Small Business Master Group Application

blue of california

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Effective April 1, 2018

Section 1 – Company information – All fields are mandatory. Please type or print clearly in black ink.

1 Full legal business name of group | Requested coverage effective date

Doing business as (DBA), if applicable:

2 Billing address: Number, street, city, state, ZIP (if providing P.O. Box, also complete No. 3 below)

3 Physical address (if different from above) | County location of physical address

Business street address where most of your employees work (if different from the physical address)

4 Primary group contact name (only designated contact can access group information) | Title

Phone number | Fax number

Email address (required):

☐ **Check here to register the primary group contact for online account access.**

Note: Online account access may be established to view and/or manage the group account. Once registered, account access may be delegated to the group's broker or other individuals within the organization, as identified by the primary group contact. For more information, please visit **blueshieldca.com/employer**.

Secondary group contact name | Title

Phone number

Email address

5 Legal entity type: ☐ S-Corporation ☐ C-Corporation ☐ Partnership ☐ Sole proprietor ☐ LLC ☐ Non-profit ☐ Other (specify) _____

Federal Tax Identification (TID) number _____ Does your group have multiple TID numbers? ☐ Yes ☐ No

If yes, provide the Federal Employer TID number for the plan sponsor: _____

List the primary products/services of your business	Standard industry classification code(s) (SIC Code)

Prior group health carrier	**Start/end date**	**Coverage still in force?** ☐ **Yes** ☐ **No**

6 Is the company currently covered by or have they previously been covered by Blue Shield of California? ☐ Yes ☐ No If yes, please provide Blue Shield Group ID and/or termination date: Blue Shield Group ID _____ Termination date _____

7 Is the group intending to offer Blue Shield alongside another carrier's plan? ☐ Yes ☐ No

Carrier name	**No. of employees:**	Open enrollment dates **From:**	**To:**

Does the group have any subsidiary or affiliated companies? ☐ Yes ☐ No

Subsidiary or affiliated company name(s)	Include in coverage?	Eligible to file a combined state tax return?
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

Are all employees covered by workers' compensation to the extent required by law? ☐ Yes ☐ No

Section 2 – Eligibility (All fields are mandatory.)

8 There are three different definitions of "employee" that are used in small group health coverage, and determine employee counts for different purposes. Blue Shield asks the group to read these definitions and provide the information requested using the definitions provided below. We rely on the information provided by the group in determining group and employee eligibility for coverage. Please contact us if you have questions or need clarification.

1. All employees – Determine the total number of all employees employed by the group by adding together all employees including full-time, part-time, eligible employees, FTE and FTE Equivalent, etc.

2. Full-time employee (FTE) and FTE Equivalent – An FTE and FTE Equivalent is defined in Section 4980H(c)(2) of the Internal Revenue Code and is used to determine if a group is a "small employer" under the Small Group Act. A group must have 1-100 FTEs, including FTE Equivalents, to be eligible for a small group health plan at issuance and renewal, in addition to meeting any applicable underwriting criteria such as contribution and participation requirements.

An FTE is an employee who has on average at least 30 hours of service per week, or at least 130 hours of service total, during a calendar month.

The number of FTE Equivalents is determined as follows: Combine the number of hours of service of all non-full-time employees for the month but do not include more than 120 hours of service per employee. Divide the total number by 120.

3. Eligible employee – This definition is used to determine which employees are eligible to enroll, and remain enrolled, in coverage. An eligible employee is an individual who:

- Is a permanent employee who works on a full-time basis in the conduct of the business of the employer, whose duties are performed at the employer's regular place(s) of business, working an average of 30 hours per work week, and who has met any statutorily authorized waiting period; or
- Meets all the conditions set forth in the first bullet except works at least 20 hours but no more than 29 hours at least 50% of the weeks in the previous calendar quarter, the group offers such employees health coverage and all similarly situated employees are offered such coverage; and
- Receives monetary compensation in the course of employment (shown through W-2); and
- Is a bona fide employee and a bona-fide employee/employer relationship exists.
- An eligible employee also includes a sole proprietor or partner of a partnership, working on a full-time basis at the employer's regular place(s) of business, working an average of 30 hours per work week.
- An eligible employee does not include individuals working on a temporary or substitute basis.

Total # of employees
a. Total # of employees

Total # of eligible employees
b. Total # of eligible full-time employees (including eligible sole proprietors and partners)
c. Total # of eligible part-time employees (if offering coverage to all similarly situated employees)

d. Total # of eligible employees enrolling in coverage:	**e. Total # of eligible employees declining coverage**
Medical coverage:	Medical coverage:
Dental coverage:	Dental coverage:
Vision coverage:	Vision coverage:
Life insurance coverage:	Life insurance coverage:

Total # of FTE and FTE Equivalents – see definition #2 above for instructions
f. Total # of FTE and FTE Equivalents

9 **Employment-based affiliation and waiting periods –** An employer may impose a bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed 90 days.

