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EMPLOYER APPLICATION (True Group Application)

🗌 N ew Busi	ness 🛛 Rene	ewal Business		for Loc. 01 - Instructions		_	SF): 30749			30749J
I. Applicant	Information									
Name of C		NASSAU CO	DUNTY BOCC	;						
	Business:	Executive of			SIC C	ode: <u>9111</u>				
Mailing Ac					. 32035-1010 re to be eligible a	والأثرية أترج أمريا وروار أترج				
Name:	Subsidiary or	Animated Con	npanies wnos	e employees a	re to be eligible a	Address:	this applica			
(turno.										
Applicant	hereby applies	s for issuance	of a Group Pe	olicy (herein re	ferred to as Polic	y) by Blue Cross	and Blue S	hield of Florida,	Inc. (B	CBSF) and/or
	tions, Inc. (HC	DI). Upon acce	ptance of this	application by	BCBSF and/or H	iOI, it will becom	e part of the	Policy issued t	the a	pplicant named
above. Prior Heal	th Carrier: Insi	urance			RES		(HMO)			
					se or treat any Co	ndition resulting			an Insu	red's job or
					ers' Compensati					
					insation and that					
					who elects exem oyees in the Gro		ers Compe	isation coverag	eanot	
	Compensation			S CASUALTY		- P ·				
	Date / Elgibil		n	The second second						
	ate of this Poli				e date of this cha ys prior written no					licy may be
Premium.	by the applica		nor by giving		ya prior written no				non pu	i filione of
			jularly work a	minimum of 2	10 hours ea	ch week and thei	r eligible de	pendents, shali	be elig	ible for coverage
	ffective Date o									
. Specity cla	issification of e	enrollees for w	nom coverage	e is being requ	ested, if other the	in eigible employ	yees as des	cuped in B abo	ve.	
				All(exce	pt Loc. 01)1st o	f the month				
New eligibl	e employees r	may be covere	ed effective or	the after 90	days/ Loc.01 Da		after 90	days of e	mployr	ment, so long as
the ali-ihi-		mite on on-"	nation to BOD		ployees. 30 days of the da	to the individual	first master	he applicable -	liaihiite	(Fe guiremente
. At least 7					under the Policy					
					ords at any time t					
request.		Ŧ			-	•				-
		Employee		Depender						
in. Health Pl	an Summary	information (select the ap	propriate box	(sj):					
Mandated Be	nefit Offering	s: (Optional)	Applicant has	been advised	of the following b	enefit offerings m	nandated by	the Federal an	d/or St	ate Law.
Applicant's de	cision to accep	pt or decline th	nese benefits	is indicated be	low:	-	-			
Included in					Included in					
product	Accept	Decline			product	Accept	Decline			
$\mathbf{\Sigma}$			Montol 9 M	ervous Disord						
X			AMERICAL OF IN	ervous Disora	er 🗵			Mammograms	Waive	r of Ded. & Coin
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NASSAU COUNTY HUMAN RESOURCES DEPARTMENT P. O. Box 1010 Fernandina Beach, Florida 32035-1010

331

MEMORANDUM

TO: Mike Mullin

FROM: HR Department

DATE: March 25, 2003

SUBJECT: Contract with Blue Cross

Attached is the contract for 2003 between Blue Cross and Nassau County that needs the Chairman's signature. Changes in this contract allow all newly hired Clerk employees (only) to be covered under health benefits the first day of hire.



NASSAU COUNTY BOARD OF COUNTY COMMISSIONERS P. O. Box 1010 Fernandina Beach, Florida 32035-1010 Nick Deonas David C. Howard Vickie Samus Floyd L. Vanzant Marianne Marshall Dist. No. 1 Fernandina Beach Dist. No. 2 Fernandina Beach Dist. No. 3 Yulee Dist. No. 4 Hilliard Dist. No. 5 Callahan

January 9, 2002

JOSEPH M. "Chip" OXLEY, JR. Ex-Officio Clerk

> MICHAEL S. MULLIN County Attorney

WALTER D. GOSSETT County Coordinator

Mr. Ned Tyson The Edwards Building 1553 Gerbing Road Fernandina Beach, FL 32034

Dear Ned:

Pursuant to our conversation during open enrollment regarding the Clerk of the Court's unique hiring requirements, please ask Blue Cross to amend our contract, effective January 1, 2002, to reflect a zero-day waiting period for new employees in this constitutional office.

