

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: _____
- 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 or HDHRA
 - Business Blue Complete (Preferred Blue) with Business Blue Secure
 - Business Blue Secure with HDHP or HDHRA
 - Business Blue Secure with Business Blue Basic
 - Business Blue Basic with HDHP or HDHRA
 - Business Blue Complete with Business Blue Basic
- 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)	Coinsurance: (pick one)	Deductible: (pick one)	Out-of-Pocket: (In/Out) (pick one)	Options for Business Blue Complete (Preferred Blue): <input type="checkbox"/> \$20/\$40 Office Visit Copayment <input type="checkbox"/> Prescription Drug Card <input type="checkbox"/> \$35 /\$60 Office Visit Copayment <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Chiropractic <input type="checkbox"/> Sustained Health
	<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 <i>Secure</i> Coinsurance: (pick one) <input type="checkbox"/> 80/60 <input type="checkbox"/> 70/50 <input type="checkbox"/> 60/40 <input type="checkbox"/> 50/50 Deductible: (In/Out) (pick one) <input type="checkbox"/> \$1,250/2,500 <input type="checkbox"/> \$1,750/3,500 <input type="checkbox"/> \$2,250/4,500 <input type="checkbox"/> \$3,250/6,500 <input type="checkbox"/> \$4,250/8,500 <input type="checkbox"/> \$5,250/10,500 Out-of-Pocket: (In/Out) (pick one) <input type="checkbox"/> \$1,750/3,500 <input type="checkbox"/> \$2,250/4,500 <input type="checkbox"/> \$3,750/7,500 <input type="checkbox"/> \$5,250/10,500	Options for Business Blue <i>Secure</i>: <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Sustained Health <input type="checkbox"/> Dental/Vision (not available if another dental option is selected)	
	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"/> Business Blue <i>Basic</i> (pick one)	<input type="checkbox"/> Plan 1		<input type="checkbox"/> Plan 2		<input type="checkbox"/> Plan 3		<input type="checkbox"/> Plan 4		Options for Business Blue <i>Basic</i>: <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Sustained Health <input type="checkbox"/> Dental/Vision (not available if another dental option is selected)
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	
Deductible – single	\$500	\$1,500	\$500	\$1,500	\$1,000	\$3,000	\$1,000	\$3,000	Prescription Drug Options: (Must choose one) <input type="checkbox"/> Basic Card <input type="checkbox"/> Basic Card 100 <input type="checkbox"/> Basic Generic Card <input type="checkbox"/> Blue Rx SM
Deductible – family	\$1,500	\$4,500	\$1,500	\$4,500	\$3,000	\$9,000	\$3,000	\$9,000	
Coinsurance	80%	60%	60%	40%	80%	60%	60%	40%	
Out-of-Pocket – single	Unlimited		\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	
Out-of-Pocket – family	Unlimited		\$10,000	\$20,000	\$10,000	\$20,000	\$10,000	\$20,000	
	<input type="checkbox"/> Plan 5		<input type="checkbox"/> Plan 6		<input type="checkbox"/> Plan 7		<input type="checkbox"/> Plan 8		
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	
Deductible – single	\$1,500	\$4,500	\$1,500	\$4,500	\$2,500	\$5,000	\$5,000	\$10,000	
Deductible – family	\$4,500	\$13,500	\$4,500	\$13,500	\$5,000	\$10,000	\$10,000	\$20,000	
Coinsurance	80%	60%	60%	40%	80%	60%	70%	50%	
Out-of-Pocket – single	\$6,000	\$12,000	\$6,000	\$12,000	\$7,500	\$15,000	Unlimited		
Out-of-Pocket – family	\$12,000	\$24,000	\$12,000	\$24,000	\$15,000	\$30,000	Unlimited		

