



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

**EMPLOYER APPLICATION  
Blues Enroll**

Renewal APPLICATION by: CITY OF JONESBORO

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

**GROUP INFORMATION**

Legal Name of Business: CITY OF JONESBORO

D/B/A: CITY OF JONESBORO

Street Address: 515 W Washigton

City, State, Zip: Jonesboro , AR , 72401

County: Craighead

Mailing Address: (if different from Street) P O BOX 1845

City, State, Zip: Jonesboro , AR , 72403

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-6013749

Exec. Contact: Harold Perrin

E-Mail:

Group Administrator: GLORIA ROARK

E-Mail:

Primary SIC Code: 9199 SIC Description: General Government, NEC

Business Type: Government Entity

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

**POLICYHOLDER AS PLAN ADMINISTRATOR**

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

**PROXY**

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting.

**Benefit Selection****RX ONLY – MEDIPAK SUPPLEMENT RX****REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2012****Waiting Period Note:** Effective Date is the first of the month following the Waiting Period.Date of Open Enrollment December

If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
4	Med supp elctd offices w 20 yrs cnt sc-rx	0 Months	Employee 25%    Dependent 0%

*Note: The Employer must pay a minimum of 50% of the Employee premium. This policy may be terminated by the company if the Policyholder fails to contribute the percentage of the Employees' premium specified above.***Maximum Dependent Age: 26****Mandated Mental Health Parity: Yes****RX ONLY****Prescription Drug Rider Plan:** \$10/\$30/\$50, 100% Value Formulary    Mail Order Drug – 2x Copay (90 days)*Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage.*

**RATES - MEDIPAK SUPPLEMENT RX**

One Tier Composite	Total Premium
Employee	\$79.25

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

**Grandfather Status** - Our records indicate that your health plan is grandfathered.

**Please confirm if you agree with the grandfathered status as indicated above.**

Yes, I agree with the status as shown.

No, I disagree with the status as shown because \_\_\_\_\_

**ATTESTATIONS**

**COBRA**

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).

Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

(Yes ) (No ) Under the governmental guidelines the group health plan is subject to Cobra, meeting the criteria for 20 or more employees.

(Yes ) (No ) If yes, do you wish to use the services of Ceridian?

If no, who will administer Cobra for you? \_\_\_\_\_

**Medical Loss Ratio** - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides

(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.

The policyholder is a  large employer  small employer (check one).

**EMPLOYEE INFORMATION**

**MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS.**

**Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).**

**Full-Time** = means an active employee with a minimum of 30 hrs/week & 48 weeks/year

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	1		1
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			1

**Minimum Number of Insured Employees.** To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.

**Minimum Participation Requirements.** Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

**This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.**

Special Group Considerations Form# 23-2232, Description retiree elected officials Rx
Special Group Considerations Form# 23-2170, Description Continuation for Municipal Emps 55+
Special Group Considerations Form# 23-2186, Description No Deductible Carryover
Special Group Considerations Form# 23-2432, Description Contin for City Cnsl Mbrs & Elect Officials
Special Group Considerations Form# 23-2546, Description alternate eligibilty hours(40/week)
Special Group Considerations Form# 23-2242, Description \$100 ER co-pay

**SIGNATURES**

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.

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

**1. Policyholder**

Signed at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
(City, State)

\_\_\_\_\_ [full legal name of Policyholder]

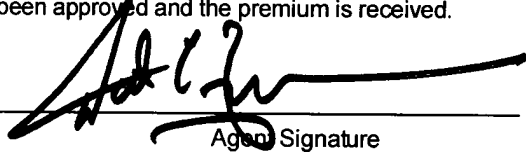
By: \_\_\_\_\_  
Authorized Signature

\_\_\_\_\_ Printed Name

\_\_\_\_\_ Title or Position

**2. Agent**

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

  
Agent Signature

23908  
Insurance License # / Agency Fed. Tax ID #

DAVID C. FERGUSON  
Agent Printed Name

\_\_\_\_\_  
Date