

SERFF Tracking Number: ARBB-127812777 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50240
Company Tracking Number: NGRODENAPP R01/12
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Dental Employer Application
Project Name/Number: Revised Application/NGrpDenApp R01/12

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Dental Employer Application SERFF Tr Num: ARBB-127812777 State: Arkansas
TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- State Tr Num: 50240
Closed

Sub-TOI: H10G.000 Health - Dental Co Tr Num: NGRODENAPP State Status: Approved-Closed
R01/12

Filing Type: Form

Reviewer(s): Rosalind Minor
Disposition Date: 11/28/2011
Authors: Christi Kittler, Yvonne
McNaughton, Frank Sewall, Rita
Thatcher, Evelyn Laney
Date Submitted: 11/10/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: Revised Application
Project Number: NGrpDenApp R01/12
Requested Filing Mode:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Arkansas is state
of domicile.

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 11/28/2011
State Status Changed: 11/28/2011

Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Created By: Evelyn Laney
Corresponding Filing Tracking Number:
Filing Description:

Deemer Date:
Submitted By: Evelyn Laney

Attached please find form NGrpDenApp R01/12 for your review and approval if indicated.

In this revised form, we have added questions to Section 3-COBRA Administration, changed the annual maximum amount, and updated the minimum participation requirement.

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule &

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Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the policies to which these amendments are attached.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
 320 West Capitol, Ste 211 501-378-2165 [Phone]
 Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$50.00	11/10/2011	53649794

<i>SERFF Tracking Number:</i>	<i>ARBB-127812777</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Arkansas Blue Cross and Blue Shield</i>	<i>State Tracking Number:</i>	<i>50240</i>
<i>Company Tracking Number:</i>	<i>NGRODENAPP R01/12</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Dental Employer Application</i>		
<i>Project Name/Number:</i>	<i>Revised Application/NGrpDenApp R01/12</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/28/2011	11/28/2011
Approved-Closed	Rosalind Minor	11/10/2011	11/10/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application	Evelyn Laney	11/16/2011	11/16/2011

SERFF Tracking Number: ARBB-127812777 *State:* Arkansas
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Product Name: Dental Employer Application
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Disposition

Disposition Date: 11/28/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>ARBB-127812777</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Arkansas Blue Cross and Blue Shield</i>	<i>State Tracking Number:</i>	<i>50240</i>
<i>Company Tracking Number:</i>	<i>NGRODENAPP R01/12</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Dental Employer Application</i>		
<i>Project Name/Number:</i>	<i>Revised Application/NGrpDenApp R01/12</i>		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes

SERFF Tracking Number: ARBB-127812777 *State:* Arkansas
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TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Dental Employer Application
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Disposition

Disposition Date: 11/10/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>ARBB-127812777</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Arkansas Blue Cross and Blue Shield</i>	<i>State Tracking Number:</i>	<i>50240</i>
<i>Company Tracking Number:</i>	<i>NGRODENAPP R01/12</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Dental Employer Application</i>		
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Amendment Letter

Submitted Date: 11/16/2011

Comments:

In Section 4, under Dental Blue, we added a line that said [Out-of-State Non-Contracted Provider Reimbursement Rate: [95% -50%]].

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
NGrpDenApp R01/12	Application/EApplication nrollment Form		Revised		NGrpDenApp p R01/10	NGrpDenApp p R01/12		NGrpDenApp R01-12 revised.pdf

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Form Schedule

Lead Form Number: NGroDenApp R01/12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 11/28/2011	NGrpDenA pp R01/12	Application/ Enrollment Form	Application	Revised	Replaced Form #: NGrpDenApp R01/12 Previous Filing #: NGrpDenApp R01/10		NGrpDenApp R01-12 revised.pdf

[Renewal] APPLICATION by:

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

[SECTION 1.] GROUP INFORMATION

Legal Name of Business:

D/B/A:

Street Address:

City, State, Zip:

County:

Mailing Address: (if different from Street)

City, State, Zip:

Telephone #:

Fax #:

Fed. Tax I.D. #:

Business Type: [Sole Proprietorship] [Legal Partnership]
[Corporation] [Government Entity]

Exec. Contact:

E-Mail:

Group Administrator:

E-Mail:

Primary SIC Code:

SIC Description:

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

[SECTION 2.] POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

[SECTION 3.] COBRA ADMINISTRATION

COBRA - Group dental plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost). Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.¹

(Yes __) (No __) Under the governmental guidelines the group dental plan is subject to Cobra, meeting the criteria for 20 or more employees.

