

ENROLLMENT SUMMARY

COBRA COMPLIANCE (CHECK APPROPRIATE BOX)

- Our company employed 20 or more full and/or part-time employees* during the previous calendar year and is subject to federal COBRA. All full and part-time common law employees of an employer are considered in determining COBRA compliance. All full time employees are counted as one employee and each part-time employee is counted as a fraction of an employee.
- Our company employed fewer than 20 full and/or part-time employees* during the previous calendar year and is subject to the Florida Health Insurance Coverage Continuation Act ("FHICCA"). All full and part-time common law employees of an employer are considered in determining COBRA compliance. All full time employees are counted as one employee and each part-time employee is counted as a fraction of an employee.

* For COBRA and FHICCA purposes, self-employed individuals, independent contractors and non-employee directors are not counted.

MEDICARE SECONDARY PAYER COMPLIANCE (CHECK APPROPRIATE BOX)

Multiple employer plan: a plan sponsored by more than one employer. Multi-employer plan: a plan jointly sponsored by employers and unions.

If you are a single employer plan:

- Yes No Our company employed 20 or more employees** each working day in 20 or more calendar weeks (does not have to be consecutive weeks) during the current or preceding calendar year.

If you are a single employer, multiple employer or a multi-employer plan:

- Yes No Our company employed 100 or more employees** on 50 percent or more of the business days during the preceding calendar year.

If you are a multiple employer or a multi-employer plan:

- Yes No All employers in our Group Health Plan (GHP) employed 20 or more employees** for 20 or more consecutive weeks in either the current or preceding calendar year.
- Yes No At least one of the employers in our GHP employed 20 or more employees** for 20 or more consecutive weeks in either the current or preceding calendar year.
- Yes No All employers in our GHP employed fewer than 20 employees** for 20 or more consecutive weeks in either the current or preceding calendar year.

**** "Employees" includes all full and/or part time employee**

I. General Information	
1. Group Name	2. Group Number
3. Group Sales Rep/Agent	4. Effective Date
5. Employer Contribution Toward Employees Premium (must be at least 50% for 1-50, 75% for 51+)	
II. Recap of Employee Participation	
1. TOTAL EMPLOYEES ON PAYROLL	=>
2. TOTAL COBRA CONTINUANTS	=>
3. TOTAL INELIGIBLE EMPLOYEES	Total of A+B+C =>
A. Total Part Time Employee(s)	=>
B. Total New Employee(s) (in Waiting Period)	=>
C. Total Employee(s) Other	=>
4. TOTAL ELIGIBLE EMPLOYEES (DETERMINES GROUP SIZE & PRODUCT)	1+2 Minus 3 =>
D. Total Employees with Other Coverage	=>
5. TOTAL ELIGIBLE FOR PARTICIPATION	4 Minus D =>
E. Total Refusals	=>
6. TOTAL ENROLLED	5 Minus E =>
7. EMPLOYEE PARTICIPATION (75% IS REQUIRED)	6 Divided by 5 =>

Employers must have an application completed for all employees, even those who are not taking the health coverage, and submit those applications to Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. It is recommended that the employer also retain a copy of all applications.

I certify that the above information is correct to the best of my knowledge. I understand that this information will be used to determine my company's compliance with Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. eligibility and Underwriting Guidelines, as well as the applicability of State and Federal laws relating to my company and plan. Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. reserves the right to request a UCT-6 or other documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and Underwriting Guidelines, as well as validate the applicability of State and Federal laws.

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.

Group Officer's Signature

Title

Date