exemption under the Patient Protection and Affordable Care Act, 45 C.F.R. §147.132 and/or §147.133.
  - ☐ Religious Employer Group (Religious employer groups are exempt from the requirement to cover contraceptive services)
  - ☐ Fully-insured Employer Group (Fully-insured groups are required to cover contraceptive services under NCGS 58-3-178 and must choose a plan that includes state-mandated contraceptive coverage)
  - ☐ Self-funded Employer Group (Self-funded groups that choose to exclude contraceptive services)
  - ☐ Self-funded Employer Group (Self-funded groups that choose to cover contraceptive services under NCGS 58-3-178 and choose a state-mandated contraceptive plan)
- ☐ None of the above. (By checking this box you will not receive a plan that excludes or limits coverage for contraceptive services.)

Are you a municipality? ☐ Yes ☐ No

Does this group file as a sole proprietorship? (File annual business income on Schedule C, E or F) ☐ Yes ☐ No

If yes, is there at least one common law employee employed, other than the sole proprietor and spouse (common law employee rules are determined by the IRS)? ☐ Yes ☐ No

Are you part of a controlled group that is considered a single employer as defined under Section 414(b), (c), (m) or (o) of the Internal Revenue Code? ☐ Yes ☐ No

If yes, how many total full-time equivalents are in the controlled group (all affiliated commonly owned businesses)?____________________

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2. GROUP ELIGIBILITY PROFILE

This information will be compared to actual enrollment, if your group does enroll. A difference between the enrollment information in the "Group Eligibility Profile" shown here and actual enrollment may impact the proposed rates.

a. Total number of full-time equivalent employees as defined by North Carolina Statutes NCGS 58-50-110[22b]:... ________________

b. Total number of full-time employees eligible for health coverage, including employees who will be eligible upon completion of their probationary period .... ________________

The Group certifies that all individuals enrolling for coverage meet the following definition of eligible employee: An eligible employee is an individual working 30 hours or more per week on a full-time basis with the employer reporting the FICA withheld by W2 Form on an annual basis. Persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible. An individual who is "statutory employee" as that term is defined under Internal Revenue Code Section 3121(d)(3) and works on a full-time basis for the Group may be considered eligible for small group coverage only.

c. Total number of eligible employees applying for health coverage.. ________________

d. Total number of eligible employees who are not applying that have other group coverage .... ________________

e. Total number of eligible employees applying for dental coverage.. ________________

f. Total number of former employees or their dependents continuing coverage through COBRA or state continuation provisions .... ________________

Please provide the following information:

Name of Participant	Emp or Dep	Age	Nature of Qualifying Event	Date of Qualifying Event	Months Remaining
	☐ ☐				
	☐ ☐				
	☐ ☐				

g. Is coverage being offered to all full-time employees? ☐ Yes ☐ No

If no, please provide an explanation: ________________________________

h. What is the employer's contribution to the cost of the health care program (minimum contribution toward employee cost is 50%)?

Employee coverage: __________ % Dependent coverage: __________ %

☐ Fixed Employee coverage: $__________ Dependent coverage: $__________

i. Please provide a copy of the current member census showing member name and full date of birth.

3. DENTAL PROFILE

a. Is the group applying for dental? ☐ Yes ☐ No

b. What is the employer's contribution to the dental program? Employee coverage: __________ % Dependent coverage: __________ %

c. Has the group had prior dental coverage in the last 12 months? ☐ Yes ☐ No

If yes, please provide the name of the prior carrier: ________________________________

4. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in the Small Employer Quote Profile, including attachments, is complete and accurate to the best of my knowledge. It is further understood that any misrepresentation or false statements will subject any issued Group Contract to immediate termination by Blue Cross NC.

Owner or Authorized Executive Signature: ________________________________ Date: ________________

Print Name: ________________________________