Sincerely yours, CHĂEL MULLTN

MSM/am

Cc: J. M. "Chip" Oxley, Jr. John Drew Chili Pope

f7/Tyson-jan-09-2002

(904) 225-2610 Board Room; 321-5703, 879-1029, (800) 958-3496

An Affirmative Action / Equal Opportunity Employer

EMPLOYER APPLICATION (True Group App.) New Business 🔲 Renewal Business Group Change - Eligibility C Change for Location 01 (Clerk of Group # (BCBSF): 30749 (HMO) Other 30749.1 п Courts) I. APPLICANT INFORMATION Div # (BCBSF): 001 NASSAU COUNTY BOCC A. Name of Group: Nature of Busin SIC Code: DM# [HMO]: Executive office 9111 002 P.O. BOX 1010 FERNANDINA BCH, FL 32035-1010 Mailing Address List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application. Address Name: Applicant hereby applies for coverage/membership through Blue Cross and Blue Strietd 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 b applicant named above. come part of the Contra represent interview and the second se BITUMINOUS CASUALTY CORP. D. Worker's Compensation certier is (HMO) Prior Carrier is: FLORIDA LEAGUE OF CITIES L. EFFECTIVE DATE / ELIGIBILITY INFORMATION . This Contract may be terminated by the applicant or BCBSF/HOI by giving at least 45 days A Effective Date of this Contract shall be 02/01/2002 prior written notice to the other party. 20 hours each week and their eligible dependents, shall be eligible for coverage B. Only active eligible employees who regularly work a minimum of upon the Effective Date of this Contract. C. Specify classification of enrolless for whom coverage is being requested, if other than eligible employees as described in B above. D. New eligible employees may be covered after All(except Loc. 01)1st of the month after 90 days/ Loc. 01 Date of of employment, so long as the Hire eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements. % of the eligible dependents must be enrolled under the Contract on the Effective E. At least 75 % of the eligible employees and 60 Date and throughout the term of the Contract. Multi-Option Split Total Total Eligible Number Enrolled Percent Enrolled ineligible PPO Employees* HMO Employees F. Enrollment data: 100 Employees 622 61 561 661 63 498 0 % DEP: 0 % *Please provide a list of name(s) and reason(s) for ineligible employees and dep Employer Contribution: EMP: 100 G. BCBSF/HOI shall have the right to sudt the applicant's perroll 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 HEALTH OPTIONS MANDATED BENEFIT OFFERINGS Non-Standard A. Health Care Benefits BlueChoice PPO PhyCopay 706 X Standard B. Benefits: Co Ins.: 90 % PPC % Non PPC (Optional) Applicant has been advised of the Custom 70 Deductible Per Person Per Calendar Year following benefit offerings as mendeled by Health Options Plan # 300 900 Deductible Family Aggregate Per Calendar Year the Federal and/or State Law, Applicant's SiveCare FQ LG Grp Plan 15 Copay: Per Office Visit scision to accept or decline these benefits B. Ru BlueCare Rx 10/25C 15 Per Adm. Deductible For All Non-PPC Hospitals is indicated below: 18 Generic 25 Brand NonPreferred 300 Maximum Out of Pocket at Decli 1500 Acc Contraceptive AB 🔲 🔯 Mental & Nervous Disorder C. Vision 🔲 Yes 🛛 No RE-EXISTING: C. Rx Program: Copay: 10 Generic 25 Brand Di Alcohol & Drug Dependency NonPreferred Menmograms Waiver of Deductible & Coineurance Contraceptives: All Bluescript IV 10/25 **Pre-Existing Applies** Enteral Formulas D. Dental: 🔲 Standard 🔲 Non-Standard With Orthodontics 🔲 Yas 🖾 No DentalEnroliment: E. Other: IV. RATE INFORMATION BCBSFL Premiums/Prepayment fee are payable monthly on or before the due HMQ date which will be determined: Employee Regular Billing - Employee applications should be submitted \$267.74 \$299.90 \$613.29 \$628.38 thirty (30) days prior to proposed effective date. Employee / Spouse \$548.50 Employee / Child(ren) \$477.36 Э. Funding Arrangements: Discount Employee / Family \$769.A1 \$855.00 HMO: Discount Other Dental Comm The reles established for this Contract will not be changed for the first twelve (12) months following the initial effective data 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 The applicant shall: 1) Notify each enrolee to the benefits selected by the applicant, their effective date, and the termination date of coverage (in this regard, In a applicant scale. 1) would each enclose to the borhous selected by the applicant, then enclose care, and the terministion date of coverage (in this regard, applicant acts as the spent of the enclose, and in no event shall the applicant be deemed an spent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retrease). 2) Deliver to covered encoless identification cards and certificates of coverage furnished by BCBSF/HOI be responsible for such notification to retrease). 2) Deliver to covered encoless covered under this Agreement. 4) List any absences at the time of initial encodement on the appropriate BCBSF/HOI form. Applications from absences will be accepted at BCBSF/HOI corporate headquarters no later than thirty (30) days from the group's effective Date. 5) Collect encoles contribution, if required, and remit premium payment/prepayment fees to BCBSF/HOI as specified above in Section IV. Rates. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, aurgical, hospital care, or benefits in the event of sickness. Any person who knowingly and with intent to injure, definited, or deceive any insurer files a statement of cluim or an application containing any false, incompt 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 suance of the Contract by BCBSF/HQI will be deemed acceptance of this application. 2/25/02 Elle. Nick D. Deonas, Chairman 61 4 Destes Print / Type Neme & Title Date

Agent License Identification Number

Blue Cross and Blue Shield of Florida, Inc. Licensed Agent