CS-1689

Employer Application
Group Dental Insurance

CM2358

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

1. Legal Name of Contractholder **NASSAU COUNTY BOCC**				
2. Address **96135 NASSAU PL STE 5,**	City **YULEE**	County **Nassau**	State **FL**	Zip Code **32097-8635**
3. Group Administrator **ASHLEY METZ**	4. Telephone Number **(9045306075)**	5. Nature of Business **EXECUTIVE OFFICES**		6. SIC Code **9111**
7. Name of Subsidiaries, Divisions, or Affiliates to be covered		8. Nature of Their Business		
9. Effective Date 12:01 A.M. Mo **10** Day **01** Year **2016**	10. Group Number **30749**	11. Number of employees currently Eligible **636** Enrolled **438**		
12. Premiums are to be paid: ☒ Monthly ☐ Other _____ Due Date: ☒ 1st of Month ☐ 15th of Month		13. Employer Contribution Employee **0** % Dependent **0** %		
14. Full-Time Employee The normal work week for your full-time employees is **30** hours. Usually, the normal work week is at least 30 hours.				
15. Benefit Eligibility Period is **60** days for present employees; and **60** days for future employees.				
16. Annual Open Enrollment Period **From: 09/01 To: 09/30**		17. Renewal Date Mo **01** Day **01**		
18. Benefit Plan Year ☐ 12 Months Following Effective Date ☒ Calendar Year (Jan 1 – Dec 31)	**FROM** Mo Day Year **10 01 2016**	**TO** Mo Day Year **12 31 2016**	19. Ineligible Classes and/or Divisions (If None, please state) **None**	

20. SCHEDULE OF BENEFITS (Attach copy of Proposal, if any.)

PLAN 1

Eligible Classes: **All Full Time**

(Select One Plan)

- ☐ BlueDental Care (Prepaid) FD305 ☐ Include Ortho
- ☐ BlueDental Care (Prepaid) FS305 ☐ Include Implants
- ☐ BlueDental Care (Prepaid) FD310 ☐ Include Ortho
- ☐ BlueDental Care (Prepaid) FS295
- ☒ BlueDental Choice (PPO)
- ☐ BlueDental Choice Plus (PPO)
  Choice Plus OON Reimbursement _____
- ☐ BlueDental Choice Copayment(PPO) Cleaning Copay ☐ $0 ☐ $10
- ☐ BlueDental Choice - Community Rated(PPO) Plan # _____
- ☐ BlueDental Choice Copayment - Community Rated (PPO) Plan # _____

For all BlueDental Choice Plans

Plan Year Deductible	Individual	Family
In-Network	$ **50**	$ **150**
Out-of-Network	$ **50**	$ **150**

Coinsurance %	Preventive	Basic	Major
In-Network	**100** %	**80** %	**50** %
Out-of-Network	**100** %	**80** %	**50** %

Major Services Waiting Period ☒ Yes ☐ No
Plan Year Maximum $ **1000** **Roll Over Benefit** ☒ Yes ☐ No
Orthodontia ☒ Yes ☐ No Ortho Waiting Period ☒ Yes ☐ No
Coinsurance **50** % Child Only Coverage(ends at age 19) ☒ Yes ☐ No
Lifetime Maximum $ **1000** All Insureds Covered ☐ Yes ☒ No

Flexibility of Services: Available to non-community rated Choice and Choice Plus plans.

	Standard	Non-Standard
Bitewing X-Rays	☒ Preventive	☐ Basic
Endodontics	☒ Basic	☐ Major
Periodontics	☒ Basic	☐ Major
Sealants	☐ Basic	☒ Preventive
Periapical /Full Mouth /Panoramic X-Rays	☐ Basic	☒ Preventive

PLAN 2

Eligible Classes: **All Full Time**

(Select One Plan)

- ☐ BlueDental Care (Prepaid) FD305 ☐ Include Ortho
- ☒ BlueDental Care (Prepaid) FS305 ☐ Include Implants
- ☐ BlueDental Care (Prepaid) FD310 ☐ Include Ortho
- ☐ BlueDental Care (Prepaid) FS295
- ☐ BlueDental Choice (PPO)
- ☐ BlueDental Choice Plus (PPO)
  Choice Plus OON Reimbursement _____
- ☐ BlueDental Choice Copayment (PPO) Cleaning Copay ☐ $0 ☐ $10
- ☐ BlueDental Choice - Community Rated(PPO) Plan # _____
- ☐ BlueDental Choice Copayment - Community Rated (PPO) Plan # _____