Please note: If the employer imposes an orientation period when completing an enrollment form for a new employee, the "date of hire" is the first day after completion of the orientation period.

9a.	**Employer orientation period** – In addition to the waiting period, does the employer impose an orientation period for new employees?	☐ Yes	☐ No
9b.	If yes, is this orientation period 30 days or less?	☐ Yes	☐ No

9c. **Employer waiting period** – The group may select one of the following options. Coverage for eligible employees will become effective following completion of the waiting period on the day specified.

☐ Effective first of the month following date of hire (If hired on the first of the month, coverage will be effective the first of the following month)
☐ Effective first of the month following 30 days from date of hire
☐ Effective first of the month following 60 days from date of hire
☐ Effective on the 91st day following date of hire

9d.	Does the group intend to offer coverage to employees currently in the employer waiting period for the original effective date of the group contract (i.e., one-time waiver of employer waiting period)?	☐ Yes	☐ No

9	**9e.** Number of employees currently in the group's waiting period?		
	9f. Are all full-time eligible employees being offered health coverage?	☐ Yes	☐ No
	9g. If the response to 9f is no, please provide the specific class/group for whom coverage is being offered.		
	9h. Are all full-time eligible employees being offered coverage actively working an average of 30 hours per week?	☐ Yes	☐ No
	9i. Will the group offer coverage to permanent employees who work at least 20 hours but not more than 29 hours per week?	☐ Yes	☐ No
	9j. Are there any out-of-state employees?	☐ Yes	☐ No
	9k. If yes, how many out-of-state employees are eligible for coverage?		
	9l. Will the group offer coverage for opposite-sex domestic partners under the age of 62 years (broad coverage)? Note: Coverage for registered same-sex domestic partners and opposite-sex domestic partners where at least one partner is 62 or older and eligible for Social Security based on age (narrow coverage) is included in Blue Shield coverage.	☐ Yes	☐ No
	9m. How will ongoing enrollment be provided?	Please choose one: ☐ BSC Online EC+ ☐ Paper ☐ Electronic via EDI	
	9n. Complete this section ONLY if enrollment changes will be submitted through a private exchange OR if the broker is part of the approved EDI-maintenance pilot program. Please provide the following EDI vendor information and/or private exchange information: EDI vendor name: _____ Contact name: _____ Contact phone: _____ Contact email: _____		
	9o. Will enrollment changes be submitted through a private exchange? If yes, must provide: Exchange name:_____	☐ Yes	☐ No

Section 3 – COBRA/Cal-COBRA continuation coverage information (All fields are mandatory.)

10	**Note: Please only answer yes to either 10a. (Cal-COBRA) or 10b. (Federal COBRA).**		
	10a. Is the group currently subject to Cal-COBRA? (Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year, then during the previous calendar quarter.)	☐ Yes	☐ No
	10b. Is the group currently subject to Federal COBRA? (Employed 20 or more total employees on at least 50% of the working days in the previous calendar year.)	☐ Yes	☐ No
	10c. Number of current Cal-COBRA enrollees?		
	10d. How many employees and/or family members are in a Cal-COBRA election period?		
	10e. Number of current COBRA enrollees?		
	10f. How many employees and/or family members are in a COBRA election period?		
	10g. Are enrollment forms attached for all enrolling COBRA/Cal-COBRA participants?	☐ Yes	☐ No

Section 4a – Health plan selection – For groups with one or more enrolling employees, the group may select plans from either the Off-Exchange or Mirror package options, but not both. Plan packages cannot be combined.

11 **Blue Shield of California Off-Exchange Package for Small Business** – The Blue Shield of California Off-Exchange Package is the only package that may be offered alongside another carrier's HMO plan. For groups with one or more enrolling employees offering Blue Shield of California, the group may choose from one up to 31 plans.

First choose plans from the 19 PPO options. You may select any combination of Full PPO, HSA-compatible HDHP, and Tandem PPO plans.

Then choose from either the 12 Access+ HMO Network and Trio ACO HMO Network plans, or from the six Local Access+ HMO Network plans. PPO plan selection does not affect HMO plan options.

PPO plans – Full PPO and HSA-compatible HDHP plans share the full Blue Shield provider network. Tandem PPO plans have a select Blue Shield provider network. You may select any combination of Full PPO Network and Tandem PPO Network plans.

