Small Group Benefit Modification Inquiry

All medical products except Blue Cross Basic PPO and Blue Cross Saver PPO offered by Blue Cross of California.
Blue Cross Basic PPO and Blue Cross Saver PPO, Life and AD&D products offered by BC Life & Health Insurance Company.

www.bluecrossca.com

This form may be used for preliminary review of existing groups (with medical coverage already) requesting to upgrade to the EmployeeElect Plus program. This form is not to be used for Risk Adjustment Factor (RAF) reviews, benefit downgrades or adding medical coverage to existing dental/life groups.

UNDERWRITING UNIT	UW1	UW2
FAX NO.	(805) 499-8623	(805) 499-0302
SUPERVISOR	Susan Davis	Eddie White
REGIONAL SALES MANAGERS	Mike Accetta, Lynda C. Anderson, John Anthony, Craig Barton, Bob Brassard, Dennis Brown, Carlos Fernandez, Robert Frank, Steve Hausman, Marilyn Jones, Carl Kirnon, Chris Laliberte, Dave Messing, Dan Michael, Sandy Millison, Cindy West	Art Carls, Roberta dePonte, Fred Fourby, Mike Framberger, Jim Goodacre, Art Gordillo, Ted Jenkins, Liz Kocir, Tom Magnus, Pat O'Brien, Chris Peters, Susan Reed, Eileen Roark, Rick Silverman, Todd Taylor, Peter Vorrises
GENERAL AGENT	BenefitMall.com, BISYS, CIMS, Dickerson, Group Benefits Plus, New Enrollment North, New Enrollment South, Pan American, RSI Insurance Brokers, Viba	Acordia of California, Beere & Purves, Cenco, LISI, Price Associates, Warner Pacific

GROUP INFORMATION

(1099 employees are not eligible for coverage)

GROUP NAME		GROUP NO.	DATE INQUIRY SUBMITTED
NO. OF FULL-TIME EMPLOYEES	NO. OF PART-TIME EMPLOYEES	NO. OF PREGNANCIES IN GROUP Due dates: / / / /	
AGENT NAME	AGENT NO.	PHONE NO. ( )	FAX. NO. ( )
GENERAL AGENT NAME	GENERAL AGENT NO.	PHONE NO. ( )	FAX NO. ( )

PLAN OPTION

☐ All plans* or designate specific plan options *(Check as many as apply)*
☐ Premier PPO $10 Copay
☐ Premier PPO $20 Copay
☐ HMO 100%
☐ PPO $30 Copay
☐ PPO $40 Copay
☐ Saver HMO
☐ Saver PPO
☐ High Deductible EPO (MSA Compatible)
☐ Basic PPO

** Basic PPO Plan is included in the "All plans" option or can be selected in combination with one or more additional PPOs only to groups uninsured for 30 or more days.*

MEDICAL CONDITIONS

To your knowledge, has any employee or dependent had claims resulting in expenses in excess of $2,500 in the last six (6) months? ☐ Yes ☐ No
If yes, please complete the information below. Attach additional pages as needed.

EMPLOYEE / DEPENDENT DATA

Specific Diagnosis	Date of Onset	Medication(s)	Prognosis / Current Treatment
			PROGNOSIS
			CURRENT TREATMENT
			PROGNOSIS
			CURRENT TREATMENT
			PROGNOSIS
			CURRENT TREATMENT

GENERAL CONCERNS AND QUESTIONS

UNDERWRITING RESPONSE – *All documentation must be received 30 days prior to the requested effective date.*

POTENTIAL FOR:
☐ Approval ☐ Decline
OR:
☐ Need additional information *(See notes below)*

SUBMIT WITH:
☐ New employer application
☐ Change of Coverage – Application for those employees requesting to change *(Medical only)*
☐ Letter from group requesting change
☐ DE6

NOTES

NAME OF UNDERWRITER	UNIT NO.	PHONE NO. ( )	DATE

Preliminary decisions resulting from this inquiry are based solely upon the completeness and accuracy of the information provided. If you apply for this benefit modification, please be sure to include a copy of this Inquiry and our response with any additional documentation that we may ask for. This response does not guarantee the benefit modification will be approved. The final decision will be based upon the underwriter's review of all documentation submitted.

Blue Cross of California and BC Life & Health are Independent Licensees of the Blue Cross Association.
® Registered Mark of the Blue Cross Association.