(Yes __)(No __) If yes, do you wish to use the services of Ceridian?

If no, who will administer Cobra for you? _____

¹ COBRA Handbook 2009, ¶4.03[E][2]; 26 CFR §54.4980B-2 Q/A 5(e).

[SECTION 4.] BENEFIT SELECTION

[DENTALBLUE PLAN:]

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.*

Maximum Dependent Age [0-27]

Deductible: Individual [\$25 - \$100] Family [\$XX - \$XX]

Annual Maximum: [\$750 - \$5,000]

Diagnostic & Preventive Services: [80% - 100%] **Basic Services:** [50% - 100%]

Major Services: [0% - 100%] **Orthodontic Service:** [0% -50%]

Orthodontic Lifetime Maximum: [\$0 - \$5,000]

Optional Benefit: Posterior Resins: Yes No

[Roll Over Balance from Previous Carrier Yes No]

[Out-of-State Non-Contracted Provider Reimbursement Rate: [95% - 50%]]

Basic Services Waiting Period [None – 6 months] | **Major Services Waiting Period [None – 12 Months]**

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least **two** [five] full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

Minimum Participation Requirements. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

[Rates]

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

[TRADITIONAL DENTAL]

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.*

Maximum Dependent Age [0-27]

Deductible: Individual [\$25 - \$100] [Deductible Applies to Preventive]

Annual Maximum: [\$1000 - \$1,500]

Diagnostic & Preventive Services: [80% - 100%]

Restorative Services: [0% - 80%] **Orthodontic Service:** [0% -50%]

Orthodontic Lifetime Maximum: [\$0 - \$1,500]

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least five full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

Minimum Participation Requirements. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

[Rates]

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

[SECTION 4.] BENEFIT SELECTION (CONTINUED)

[VOLUNTARY DENTALBLUE PLAN:]

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution		
		[0 – 12 months] [other]	Employee	%	Dependent %

Note: Employer Contribution is 0% to 49%.

Maximum Dependent Age [0-27]

Deductible: Individual [\$25 - \$100] Family [\$XX - \$XX]

Annual Maximum: [\$750 - \$5,000]

Diagnostic & Preventive Services: [80% - 100%] **Basic Services:** [50% - 100%]

Major Services: [0% - 100%] **Orthodontic Service:** [0% -50%]

Orthodontic Lifetime Maximum: [\$0 - \$5,000]

Optional Benefits: Posterior Resin: Yes No

[Roll Over Balance from Previous Carrier Yes No]

Basic Services Waiting Period [None – 6 months] | **Major Services Waiting Period [None – 12 Months]**

Minimum Participation Requirements and Minimum Number of Insured Employees. This policy may be terminated by the Company if the percentage of eligible Employees of the Policyholder covered by the policy becomes less than twenty percent (20%) of eligible Employees specified above, or if the number of insured Employees falls below [five (5)] [ten (10)] insured Employees.

[Rates]

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

[SECTION 5.] EMPLOYEE INFORMATION

MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS.

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year	In State	OUT OF STATE	TOTAL
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):			
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continueses (Enrolling)			
Total Enrolling and Waiving			
[New Full-Time Employees who will NOT satisfy the Waiting Period within 3 months after the eff. Date:]			
Part Time / Seasonal / Temporary Employees			
Total # of Employees			

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above

[Special Group Considerations Form # _____, Description _____]

[SECTION 6.] PROXY

The Policyholder hereby appoints the Board of Directors (“Board”) of Arkansas Blue Cross and Blue Shield (“ABCBS”), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder’s membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members’ meeting.

