EMPLOYER APPLICATION

(Care Manager True Group App.)

☐ New Business ☒ Renewal Business Other _____ Group # (BCBSF): 30749 (HMO) 30749J

I. APPLICANT INFORMATION

Name of Group: NASSAU COUNTY BOCC Div # (BCBSF): 001

Nature of Business: Executive offices SIC Code: 9111 Div# (HMO): 002

Mailing Address: P.O. BOX 1010 FERNANDINA BCH, FL 32035-1010

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name: _____ Address _____

B. Applicant hereby applies for coverage/membership through Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI) Group Contract (herein referred to as the Contract). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Contract issued to the applicant named above.

C. The Contract benefits do not cover any service or supply to diagnose or treat any Condition resulting from or in connection with a insured's job or employment (e.g., any service or supply which is covered by Worker's Compensation Insurance). Benefits will not be provided under the Contract to an individual who elects and is statutorily authorized for exemption from Worker's Compensation coverage.

D. Worker's Compensation carrier is CARRIER NOT ON LIST - SEE COMMENTS BELOW

Prior Carrier is: (BCBSF) CARRIER NOT ON LIST - SEE COMMENTS BELOW (HMO)

II. EFFECTIVE DATE / ELIGIBILITY INFORMATION

A. Effective Date of this Contract shall be 01/01/2001. This Contract may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party.

B. Only active eligible employees who regularly work a minimum of _____ hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Contract.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered after _____ of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least _____ % of the eligible employees and _____ % of the eligible dependents must be enrolled under the Contract on the Effective Date and throughout the term of the Contract.

F. Enrollment data:

	Total Employees	Ineligible Employees*	Total Eligible	Number Enrolled	Percent Enrolled	Multi-Option Split PPO	HMO	
Employees	622	123	499	0	0	0	0	0

Employer Contribution: EMP: 100 % DEP: 0 % *Please provide a list of name(s) and reason(s) for ineligible employees and dependents.

G. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage; applicant agrees to furnish any such records upon request.

III. HEALTH PLAN SUMMARY INFORMATION (select the appropriate box(s)):

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. ☒ Standard ☐ Non Standard ☐ Custom

A. Health Care Benefits Option # PCM C 6

B. Benefits: Co Ins.: 90 % Authorized 70 % Non Authorized

300/300	Deductible Per Person Auth/Non-Auth
900/900	Deductible Family Aggregate: Auth/Non-Auth
10/70% Al'wd	Copay: Phy Off Serv/Specialty
0/1000	Per Adm. Deductible Authorized/Non-Authorized
1000/3000	Out Of Pocket: Per Person Auth/Non-Auth
3000/9000	Out Of Pocket: Family Aggregate: Auth/Non-Auth

C. Rx Program: Copay: $10 Generic $25 Brand NonPreferred

Bluescript II 10/25C Contraceptives: Oral

MANDATED BENEFIT OFFERINGS

(Optional) Applicant has been advised of the following benefit offerings as mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below:

Accept	Decline	
☐	☒	Mental & Nervous Disorder
☐	☒	Alcohol & Drug Dependency
☐	☒	Mammograms Waiver of Deductible & Coinsurance
☐	☒	Enteral Formulas

HEALTH OPTIONS ☒ Standard ☐ Non-Standard ☐ Custom

A. Health Options Plan # BlueCare FQ LG Grp Plan 18

B. Rx BlueCare Rx 18/25C

$10 Generic $25 Brand NonPreferred

Contraceptive All

C. Vision ☐ Yes ☒ No

PRE-EXISTING:

D. Dental: ☐ Standard ☐ Non-Standard With Orthodontics ☐ Yes ☐ No Dental Enrollment:

E. Other:

IV. RATE INFORMATION

A. Premiums/Prepayment fee are payable monthly on or before the due date which will be determined:

Regular Billing - Employee applications should be submitted thirty (30) days prior to proposed effective date.

	HMO	BCBSFL ~~$208.24~~
Employee	$155.91	~~$208.24~~
Employee / Spouse	$300.85	$425.88
Employee / Child(ren)	$331.48	$368.80
Employee / Family	$534.26	$693.86
Other		
Comments:		

B. Funding Arrangements: Discount

HMO: Discount

Dental

The rates established for this Contract will not be changed for the first twelve (12) months following the initial effective date of Coverage. However, BCBSF/HOI may change the rates which are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed rates forty-five (45) days prior to their effective date.

V. APPLICANT RESPONSIBILITIES

A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their effective date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's effective Date. 5) Collect enrollee contribution, if required, and remit premium payment/prepayment fees to BCBSF/HOI as specified above in Section IV. Rates.

B. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.

C. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VI. FINAL PREMIUMS, BENEFITS AND EFFECTIVE DATES ARE SUBJECT TO APPROVAL BY BCBSF CORPORATE HEADQUARTERS

Issuance of the Contract by BCBSF/HOI will be deemed acceptance of this application.

10/16/00 [signature] Nick D. Deonas, Chairman

Date Signature of Applicant Print / Type Name & Title

Nov 3, 2000 [signature] _____

Date Blue Cross and Blue Shield of Florida, Inc. Licensed Agent Agent License Identification Number

Blue Cross and Blue Shield of Florida, Inc. and Health Options, Inc. are Independent Licensees of the Blue Cross and Blue Shield Association.

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