

SERFF Tracking Number: ARBB-127837920 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50306
Company Tracking Number: 10-04ABCBSWEBLGAPP 01/12
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Large Group Application
Project Name/Number: Application/10-04ABCBSWEBLGAPP 01/12

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Large Group Application SERFF Tr Num: ARBB-127837920 State: Arkansas
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved State Tr Num: 50306
Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: 10- State Status: Approved-Closed
04ABCBSWEBLGAPP 01/12

Filing Type: Form

Reviewer(s): Donna Lambert
Disposition Date: 11/23/2011
Authors: Christi Kittler, Yvonne
McNaughton, Frank Sewall, Rita
Thatcher, Evelyn Laney
Date Submitted: 11/21/2011 Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 12/23/2011

State Filing Description:

General Information

Project Name: Application
Project Number: 10-04ABCBSWEBLGAPP 01/12
Requested Filing Mode: Review & Approval

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

Explanation for Combination/Other:

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

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 11/23/2011

State Status Changed: 11/23/2011

Created By: Evelyn Laney

Deemer Date:
Submitted By: Evelyn Laney

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Attached please find form 10-04ABCBSWEBLGAPP 01/12 for your review and approval if indicated.

This is a new Web Application Form that will be used by large employers, only. This application is similar to previously filed applications. However, the only difference is that this form is presented on the Web.

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.

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

SERFF Tracking Number: ARBB-127837920 State: Arkansas
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50306
 Company Tracking Number: 10-04ABCBSWEBLGAPP 01/12
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Large Group Application
 Project Name/Number: Application/10-04ABCBSWEBLGAPP 01/12

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	11/21/2011	53921900

SERFF Tracking Number: ARBB-127837920 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50306
Company Tracking Number: 10-04ABCBSWEBLGAPP 01/12
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Large Group Application
Project Name/Number: Application/10-04ABCBSWEBLGAPP 01/12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	11/23/2011	11/23/2011

SERFF Tracking Number: ARBB-127837920 *State:* Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield *State Tracking Number:* 50306
Company Tracking Number: 10-04ABCBSWEBLGAPP 01/12
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: Large Group Application
Project Name/Number: Application/10-04ABCBSWEBLGAPP 01/12

Disposition

Disposition Date: 11/23/2011

Implementation Date: 12/23/2011

Status: Approved

HHS Status: HHS Approved

State Review: Not Reviewed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ARBB-127837920 *State:* Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield *State Tracking Number:* 50306
Company Tracking Number: 10-04ABCBSWEBLGAPP 01/12
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: Large Group Application
Project Name/Number: Application/10-04ABCBSWEBLGAPP 01/12

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Form	Application	Approved	Yes

SERFF Tracking Number: ARBB-127837920 State: Arkansas
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50306
 Company Tracking Number: 10-04ABCBSWEBLGAPP 01/12
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Large Group Application
 Project Name/Number: Application/10-04ABCBSWEBLGAPP 01/12

Form Schedule

Lead Form Number: 10-04ABCBSWEBLGAPP 01/12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/23/2011	10-04ABCBS WEBLGAPP P 01/12	Application/ Enrollment Form	Application/ Enrollment Form	Initial			10-04ABCBSWE BLGAPP 01- 12.pdf



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

LARGE GROUP EMPLOYEE APPLICATION

Please check the appropriate box and fill in blanks below in ink.

Group No.:

I.D. No.:

Is the Employee waiving coverage in the plan? Yes No If yes, complete Sections 1, 4 & 7 only.

FOR OFFICE USE ONLY

Yes Arkansas Blue Cross and Blue Shield

Life Only (complete Sections 1,6 & 7)

New Enrollee

Add a Family Member:

Loss of Other Coverage

Newborn - Date of Birth: _____

Marriage - Marriage Date: _____ (Submit copy of marriage certificate.)

Date of Full-Time Employment

COBRA Effective Date

COBRA Termination Date

Reason for COBRA:

Mo	Day	Year
----	-----	------

Mo	Day	Year
----	-----	------

Mo	Day	Year
----	-----	------

SECTION 1. EMPLOYEE INFORMATION

First Name	Middle Name	Last Name	Marital Status:	Married	Single
				Divorced	Widowed

Home Address	City	State	Zip Code
--------------	------	-------	----------

Home Phone No.	Work Phone No.	Employer	Job Title
----------------	----------------	----------	-----------

Coverage Desired:	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee, Spouse & Child(ren)	Employment Status:	Hourly	Hours Worked Weekly
						Salaried	_____
						Other	

SECTION 2. (Complete this section on all members to be covered.)

Social Security Number	First Name	M.I.	Last Name	Birth Date Mo/Day/Yr	Sex M or F

SECTION 3. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)

Will you, your spouse or dependents be continuing any other health insurance coverage including Medicare?