[SECTION 7.] [SECURED EMPLOYERS WEBSITE]

[Our records indicate that you are currently utilizing the Secured Employer Web Site and we hope that site is useful in the administration of your group health plan. We are always looking for feedback and to assist you with the site if needed, our email address is ewssupport@arkbluecross.com or call us toll free at 1-800-800-5641.

Web Administrator: _____ Email Address: _____]

[Our records indicate that you signed up for the Secured Employer Web Site but have not visited the site and registered to utilize the web functionality. If you need assistance activating your registration, lost the link or need to change the web administrator we can help. Our toll free phone number is 1-800-800-5641 and our email address is ewssupport@arkbluecross.com.

Web Administrator: _____ Email Address: _____]

[Yes No

We have a web site for our small group customers who wish to utilize a “secured” web site which has been very well received by the current users. The site is password protected and all that is required of the group is to have email capability. If you have internet access and wish to utilize the site please mark the “yes” box above, please mark the “no” box if you do not wish to utilize the site at this time.

If you have selected to use the site, please fill in the name of the person who you are designating as “Web Administrator” along with their email address. We will automatically forward a link to this individual shortly after processing this renewal. The link will allow the person to set up their log-on ID and password. In addition to the link, they will receive a guide with detailed instructions on how to use the website.

[SECTION 8.] SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

[I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

[I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____ day of _____ 20____
(City, State)

[full legal name of Policyholder]

By: _____

Authorized Signature	Printed Name
Title or Position	

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

Agent Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	Date

<i>SERFF Tracking Number:</i>	<i>ARBB-127812777</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Arkansas Blue Cross and Blue Shield</i>	<i>State Tracking Number:</i>	<i>50240</i>
<i>Company Tracking Number:</i>	<i>NGRODENAPP R01/12</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Dental Employer Application</i>		
<i>Project Name/Number:</i>	<i>Revised Application/NGrpDenApp R01/12</i>		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	11/10/2011
Bypass Reason:	Not needed.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/10/2011
Comments:	See attached.		
Attachment:	NGrpDenApp R01-12 revised.pdf		

[Renewal] APPLICATION by:

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

[SECTION 1.] GROUP INFORMATION

Legal Name of Business:

D/B/A:

Street Address:

City, State, Zip:

County:

Mailing Address: (if different from Street)

City, State, Zip:

Telephone #:

Fax #:

Fed. Tax I.D. #:

Business Type: [Sole Proprietorship] [Legal Partnership]
[Corporation] [Government Entity]

Exec. Contact:

E-Mail:

Group Administrator:

E-Mail:

Primary SIC Code:

SIC Description:

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

[SECTION 2.] POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

[SECTION 3.] COBRA ADMINISTRATION

COBRA - Group dental plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost). Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.¹

(Yes__)(No__) Under the governmental guidelines the group dental plan is subject to Cobra, meeting the criteria for 20 or more employees.

(Yes__)(No__) If yes, do you wish to use the services of Ceridian?

If no, who will administer Cobra for you? _____

¹ COBRA Handbook 2009, ¶4.03[E][2]; 26 CFR §54.4980B-2 Q/A 5(e).

[SECTION 4.] BENEFIT SELECTION**[DENTALBLUE PLAN:]****REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS:** _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.

Maximum Dependent Age [0-27]**Deductible:** Individual [\$25 - \$100] Family [\$XX - \$XX]**Annual Maximum:** [\$750 - \$5,000]**Diagnostic & Preventive Services:** [80% - 100%] **Basic Services:** [50% - 100%]**Major Services:** [0% - 100%] **Orthodontic Service:** [0% -50%]**Orthodontic Lifetime Maximum:** [\$0 - \$5,000]**Optional Benefit:** Posterior Resins: Yes No[Roll Over Balance from Previous Carrier Yes No]**Basic Services Waiting Period** [None – 6 months] **Major Services Waiting Period** [None – 12 Months]

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least [two] [five] full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

Minimum Participation Requirements. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

[Rates]

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

[TRADITIONAL DENTAL]**REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS:** _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.