Choose up to all 19 plans from the Full PPO Network (including HDHP plans) and the Tandem PPO Network.

PPO plans – Full PPO Network

☐ Choose all Full PPO Network plans **OR** select from individual plans below:

☐ Platinum Full PPO 0/10 OffEx
☐ Platinum Full PPO 250/15 OffEx
☐ Gold Full PPO 0/20 OffEx
☐ Gold Full PPO 450/30 OffEx
☐ Gold Full PPO 750/30 OffEx
☐ Gold Full PPO 1200/35 OffEx
☐ Silver Full PPO 1700/55 OffEx
☐ Silver Full PPO 2000/45 OffEx
☐ Bronze Full PPO 3750/65 OffEx
☐ Bronze Full PPO 5700/60 OffEx

HSA-compatible HDHP plans – Full PPO Network

☐ Choose all HSA-compatible HDHP plans **OR** select from individual plans below:

☐ Silver Full PPO Savings 2000/20% OffEx
☐ Bronze Full PPO Savings 4300/40% OffEx
☐ Bronze Full PPO Savings 6550 OffEx

Choosing HealthEquity means Blue Shield shares eligibility and claims data for a seamless experience.

☐ Yes, we will offer HealthEquity as the HSA administrator.

If you do not select yes, work directly with your own HSA administrator.

Tandem PPO plans – Tandem PPO Network

☐ Choose all Tandem PPO plans **OR** select from individual plans below:

☐ Platinum Tandem PPO 0/10 OffEx
☐ Platinum Tandem PPO 250/15 OffEx
☐ Gold Tandem PPO 750/30 OffEx
☐ Silver Tandem PPO 1700/55 OffEx
☐ Silver Tandem PPO 2000/45 OffEx
☐ Bronze Tandem PPO 3750/65 OffEx

HMO plans – Access+ HMO plans, Local Access+ HMO plans and Trio HMO plans have different provider networks. Access+ HMO plans, which have a full network, and Trio HMO plans, which have a select network, may be offered together.
Local Access+ HMO plans, however, may **not** be offered with Access+ HMO plans or Trio HMO plans.

Choose up to all 12 plans from the Access+ HMO Network and Trio ACO HMO Network — **OR** — **Choose up to all six plans from the Local Access+ HMO Network**

Access+ HMO plans – Access+ HMO Network

☐ Choose all Access+ HMO plans **OR** select from individual plans below:

☐ Platinum Access+ HMO® 0/20 OffEx
☐ Platinum Access+ HMO® 0/25 OffEx
☐ Platinum Access+ HMO® 0/30 OffEx
☐ Gold Access+ HMO® 500/35 OffEx
☐ Gold Access+ HMO® 1700/35 OffEx
☐ Silver Access+ HMO® 1750/55 OffEx

Trio HMO plans – Trio ACO HMO Network

☐ Choose all Trio HMO plans **OR** select from individual plans below:

☐ Platinum Trio HMO 0/20 OffEx
☐ Platinum Trio HMO 0/25 OffEx
☐ Platinum Trio HMO 0/30 OffEx
☐ Gold Trio HMO 500/35 OffEx
☐ Gold Trio HMO 1700/35 OffEx
☐ Silver Trio HMO 1750/55 OffEx

Local Access+ HMO plans – Local Access+ HMO Network

☐ Choose all Local Access+ HMO plans **OR** select from individual plans below:

☐ Platinum Local Access+ HMO® 0/20 OffEx
☐ Platinum Local Access+ HMO® 0/25 OffEx
☐ Platinum Local Access+ HMO® 0/30 OffEx
☐ Gold Local Access+ HMO® 500/35 OffEx
☐ Gold Local Access+ HMO® 1700/35 OffEx
☐ Silver Local Access+ HMO® 1750/55 OffEx

Blue Shield of California Mirror Package for Small Business

Mirror package plans cannot be offered alongside our Off-Exchange plan package, or alongside any other carrier's plans.
The plans in these packages "mirror" the standardized plans offered through Covered California. Groups with one or more enrolling employees who select this package may select any number of plans from the options below.
A group has the option of choosing an HMO plan utilizing the Trio ACO HMO provider network along with a PPO plan utilizing the Full PPO Network.