For all BlueDental Choice Plans

Plan Year Deductible	Individual	Family
In-Network	$	$
Out-of-Network	$	$

Coinsurance %	Preventive	Basic	Major
In-Network	%	%	%
Out-of-Network	%	%	%

Major Services Waiting Period ☐ Yes ☐ No
Plan Year Maximum $ _____ **Roll Over Benefit** ☐ Yes ☐ No
Orthodontia ☐ Yes ☐ No Ortho Waiting Period ☐ Yes ☐ No
Coinsurance _____ % Child Only Coverage(ends at age 19) ☐ Yes ☐ No
Lifetime Maximum $ _____ All Insureds Covered ☐ Yes ☐ No

Flexibility of Services:

	Standard	Non-Standard
Bitewing X-Rays	☐ Preventive	☐ Basic
Endodontics	☐ Basic	☐ Major
Periodontics	☐ Basic	☐ Major
Sealants	☐ Basic	☐ Preventive
Periapical /Full Mouth /Panoramic X-Rays	☐ Basic	☐ Preventive

PLAN 1 (Continued)

Domestic Partner: (Large Group Only 51+)

- [x] Not Included
- [ ] Domestic Partner Only
- [ ] Domestic Partner with Dependents

Over Age Dependent: (Large Group Only 51+)

- [x] Age 26
- [ ] Age 27 with Qualifying Questions ☐ Yes ☐ No
- [ ] Age 28 with Qualifying Questions ☐ Yes ☐ No
- [ ] Age 29 with Qualifying Questions ☐ Yes ☐ No
- [ ] Age 30 with Qualifying Questions ☐ Yes ☐ No (Standard)

*Premiums	EE only	EE+ Spouse	EE+ Child	Family
	$ 24.08	$ 48.43	$ 44.12	$ 81.57

PLAN 2 (Continued)

Domestic Partner: (Large Group Only 51+)

- [x] Not Included
- [ ] Domestic Partner Only
- [ ] Domestic Partner with Dependents

Over Age Dependent: (Large Group Only 51+)

- [x] Age 26
- [ ] Age 27 with Qualifying Questions ☐ Yes ☐ No
- [ ] Age 28 with Qualifying Questions ☐ Yes ☐ No
- [ ] Age 29 with Qualifying Questions ☐ Yes ☐ No
- [ ] Age 30 with Qualifying Questions ☐ Yes ☐ No (Standard)

*Premiums	EE only	EE+ Spouse	EE+ Child	Family
	$ 13.00	$ 26.00	$ 29.24	$ 47.04

(*Premiums are subject to change based on final rating by FCL and are valid for 12 months following effective date.)

21. Replacement: Will this insurance replace any insurance now in force with another insurer covering employees eligible for this insurance? (If yes, attach copy of current policy.) ☐ No ☒ Yes

Name of insurance company: **HUMANA** Date to which premiums paid: **09/30/2016**

22. Special Remarks **15 month rate hold, next renewal is 1/1/2017. Benefit Period will reset effective 1/1/17 and update to 1/1/17 – 12/31/17.**

The applicant hereby certifies that the information contained in this application, including any attachment to it, is true and complete. The applicant understands that Florida Combined Life Insurance Company, Inc. (FCL), relies upon such information in considering or accepting this application, which will become part of the contract. If the policy is issued, it will be binding on you and us. It is also agreed that no insurance will become effective until approved by FCL.**(Please print, except where signature is requested.)**

For (Name of Applicant)	Group Representative	Licensed Agent (FL)
NASSAU COUNTY BOCC	**ANDREW CARROLL**	**MARK BAILEY**
By and Title Walter J. Boatright, Chairman	Group Representative Code & License # **A03**	License # (Social Security #/Federal Tax ID) **5037-001**
Signature	Group Representative Signature	Licensed Agent Signature
Signature of Witness	Dated At 10/25/16	Date

Florida Combined Life, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association

FRAUD NOTICE: 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.

Ashley Metz, HR Director/Decision Maker _____ Signature _____ 10/18/16 Date