DOCUMENTS THAT CONTAIN WHITE-OUT CANNOT BE ACCEPTED

Administrative Form		
Section Line#	**Description**	**Instructions**
		Group Number: To be completed by BlueCross BlueShield of Tennessee
		Effective Date: To be completed by BlueCross BlueShield of Tennessee
Section A - General Information		
1	Group Name	Name of group is listed here, including dba name.
2	Physical Location	This is the physical location of the group.
3	Billing Address	This is the address where bills are to be sent.
4	Telephone Number / Extension	Group's telephone number and extension.
4a	Fax Number	Group's fax number.
5	Name of Group Administrator	Name of the group administrator.
5a	Title	Title of the Employer's Group Administrator.
6	E-mail Address	Group Administrator's E-mail address. Select none or as follows & enter address.
7	Nature of Business	Detailed description of business.
8	Current Group Medical Carrier	Who is the current medical carrier?
8a	Current Dental Carrier	Who is the current dental carrier?
9	Union-negotiated contract	Answer yes or no. If yes, enter expiration date.
9a	Minority ownership	Answer yes or no.
9b	Government contract	Answer yes or no.
10	What is employer's fiscal year	List fiscal year (ie: 01/01-12/31)
11	Creditor filed request for employer bankruptcy (in past 36 months)	Answer yes or no.
12	Employer filed bankruptcy (in past 36 months)	Answer yes or no.
13	Who can make changes via Web (Blue Access & e-Health Services) for Employee Addresses, Coordination of Benefits and Enrollment?	Check Group, Member and/or Broker for each one.
14	Initial ID card mailing	Where are initial ID cards to be mailed?
15	Future ID card mailing	Where are any future ID cards to be mailed?
Section B – Plan Eligibility (Medical and/or Dental)		
1	Does Employer have any group coverage with BCBST.	Answer yes or no.
	Current group number	If 1 is answered yes, enter current group number.
2	Employer contribution	Enter employer's contribution for medical & dental.
3	Requested Billing Cycle	Enter group's requested bill cycle, **if** it is different from the effective date (ie: 01/15).
Employee Grid: Enter number of Employees eligible and enrolling at the effective date of this coverage for each class indicated..		
Section C - HSA - Skip this section if HSA is not a part of the Plan.		
1	If Employer is electing to offer HSA, complete the following. Otherwise, skip this section.	
1a	HSA Bank Selection	Check one

1b	Is Employer contributing to HSA	Check yes or no & enter amounts

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Section D - BCBST Internal Use Only (To be completed by BCBST)		
1	Apply deductible and out-of-pocket credit on initial enrollment?	Check yes or no
2	Electronic Data Interchange	Check yes or no for electronic enrollment.
3	Premium billed	Check BCBST billed for all fully insured business. Group billed is not available at this time.
4 – 6a	Subgroup	List subgroups names & addresses, if applicable.
7 – 8	Department Name & Number	List dept names & numbers if applicable.
9	Primary & Co-Broker	This is the broker's commission code
10	Special Notes	List any special requests or issues here
11	Additional materials needed.	Check yes or no for each material type. If yes is checked, enter number of Medical Directories, Dental Directories and Group Administrative Reference Manuals needed and where they are to be mailed.
12	Sales Executive	Sales Executive name & number
13	Account Manager	Account Manager name & number