Platinum Mirror plans

☐ Blue Shield Platinum 90 HMO 0/15 Trio + Child Dental
☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental

Gold Mirror plans

☐ Blue Shield Gold 80 HMO 0/25 Trio + Child Dental
☐ Blue Shield Gold 80 PPO 0/25 + Child Dental

Silver Mirror plans

☐ Blue Shield Silver 70 HMO 2000/45 Trio + Child Dental
☐ Blue Shield Silver 70 PPO 2000/45 + Child Dental

Bronze Mirror plans

☐ Blue Shield Bronze 60 PPO 6300/75 + Child Dental

11a. Optional benefit – A rider for infertility benefits may be offered with either the Blue Shield of California Off-Exchange Package for Small Business or with the Blue Shield of California Mirror Package for Small Business. If selected, it must be offered with all medical plans – PPO and HMO.

☐ Infertility benefits rider

11b. Note: Summary of Benefits and Coverage (SBC) forms are available for all health plans. These forms summarize coverage and benefits for all plans in a uniform manner. Log in to **blueshieldca.com/sbc** to review SBC forms for any plan prior to submitting an application. Once the group's application for coverage is approved, download the SBC form(s) for benefit plans specific to your group at **bscadocs.com/sbc** to distribute to employees.

11c. Indicate medical plan employer contribution amount here:

For employees _____% or $ _____ For dependents _____% or $ _____

The employer must contribute either (1) at least 50% of the total employee rates, or (2) a defined contribution of a minimum of $100 per employee (or the cost of the total employee rates, whichever is less). If 100% of the employee's premium is paid by the employer, all eligible employees must enroll in coverage.

Section 4b – Specialty benefits – dental,* vision* and life insurance* plan selection

11 Section SB1 – Dental benefits

Dental plan options – The group may offer Blue Shield dental coverage with or without a medical plan.

☐ When adding dental coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees and dependents elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing dental coverage.

The group may select from one of the plan options below.

☐ **Single Dental Plan Option**

☐ **Dual Choice Dental Plan Option** – Please select any two plans from the options below.

☐ **Triple Choice Dental Plan Option** – Available with or without a Blue Shield medical plan. Please select three plans from the options below in one of the following combinations:

☐ 2 Dental HMO plans and 1 Dental PPO plan	☐ 2 Dental HMO plans and 1 Dental INO plan	☐ 3 Dental HMO plans

The following Triple Choice Dental Plan options are only available when purchased with a Blue Shield medical plan:

☐ 2 Dental PPO plans and 1 Dental HMO plan	☐ 2 Dental INO plans and 1 Dental HMO plan	☐ 1 Dental PPO plan, 1 Dental INO plan, and 1 Dental HMO plan

Dental HMO plans

☐ DHMO Basic	☐ DHMO Plus	☐ DHMO Deluxe	☐ DHMO Voluntary

Dental PPO plans

☐ Ultimate Dental PPO for Small Business 50/2000	☐ Smile 50/1500/No Ortho/MAC
☐ Ultimate Dental Plus PPO for Small Business 50/2000	☐ Smile Plus 50/1500/Ortho/MAC
☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC	☐ Smile Value 50/1500/No Ortho/MAC
☐ Smile Deluxe Plus 2000 50/2000/Ortho/MAC	☐ Smile Plus Gold 50/1500/Ortho/U85
☐ Smile Deluxe 50/1500/Ortho/MAC	☐ Smile Basic 75/1000/No Ortho/MAC
☐ Smile Deluxe Gold 50/1500/Ortho/U85	☐ Smile Basic Voluntary 75/1000/No Ortho/MAC

Dental In-Network Only (INO) plans*

☐ Smile INO Dental Plan 50/1500/Endo-Perio 80%/Ortho	☐ Smile INO Dental Plan 50/2500/Endo-Perio 80%/Ortho
☐ Smile INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho	☐ Smile INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho
☐ Smile INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho[1]	☐ Smile INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho[1]
☐ Smile INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho[1]	☐ Smile INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho[1]

Indicate dental plan employer contribution amount here:

For dental coverage, the employer must contribute at least 50% of the employee's premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

For employees _____% or $ _____ For dependents _____% or $ _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
1 Voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

Section SB2 – Vision coverage

Vision coverage* – The group may offer Blue Shield vision coverage with or without a medical plan.

☐ When adding vision coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees and dependents elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing vision coverage.

The group may select from one of the plan options below.