<input type="checkbox"/> Business BlueSM <i>High Deductible Health</i> (HSA Qualified HDHP)	<input type="checkbox"/> HD1		<input type="checkbox"/> HD2		<input type="checkbox"/> HD3		<input type="checkbox"/> HD4		<input type="checkbox"/> HD5	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$2,600	\$2,600	\$2,600	\$2,600
Deductible – family	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$5,200	\$5,200	\$5,200	\$5,200
Coinsurance	100%	60%	80%	60%	70%	50%	100%	60%	80%	60%
Out-of-Pocket – single	\$1,500	\$3,000	\$3,000	\$4,500	\$3,000	\$4,500	\$2,600	\$5,200	\$5,200	\$7,800
Out-of-Pocket – family	\$3,000	\$6,000	\$6,000	\$9,000	\$6,000	\$9,000	\$5,200	\$10,400	\$10,400	\$15,600
	<input type="checkbox"/> HD6		<input type="checkbox"/> HD7		<input type="checkbox"/> HD8		<input type="checkbox"/> HD9		<input type="checkbox"/> HD10	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	\$2,600	\$2,600	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$5,000	\$5,000
Deductible – family	\$5,200	\$5,200	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$10,000	\$10,000
Coinsurance	70%	50%	100%	60%	80%	60%	70%	50%	100%	60%
Out-of-Pocket – single	\$5,200	\$7,800	\$3,500	\$5,500	\$5,500	\$7,500	\$5,500	\$7,500	\$5,000	\$10,000
Out-of-Pocket – family	\$10,400	\$15,600	\$7,000	\$11,000	\$11,000	\$15,000	\$11,000	\$15,000	\$10,000	\$20,000

Options for High Deductible Health Plans: Chiropractic Sustained Health

We will open HSA accounts through BlueCross BlueShield of South Carolina.

Business Blue High Deductible for HRA

(Not HSA Qualified)

	<input type="checkbox"/> HDHRA1		<input type="checkbox"/> HDHRA2		<input type="checkbox"/> HDHRA3		<input type="checkbox"/> HDHRA4		<input type="checkbox"/> HDHRA5	
	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Deductible – single	\$2,000	\$2,000	\$3,000	\$3,000	\$5,000	\$5,000	\$7,500	\$7,500	\$10,000	\$10,000
Deductible – family	\$4,000	\$4,000	\$6,000	\$6,000	\$10,000	\$10,000	\$15,000	\$15,000	\$20,000	\$20,000
Coinsurance	100%	60%	100%	60%	100%	60%	100%	60%	100%	60%
Out-of-Pocket – single	\$2,000	\$4,000	\$3,000	\$6,000	\$5,000	\$10,000	\$7,500	\$15,000	\$10,000	\$20,000
Out-of-Pocket – family	\$4,000	\$8,000	\$6,000	\$12,000	\$10,000	\$20,000	\$15,000	\$30,000	\$20,000	\$40,000

Options for HDHRA:

- \$20/\$40 Office Visit Copayment
- \$35/\$60 Office Visit Copayment
- Chiropractic
- Sustained Health

Prescription Drug Options: (Must choose one)

- Drug Card
- Secure Card
- Secure Generic Card
- Blue Rx

Options for all Business Blue Plans:

- Dental High Option
- Dental Standard Option
- Orthodontics (13-50 Enrolled)

Note: Information provided on this form may be verified by phone, personal interview or other means prior to or after requested effective date.

The statements furnished herein are true and correct to the best of my knowledge and belief, and they are offered to Blue Cross and Blue Shield of South Carolina, an independent licensee of the Blue Cross and Blue Shield Association, and/or Companion Life Insurance Company as part of an application for group insurance covering the employees or members of the firm or organization I represent. I understand that any misstatements or omission of information may be the basis for cancellation of any coverage granted.

Coverage is not effective unless and until approved in writing by the Underwriting department at the home office of Blue Cross and Blue Shield of South Carolina and/or Companion Life Insurance Company. Any existing coverage should not be terminated before receipt of approval.

Signed: _____ Title: _____ Date: ____ / ____ / ____
(Principal or Executive Correspondent)

Signed: _____ Date: ____ / ____ / ____
(Agent)