FirstCarolinaCare Insurance Company
EMPLOYER APPLICATION

SECTION 1- EMPLOYER INFORMATION

Legal Name of Company _____

DBA _____

Physical address _____

Mailing address (if different) _____

How many other location(s)? ____ If any, list: _____

Telephone _____ Fax _____

Name of responsible party _____ E-mail address _____

Name of primary contact _____ E-mail address _____

Type of business _____ SIC Code _____ Tax ID _____

☐ Corporation ☐ Partnership ☐ Proprietorship Date established _____

Does applicant presently have group coverage with another carrier? ☐ Yes ☐ No

If Yes, please identify below and send in a copy of the last month's billing statement along with this application.

Current Carrier Name:		
Current Effective Date:	Current End Date:	Renewal Increase:
Prior Year Carrier:		
Prior Year Effective Date:	Prior Year End Date:	Renewal Increase:
2 Years Prior Carrier:		
2 Years Prior Effective Date:	2 Years Prior End Date:	Renewal Increase:

Is the applicant self-insuring any part of the individual deductible? ☐ Yes ☐ No Above what dollar amount? $_____

Requested effective date of coverage: _____ (*Actual effective date will be determined by FCC*)

Requested benefit period: ☐ Calendar Year ☐ Plan Year

Name of workers' compensation carrier: _____

Are all eligible employees covered by workers' compensation? ☐ Yes ☐ No If No, please provide list of individuals and explain why _____

Do any employees work out of state? ☐ Yes ☐ No

SECTION 2 – ELIGIBILITY

Note: For small employers (50 employees or less), eligible employees (including owners, partners, and executive officers) are those who work a minimum of 30 hours per week for the applicant.

Dollar amount or percentage applicant pays toward monthly premium: Employee _____ Dependent _____

Total number of full-time employees _____ Total number of part-time employees _____

Total number of full-time equivalent employees _____ Number of employees enrolled in the current plan _____

Are any employees not actively at work? ☐ Yes ☐ No If Yes, list names and reason, e.g. leave of absence, disability, etc.

_____

Is anyone currently covered under COBRA or State continuation coverage? ☐ Yes ☐ No (If yes, please provide effective date of coverage and the qualifying event, i.e., termination of employment, disability, etc.). _____

_____

Is there any dependent over age 26 who is physically handicapped or intellectually disabled covered by the current carrier?

☐ Yes ☐ No

Does the employer allow early retirees, < 65 years of age, to remain on the coverage? (***Note**: If Yes, provide a copy of the retiree policy*) ☐ Yes ☐ No

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SECTION 2 – ELIGIBILITY (continued)

Probationary/waiting period for **new employees** (*Effective date is the next day following the probationary/waiting period*)

☐ None ☐ 30 days ☐ 60 days ☐ 90 days ☐ First of month after hire date ☐ Other _____

Newly eligible enrollee (i.e., part-time to full-time) ☐ Same as new employees ☐ First of month following change of hours

Termination effective date ☐ Date of term ☐ End of month

Does applicant prefer a departmentalized premium bill? (***Note**: If Yes, provide department names*) ☐ Yes ☐ No

Delivery of identification cards after group enrollment? ☐ Overnight to the group ☐ Mail directly to members

Is a Section 125 Cafeteria Plan or a Premium Only Plan being used? ☐ Yes ☐ No

Is your company currently subject to COBRA (employed 20 or more total employees on a least 50% of the working days in the previous calendar year)? ☐ Yes ☐ No

- If Yes, is FCC administering COBRA? ☐ Yes ☐ No
- If FCC is not administering COBRA, please provide COBRA administrator: _____

If No, your company is subject to State Continuation (employed 19 or less total employees on a least 50% of the working days in the previous calendar year). ☐ Yes

- If Yes, is FCC administering State Continuation? ☐ Yes ☐ No

Additional Services: FCC offers administration of COBRA/State Continuation for dental and/or vision. (***Note**: A separate agreement and administrative fees apply*)

Is FCC administering Additional Services as described above? ☐ Yes ☐ No If Yes, ☐ Dental ☐ Vision

SECTION 3 - MEDICAL INFORMATION [DOES NOT APPLY TO SMALL EMPLOYER][1]

The following questions apply for any individual applying for coverage (employee, spouse, and other dependents). The time period for which the questions apply is the past 2 years (except for questions 6 and 7).