Maximum Dependent Age [0-27]**Deductible:** Individual [\$25 - \$100] [Deductible Applies to Preventive]**Annual Maximum:** [\$1000 - \$1,500]**Diagnostic & Preventive Services:** [80% - 100%]**Restorative Services:** [0% - 80%] **Orthodontic Service:** [0% -50%]**Orthodontic Lifetime Maximum:** [\$0 - \$1,500]

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least five full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

Minimum Participation Requirements. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

[Rates]

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation

[SECTION 5.] EMPLOYEE INFORMATION

MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS.

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year	In State	OUT OF STATE	TOTAL
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):			
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continueses (Enrolling)			
Total Enrolling and Waiving			
[New Full-Time Employees who will NOT satisfy the Waiting Period within 3 months after the eff. Date:]			
Part Time / Seasonal / Temporary Employees			
Total # of Employees			

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above

[Special Group Considerations Form # _____, Description _____]

[SECTION 6.] PROXY

The Policyholder hereby appoints the Board of Directors (“Board”) of Arkansas Blue Cross and Blue Shield (“ABCBS”), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder’s membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members’ meeting.

[SECTION 7.] [SECURED EMPLOYERS WEBSITE]

[Our records indicate that you are currently utilizing the Secured Employer Web Site and we hope that site is useful in the administration of your group health plan. We are always looking for feedback and to assist you with the site if needed, our email address is ewssupport@arkbluecross.com or call us toll free at 1-800-800-5641.

Web Administrator: _____ Email Address: _____]

[Our records indicate that you signed up for the Secured Employer Web Site but have not visited the site and registered to utilize the web functionality. If you need assistance activating your registration, lost the link or need to change the web administrator we can help. Our toll free phone number is 1-800-800-5641 and our email address is ewssupport@arkbluecross.com.

Web Administrator: _____ Email Address: _____]

[Yes No]

We have a web site for our small group customers who wish to utilize a “secured” web site which has been very well received by the current users. The site is password protected and all that is required of the group is to have email capability. If you have internet access and wish to utilize the site please mark the “yes” box above, please mark the “no” box if you do not wish to utilize the site at this time.

If you have selected to use the site, please fill in the name of the person who you are designating as “Web Administrator” along with their email address. We will automatically forward a link to this individual shortly after processing this renewal. The link will allow the person to set up their log-on ID and password. In addition to the link, they will receive a guide with detailed instructions on how to use the website.

[SECTION 8.] SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

[I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

[I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____ day of _____ 20____
(City, State)

[full legal name of Policyholder]

By: _____

Authorized Signature	Printed Name
Title or Position	

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

Agent Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	Date

SERFF Tracking Number: ARBB-127812777 *State:* Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield *State Tracking Number:* 50240
Company Tracking Number: NGRODENAPP R01/12
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Dental Employer Application
Project Name/Number: Revised Application/NGrpDenApp R01/12

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/10/2011	Form	Application	11/16/2011	NGrpDenApp R01-12 revised.pdf (Superseded)

[Renewal] APPLICATION by:

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

[SECTION 1.] GROUP INFORMATION

Legal Name of Business:

D/B/A:

Street Address:

City, State, Zip:

County:

Mailing Address: (if different from Street)

City, State, Zip:

Telephone #:

Fax #:

Fed. Tax I.D. #:

Business Type: [Sole Proprietorship] [Legal Partnership]
[Corporation] [Government Entity]

Exec. Contact:

E-Mail:

Group Administrator:

E-Mail:

Primary SIC Code:

SIC Description:

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

[SECTION 2.] POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

[SECTION 3.] COBRA ADMINISTRATION

COBRA - Group dental plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost). Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.¹

(Yes__)(No__) Under the governmental guidelines the group dental plan is subject to Cobra, meeting the criteria for 20 or more employees.

