Small Employer Quote Profile

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

BROKER NAME AND **P** NUMBER

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

1. BUSINESS PROFILE

BUSINESS NAME | TELEPHONE NUMBER

BUSINESS ADDRESS (MUST BE A PHYSICAL STREET ADDRESS) | CITY | COUNTY | STATE | ZIP | COUNTY CODE

BUSINESS HEADQUARTERS (CITY, STATE) | GROUP ADMINISTRATOR'S NAME

TYPE OF BUSINESS | NAICS CODE

Are you a municipality? ☐ 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)?_____

Please list any affiliated groups (including group name and number) currently enrolled with Blue Cross Blue Shield of North Carolina:

_____

Does this group file its taxes as a sole proprietor employer? ☐ Yes ☐ No

If yes, is there at least one common law employee employed (common law employee rules are determined by the IRS; e.g., not a family member, etc.)? ☐ Yes ☐ No

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

A Small Employer is, with respect to a calendar year and a plan year, an employer that employed an average of at least one but not more than 50 Full Time Equivalent employees on business days during the preceding calendar year and that 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.

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[22a]: _____

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" means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a partner or partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis. For groups defined as Small Employer groups, persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible.

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. Does your business have multiple locations in North Carolina? ..... ☐ Yes ☐ No

If yes, please provide the following information for each location:

GROUP LOCATION	STREET NAME, CITY, ZIP CODE, COUNTY	TOTAL NUMBER OF FT ENROLLED EEs

i. 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 _____ %

j. Please attach 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 and Blue Shield of North Carolina.

Owner or Authorized Executive Signature _____ Date _____

Print Name _____