If you answered Yes, complete Part 1 and/or Part 2 as applicable

Part 1: If continuing coverage is Medicare, complete the following:

Reason for Medicare Coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name:	Relationship of Beneficiary to Policyholder:
----------------------------	--

Medicare Health Identification Contract (HIC) Number:

Type of Medicare Coverage (check all that apply)
--

Medicare Part A - Effective Date:	Medicare Part B - Effective Date:
-----------------------------------	-----------------------------------

SECTION 3. OTHER MEDICAL INSURANCE (continued)

Part 2: If continuing coverage is other than Medicare, complete the following:

Name of Insurance:		Address:		Phone:	
Policyholder Name:			Date of Birth:		FOR OFFICE USE ONLY
Member ID #				C/T	PKG WWP
List the following information for all family members covered by this policy				Eff Date	IMP
First Name	Last Name	Relationship	Effective Date of Coverage	Life	AD&D
For members listed above, are you responsible for providing primary health insurance coverage? Please name responsible party:				Timely	UND
				Late	Date
				OTHER	

SECTION 4. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS

Please list individual(s), including yourself, if applicable, for whom you did not apply for coverage. Indicate whether the named individual(s) have coverage with another group plan or other insurance:

Name	Dependency Relationship	Other Coverage	Name of Health Insurance Co.

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I may be enrolled as a Late Enrollee or my request may be deferred until open enrollment.

Special Enrollment Period. If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer's plan in the future without being considered a Late Enrollee you must: (1) Indicate on this application form that the reason you or your dependent(s) are declining coverage now is because you or your dependent(s) have coverage under another group health plan; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 30 days after coverage ends under the other group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and/or your new dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 5. CREDITABLE COVERAGE INFORMATION

If the insurance or HMO coverage for which you are making application contains a pre-existing condition limitation period, you may be able to offset part or all of such period by attaching a Certificate of Creditable Coverage to this application. Federal and state law require your prior health plan(s) or health insurance company(ies) to provide you such Certificate(s) of Creditable Coverage upon request. If, for some reason you are unable to attach such a Certificate of Creditable Coverage, please include whatever documents you have (i.e., explanation of benefits forms, correspondence from your former health plan or health insurer, former identification card, or benefit certificate) which will assist us to corroborate your prior creditable coverage.

Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days? If YES, please provide the coverage history for the past 18 months in the spaces below.

Name of Persons covered	Name, Address, Phone No. & Policy No. of Prior Health Insurance Co.	Effective Date	Termination Date	Reason for Termination

SECTION 6. LIFE INSURANCE (Issued by USABLE Life for any employer with 51-100 employees)

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary. USABLE Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield . USABLE Life does not sell or service Arkansas Blue Cross and Blue Shield products . USABLE Life is solely responsible for life insurance.

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 7. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

I understand that the benefits for which I (we) will be eligible are those described in the Arkansas Blue Cross and Blue Shield and USABLE Life group policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date . I understand that in addition to other exclusions and limitations provided in the Arkansas Blue Cross and Blue Shield and USABLE Life group policies , NO BENEFITS WILL BE AVAILABLE TO COVERED PERSONS AGE 19 OR OLDER DURING THE APPLICABLE PRE-EXISTING CONDITION EXCLUSION PERIOD FOR TREATMENT OF ANY CONDITION FOR WHICH A COVERED PERSON RECEIVED MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WITHIN THE SIX (6) MONTH PERIOD ENDING ON THE EFFECTIVE DATE OR THE FIRST DAY OF THE WAITING PERIOD, WHICHEVER IS EARLIER.

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that Arkansas Blue Cross and Blue Shield or USABLE Life may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, Arkansas Blue Cross and Blue Shield or USABLE Life may take legal action at any time.

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

Print Name of Applicant (Employee)

Signature of Applicant (Employee)

Date

Print Employer/Group Administrator

Signature Employer/Group Administrator

Date

SERFF Tracking Number: ARBB-127837920 State: Arkansas
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 50306
 Company Tracking Number: 10-04ABCBSWEBLGAPP 01/12
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Large Group Application
 Project Name/Number: Application/10-04ABCBSWEBLGAPP 01/12

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved	11/23/2011
Bypass Reason:	Not required.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	11/23/2011
Comments:			
Attachment:			
	10-04ABCBSWEBLGAPP 01-12.pdf		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	11/23/2011
Bypass Reason:	Not PPACA related.		
Comments:			



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

LARGE GROUP EMPLOYEE APPLICATION

Please check the appropriate box and fill in blanks below in ink.

Group No.:

I.D. No.:

Is the Employee waiving coverage in the plan? Yes No If yes, complete Sections 1, 4 & 7 only.

FOR OFFICE USE ONLY

Yes Arkansas Blue Cross and Blue Shield

Life Only (complete Sections 1,6 & 7)

New Enrollee

Add a Family Member:

Loss of Other Coverage

Newborn - Date of Birth: _____

Marriage - Marriage Date: _____ (Submit copy of marriage certificate.)