1. Has anyone incurred medical expenses in excess of $10,000? ☐ Yes ☐ No
2. Has anyone been treated for heart or circulatory problems, stroke, cancer, back or spinal problems, mental or nervous disorders, alcoholism or drug abuse? ☐ Yes ☐ No
3. Has anyone been treated for immune deficiency (e.g. Acquired Immune Deficiency Syndrome (AIDS) or Acquired Immune Deficiency Syndrome Related Complex (ARC)), Hepatitis C, multiple sclerosis or renal disease? ☐ Yes ☐ No
4. Is anyone disabled? ☐ Yes ☐ No
5. Has anyone been told that they will or may have to be placed in or receive treatment by or in a hospital? ☐ Yes ☐ No
6. Is anyone currently pregnant? ☐ Yes ☐ No
7. Is anyone currently in the hospital? ☐ Yes ☐ No

If you checked Yes for any of the questions above, please complete the following:

Name of Employee or Dependent	Approximate Amount of Medical Expense Incurred and Date	Nature of Medical Condition

[1] Only certain sole proprietors can be covered as a small employer under NCGS 58-50-110.

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SECTION 4 - IMPORTANT NOTICES

COVERAGE WILL NOT BECOME EFFECTIVE UNLESS: (A) THIS APPLICATION IS APPROVED BY FIRSTCAROLINACARE INSURANCE COMPANY ("FCC"); (B) ELIGIBILITY REQUIREMENTS ARE SATISFIED; AND (C) PARTICIPATION REQUIREMENTS, WHEN APPLICABLE, ARE SATISFIED. **REQUIRED DISCLOSURE: A SMALL EMPLOYER (50 EMPLOYEES OR LESS) IS ENTITLED TO REVIEW, UPON REQUEST, FCC AGREEMENT PROVISIONS: (A) CONCERNING FCC'S RIGHT TO CHANGE PREMIUM RATES AND THE FACTORS OTHER THAN CLAIMS EXPERIENCE THAT AFFECT SUCH CHANGES, (B) RELATING TO RENEWABILITY OF COVERAGE AND, (C) DESCRIBING BENEFITS AVAILABLE AND PREMIUMS CHARGED FOR ALL PLANS FOR WHICH THE SMALL EMPLOYER IS ELIGIBLE.**

The authorized representative of the applicant certifies that: I have read and understood the Employer Application and all answers in it are true and complete to the best of my knowledge and belief.

Date:_____ Name of person completing application_____

Signature_____ Title_____

Witnessed by (signature)_____ Title_____

AGENT'S REPORT [2]

Is this is a takeover from an existing group insurance plan? ☐ Yes ☐ No
Have you explained to the employer that coverage will not become effective until application is accepted and then only upon the effective date to be determined by FirstCarolinaCare Insurance Company? ☐ Yes ☐ No
Are you the incumbent agent for the group? ☐ Yes ☐ No

I have complied with the FirstCarolinaCare Insurance Company's underwriting rules and regulations and have explained in detail the available coverages to the applicant. Information concerning the benefits and administrative procedures was left with the applicant. I hereby certify that all of the information contained in this application is correct to the best of my knowledge and that I know nothing unfavorable about the risk or any individual proposed for coverage excepted as noted above.

_____
Agent's Name (Please Print)

_____
Agency Name

_____
Agency Address City, State, Zip

_____
Agency Telephone Number

_____
Signature of Agent

ADDITIONAL COMMENTS:

[2] **Note**: FCC believes that using the services of an Agent/Broker can add value to the insurance buying process. The choice to use an agent or a broker will not affect premium rating.