Ultimate Vision for Small Business (12-12-12)	**Preferred Vision for Small Business (12-12-24)**	**Enhanced Vision for Small Business (12-24-24)**
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Enhanced Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Enhanced Vision 0/0/150
☐ Ultimate Vision Plus 15/25/150/120	☐ Preferred Vision Plus 15/25/150/120	☐ Enhanced Vision Plus 15/25/150/120
☐ Ultimate Vision 15/25/150	☐ Preferred Vision 15/25/150	☐ Enhanced Vision 15/25/150
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 0/0/120	☐ Enhanced Vision 0/0/120
☐ Ultimate Vision 15/25/120	☐ Preferred Vision 15/25/120	☐ Enhanced Vision 15/25/120
☐ Ultimate Vision Voluntary 15/25/150[1]	☐ Preferred Vision Voluntary 15/25/120[1]	☐ Enhanced Vision Voluntary 15/25/120[1]

Indicate vision plan employer contribution amount here:

For vision coverage, the employer must contribute a minimum of 25% of the total employee premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

For employees _____% or $ _____ For dependents _____% or $ _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
1 Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

11 Section SB3 – Life/AD&D insurance

Group term life insurance* – Requires a minimum of two eligible employees.

The group may offer Blue Shield group term life and AD&D insurance coverage with or without a medical plan.

☐ When adding life insurance coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please complete an enrollment, refusal of coverage, or subscriber change request form for all eligible employees. (Refusal of coverage is only allowed for contributory plans.)

The group may select from one of the plan options and coverage amounts below. Benefit amounts are available in $5,000 increments between the designated guaranteed issue benefit amounts listed.

Benefit amount:
2-9 eligible employees: $15,000-$30,000
10-24 eligible employees: $15,000-$100,000
25-50 eligible employees: $15,000-$150,000
51-100 eligible employees: $15,000-$150,000 or $175,000 or $200,000

☐ **Flat amount** – All employees are covered at the same flat amount (up to a maximum benefit amount). $ _____

☐ **Multiple of salary** – All employees are covered for the same multiple of salary at a 1 or 2 times annual salary (up to maximum benefit amount). Benefit amounts established by salary are rounded to the next highest $1,000. ____ times salary, maximum $ _____

☐ **Graded** – Employees are covered by class (up to 4), defined with different levels of benefits. The benefit amount for each class must be no more than 2.5 times that of the next lower class.

- ☐ 1. Class description _____ flat amount $ _____
- ☐ 2. Class description _____ flat amount $ _____
- ☐ 3. Class description _____ flat amount $ _____
- ☐ 4. Class description _____ flat amount $ _____

☐ **Dependent life insurance** – Coverage amounts listed are per dependent, and are only available for employees electing life insurance. The maximum dependent benefit may not be more than 50% of the employee benefit. Benefits for children age 14 days to 6 months are 10% of the total benefit, and there is no coverage for infants from birth to 14 days. AD&D insurance coverage is not available for dependents.
(Choose one): ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $4,000 ☐ $5,000

Indicate group term life insurance plan employer contribution amount here:

For life insurance coverage, the employer must contribute a minimum of 25% of the total employee premium. If a plan is non-contributory (100% paid by the employer), all eligible employees must enroll, no exceptions allowed.

For employees _____% or $ _____ For dependents _____% or $ _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Section 5 – Electronic distribution of *Evidence of Coverage* (EOC) and notices

12 The group is responsible for the prompt distribution of the *Evidence of Coverage* booklets and other required coverage notices ("required materials") to covered employees. Electronic versions of required materials are emailed directly to the group administrator.

For printed versions of required materials, please contact us at **(800) 559-5905**.

Authorization and signature (All fields are mandatory.)

13 This is an application for coverage. The group understands that no contract for coverage will exist until Blue Shield has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted and a group health service contract has been issued. The group representative certifies that, to the best of his or her knowledge and belief, all of the responses provided in this application are true, correct and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of issuance of coverage, Blue Shield may pursue one of the following remedies: Coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the health service contract may be rescinded.

Authorized group representative signature _____ Date _____

Group representative name (please print) _____

Group representative title (please print) _____

Producer information (To be completed by producer or general agent. All fields are mandatory.)

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Agency name		Tax ID number (for commission payments)
Producer name (agent who wrote the group)		Producer CDI license number
Producer email		Producer phone number
Producer contact		Producer contact email
Producer street address (P.O. Box not acceptable)		
City	State	ZIP code
Is this a split commission? ☐ Yes ☐ No	If yes, define split Producer #1 _____ % Producer #2 _____ %	Name of second producer Second producer tax ID number
General agency name		General agency tax ID number (for commission payments)
General agency producer name		General agency producer email

Today's date (required) _____

Producer signature (required) X_____

Producer print name (required) _____

I certify that, to the best of my knowledge and belief, all responses given above are true, correct and complete.

Items to be completed internally by Blue Shield	
Blue Shield account executive	Phone number
Blue Shield account manager	Phone number
Blue Shield sales assistant	Phone number

Check Form