Date of Full-Time Employment

COBRA Effective Date

COBRA Termination Date

Reason for COBRA:

Mo	Day	Year
----	-----	------

Mo	Day	Year
----	-----	------

Mo	Day	Year
----	-----	------

SECTION 1. EMPLOYEE INFORMATION

First Name	Middle Name	Last Name	Marital Status:	Married	Single
				Divorced	Widowed

Home Address	City	State	Zip Code
--------------	------	-------	----------

Home Phone No.	Work Phone No.	Employer	Job Title
----------------	----------------	----------	-----------

Coverage Desired:	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee, Spouse & Child(ren)	Employment Status:	Hourly	Hours Worked Weekly
						Salaried	_____
						Other	

SECTION 2. (Complete this section on all members to be covered.)

Social Security Number	First Name	M.I.	Last Name	Birth Date Mo/Day/Yr	Sex M or F

SECTION 3. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)

Will you, your spouse or dependents be continuing any other health insurance coverage including Medicare?

If you answered Yes, complete Part 1 and/or Part 2 as applicable

Part 1: If continuing coverage is Medicare, complete the following:

Reason for Medicare Coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name:	Relationship of Beneficiary to Policyholder:
----------------------------	--

Medicare Health Identification Contract (HIC) Number:

Type of Medicare Coverage (check all that apply)
--

Medicare Part A - Effective Date:	Medicare Part B - Effective Date:
-----------------------------------	-----------------------------------

SECTION 3. OTHER MEDICAL INSURANCE (continued)

Part 2: If continuing coverage is other than Medicare, complete the following:

Name of Insurance:		Address:		Phone:	
Policyholder Name:			Date of Birth:		FOR OFFICE USE ONLY
Member ID #				C/T	PKG WWP
List the following information for all family members covered by this policy				Eff Date	IMP
First Name	Last Name	Relationship	Effective Date of Coverage	Life	AD&D
For members listed above, are you responsible for providing primary health insurance coverage? Please name responsible party:				Timely	UND
				Late	Date
				OTHER	

SECTION 4. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS

Please list individual(s), including yourself, if applicable, for whom you did not apply for coverage. Indicate whether the named individual(s) have coverage with another group plan or other insurance:

Name	Dependency Relationship	Other Coverage	Name of Health Insurance Co.

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I may be enrolled as a Late Enrollee or my request may be deferred until open enrollment.

Special Enrollment Period. If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer's plan in the future without being considered a Late Enrollee you must: (1) Indicate on this application form that the reason you or your dependent(s) are declining coverage now is because you or your dependent(s) have coverage under another group health plan; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 30 days after coverage ends under the other group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and/or your new dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 5. CREDITABLE COVERAGE INFORMATION

If the insurance or HMO coverage for which you are making application contains a pre-existing condition limitation period, you may be able to offset part or all of such period by attaching a Certificate of Creditable Coverage to this application. Federal and state law require your prior health plan(s) or health insurance company(ies) to provide you such Certificate(s) of Creditable Coverage upon request. If, for some reason you are unable to attach such a Certificate of Creditable Coverage, please include whatever documents you have (i.e., explanation of benefits forms, correspondence from your former health plan or health insurer, former identification card, or benefit certificate) which will assist us to corroborate your prior creditable coverage.

Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days? If YES, please provide the coverage history for the past 18 months in the spaces below.

Name of Persons covered	Name, Address, Phone No. & Policy No. of Prior Health Insurance Co.	Effective Date	Termination Date	Reason for Termination

SECTION 6. LIFE INSURANCE (Issued by USABLE Life for any employer with 51-100 employees)

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary. USABLE Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield . USABLE Life does not sell or service Arkansas Blue Cross and Blue Shield products . USABLE Life is solely responsible for life insurance.

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 7. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

I understand that the benefits for which I (we) will be eligible are those described in the Arkansas Blue Cross and Blue Shield and USABLE Life group policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date . I understand that in addition to other exclusions and limitations provided in the Arkansas Blue Cross and Blue Shield and USABLE Life group policies , NO BENEFITS WILL BE AVAILABLE TO COVERED PERSONS AGE 19 OR OLDER DURING THE APPLICABLE PRE-EXISTING CONDITION EXCLUSION PERIOD FOR TREATMENT OF ANY CONDITION FOR WHICH A COVERED PERSON RECEIVED MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WITHIN THE SIX (6) MONTH PERIOD ENDING ON THE EFFECTIVE DATE OR THE FIRST DAY OF THE WAITING PERIOD, WHICHEVER IS EARLIER.

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that Arkansas Blue Cross and Blue Shield or USABLE Life may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, Arkansas Blue Cross and Blue Shield or USABLE Life may take legal action at any time.

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

Print Name of Applicant (Employee)

Signature of Applicant (Employee)

Date

Print Employer/Group Administrator

Signature Employer/Group Administrator

Date