(Yes__)(No__) If yes, do you wish to use the services of Ceridian?

If no, who will administer Cobra for you? _____

¹ COBRA Handbook 2009, ¶4.03[E][2]; 26 CFR §54.4980B-2 Q/A 5(e).

[SECTION 4.] BENEFIT SELECTION**[DENTALBLUE PLAN:]****REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS:** _____

Effective Date is [first of the month][fifteenth of the month] following the Waiting Period

[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.

Maximum Dependent Age [0-27]**Deductible:** Individual [\$25 - \$100] Family [\$XX - \$XX]**Annual Maximum:** [\$750 - \$5,000]**Diagnostic & Preventive Services:** [80% - 100%] **Basic Services:** [50% - 100%]**Major Services:** [0% - 100%] **Orthodontic Service:** [0% -50%]**Orthodontic Lifetime Maximum:** [\$0 - \$5,000]**Optional Benefit:** Posterior Resins: Yes No[Roll Over Balance from Previous Carrier Yes No]**Basic Services Waiting Period** [None – 6 months] **Major Services Waiting Period** [None – 12 Months]

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least [two] [five] full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

Minimum Participation Requirements. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

[Rates]

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[Is Waiting Period for Initial Enrollment Waived? [Yes][No]] [Date of Open Enrollment _____]

[If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.]

Class	Class Description	Waiting Period	Contribution
		[0 – 12 months] [other]	Employee % Dependent %

Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.

Maximum Dependent Age [0-27]**Deductible:** Individual [\$25 - \$100] [Deductible Applies to Preventive]**Annual Maximum:** [\$1000 - \$1,500]**Diagnostic & Preventive Services:** [80% - 100%]**Restorative Services:** [0% - 80%] **Orthodontic Service:** [0% -50%]**Orthodontic Lifetime Maximum:** [\$0 - \$1,500]

Minimum Number of Insured Employees. [To meet small group enrollment guidelines a group must have at least five full-time enrolled employees, of which no more than 50% may reside in the same household.] [To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal]

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[SECTION 5.] EMPLOYEE INFORMATION

MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS.

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year	In State	OUT OF STATE	TOTAL
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):			
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continueses (Enrolling)			
Total Enrolling and Waiving			
[New Full-Time Employees who will NOT satisfy the Waiting Period within 3 months after the eff. Date:]			
Part Time / Seasonal / Temporary Employees			
Total # of Employees			

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above

[Special Group Considerations Form # _____, Description _____]

[SECTION 6.] PROXY

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[SECTION 7.] [SECURED EMPLOYERS WEBSITE]

[Our records indicate that you are currently utilizing the Secured Employer Web Site and we hope that site is useful in the administration of your group health plan. We are always looking for feedback and to assist you with the site if needed, our email address is ewssupport@arkbluecross.com or call us toll free at 1-800-800-5641.

Web Administrator: _____ Email Address: _____]

[Our records indicate that you signed up for the Secured Employer Web Site but have not visited the site and registered to utilize the web functionality. If you need assistance activating your registration, lost the link or need to change the web administrator we can help. Our toll free phone number is 1-800-800-5641 and our email address is ewssupport@arkbluecross.com.

Web Administrator: _____ Email Address: _____]

[Yes No]

We have a web site for our small group customers who wish to utilize a “secured” web site which has been very well received by the current users. The site is password protected and all that is required of the group is to have email capability. If you have internet access and wish to utilize the site please mark the “yes” box above, please mark the “no” box if you do not wish to utilize the site at this time.

If you have selected to use the site, please fill in the name of the person who you are designating as “Web Administrator” along with their email address. We will automatically forward a link to this individual shortly after processing this renewal. The link will allow the person to set up their log-on ID and password. In addition to the link, they will receive a guide with detailed instructions on how to use the website.

[SECTION 8.] SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

[I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

[I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____ day of _____ 20____
(City, State)

[full legal name of Policyholder]

By: _____

Authorized Signature	Printed Name
Title or Position	

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

Agent Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	Date