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VA LEVEL FUNDING NEW BUSINESS PACKET

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Revised as of 7/2026

GROUP INSTALLATION CHECKLIST

Group Installation Checklist

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To complete Group setup, the information listed below must be submitted. For step-by-step guidance on how to install a group through the Broker Portal, view the "**How To Install a Group Approved for CareFirst Level Funding"** video.

	ACTION ITEMS	REQUIRED FOR GROUP INSTALLATION?
Group Information Form (GIF) for Medical and Rx	Fill out digitally on Broker Portal	Yes
ACH Banking Details for Autopay (i.e., CareFirst Monthly AutoPay Agreement)	Fill out digitally on Broker Portal; use the document in this packet as a reference	Yes
Group Size Full-Time Equivalent (FTE) Submission Form	Fill out digitally on Broker Portal; upload a signed form	Yes
Medicare Secondary Payor (MSP) Calculation Form	Fill out digitally on Broker Portal; upload a signed form	Yes
Group Contract Application (GCA) (Dental and Vision)	Fill out digitally on Broker Portal; upload a signed form	Required only for groups electing Dental or Vision coverage
Most Recent Denoted Wage & Tax Form	Upload to Broker Portal	Yes, required for all Level Funding groups, including new business and ACA conversion
Stop Loss Risk Disclosure Form (Stop Loss Insurance Disclosure)	Complete form referenced in packet; upload to Broker Portal	Required only for new business
Stop Loss Insurance Application (Application for Stop Loss Insurance)	Complete form referenced in packet; upload to Broker Portal	Yes

LEVEL FUNDING GROUP INFORMATION FORM

Level Funding Group Information Form

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GENERAL INFORMATION

Group Number:	Group Effective Date:
Name of Group:	
Standard Industry Code (SIC):	Federal Tax Identification Number:

PHYSICAL LOCATION

Street Address/Suite:		
City:	County:	
State:	ZIP:	Phone:

GROUP ADMINISTRATOR (CONTACT PERSON)

Name:		
Title:	Phone:	
Street Address/Suite:		
City:	State:	ZIP:
Email Address:		

FIRM EXECUTIVE (CHIEF EXECUTIVE OFFICER/PRESIDENT)

Name:		
Title:	Phone:	
Street Address/Suite:		
City:	State:	ZIP:
Email Address:		

BROKER/PRODUCER INFORMATION

Broker Name:	Broker Tax ID:
Agency Name:	Agency Tax ID:
General Producer Name:	General Producer Tax ID:

- Yes ☐ No ☐ Part-time employees working at least 17.5 hours per week and are not full time employees. (Those part-time employees working less than this required time period are not eligible).
- Yes ☐ No ☐ Domestic Partners of Eligibility Employees

AGE LIMITS FOR DEPENDENT CHILDREN

Dependent children enrolled by an Eligible Employee (other than an incapacitated Dependent Child) are covered until the last day of the month of their 26th birthday.

EFFECTIVE DATES FOR NEWLY ELIGIBLE EMPLOYEES (MARYLAND GROUPS)

- ○ Coverage for a new Eligible Employee will be effective on the first day of the month following the date of employment or eligibility, whichever is later, unless otherwise specified below:
- ○ On the date of employment or eligibility, whichever is later.
- ○ On the first day of the month following 30 days of employment or eligibility, whichever is later.
- ○ On the first day of the month following 60 days of employment or eligibility, whichever is later.
- ○ On the day following days of employment or eligibility, whichever is later (day range cannot exceed a total of ninety (90) days).
- ○ On the day following the completion of the Group's Waiting Period. The Group's Waiting Period for professional employees is days from the date of employment or eligibility, whichever is later and, for non-professional employees, is days from the date of employment or eligibility, whichever is later (day ranges cannot exceed a total of ninety (90) days.).
- ○ On the first day of the month following the completion of the Group's Waiting Period. The Group's Waiting Period for professional employees is days from the date of employment or eligibility, whichever is later and, for non-professional employees, is days from the date of employment or eligibility, whichever is later (day ranges cannot exceed a total of sixty (60) days to ensure compliance with applicable law).

EFFECTIVE DATES FOR NEWLY ELIGIBLE EMPLOYEES (VIRGINIA GROUPS)

- ○ On the date of employment
- ○ On the first day of the month following the date of employment.
- ○ On the first of the month following 30 days of employment or eligibility.
- ○ On the first of the month following 60 days of employment or eligibility.
- ○ Other (Specify. Date cannot exceed a total of ninety (90) days.

TERMINATION OF COVERAGE RULE FOR MARYLAND GROUPS

Coverage for enrolled Subscribers who are no longer eligible (and any enrolled Dependents) terminates on the last day of the month in which the Subscriber's employment or eligibility terminates.

TERMINATION OF COVERAGE RULE FOR VIRGINIA GROUPS

Coverage for enrolled Subscribers and their enrolled Dependents terminates on the date stated below:

- ○ On the date on which the Subscriber's employment or eligibility terminates.
- ○ On the last day of the month in which the Subscriber's employment or eligibility terminates.

CAREFIRST MONTHLY AUTOPAY AGREEMENT

Required for all Level Funding groups, including new business and ACA conversions.

CareFirst Monthly Autopay Agreement

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GENERAL INFORMATION	
Account Holder's Name	
Routing Number:	Account Number:
Account Type ☐ Checking Account ☐ Savings Account	Name of Bank

By submitting my banking information, I consent to its retention and to my enrollment in Autopay. Autopay payments will be processed on the first day of each month, including holidays, and may be canceled or modified until 3:00 p.m. Eastern Time on that day. A one-time payment may also be submitted through the Employer Portal.

I authorize CareFirst BlueCross BlueShield to debit my account for the total costs due. In the event any check draft or electronic debit is rejected for any reason, or is presented after I have withdrawn authorization, the financial institution shall bear no liability. I acknowledge that failure to remit payment in full, including due to declined payment attempts, may result in cancellation of coverage.

Total First Month Cost

- Initial Payment will be processed once the benefits are in effect.
- Once the group is installed, the payment will be processed within 24 hours.

I agree to the above Autopay rules.

Signature of Group Administrator

Date

GROUP SIZE FULL-TIME EQUIVALENT (FTE) SUBMISSION FORM

Group Size Full-Time Equivalent (FTE) Submission Form

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INSTRUCTIONS

Submit this form using one of the following methods:

- **Groups:**
  - ☐ Enter FTE data on the *Employer Portal*, along with an uploaded image of this form. Please select the Full Time Equivalent (FTE) Dashboard hyperlink under Quick links. (DCHL Group Business must be updated through DC Health Link.)
  - ☐ **The portal allows an end user to modify the previous FTE and upload supporting documentation; however, if the FTE remains the same the user is to upload the form and select confirm.**
- **Brokers:**
  - ☐ Enter FTE data into *Broker Express* or the *Broker Portal*, along with an uploaded image of this form. Please select the Full Time Equivalent (FTE) Dashboard hyperlink under Quick links. (DCHL Group Business must be updated through DC Health Link.)
  - ☐ **The portal allows an end user to modify the previous FTE and upload supporting documentation; however, if the FTE remains the same the user is to upload the form and select confirm.**

CALCULATING FTE EMPLOYEES (GENERAL INSTRUCTIONS)

- An employee is any person whose work is controlled and directed by the employer, including hours worked, projects assigned and the time spent on each project. Employees will generally receive a W-2.
- Employees may work full-time, part-time or on a seasonal basis. Individuals do not have to qualify for medical coverage to be considered employees.
- There are special rules regarding whether to include employees who do not receive W-2s. Please reference the Internal Revenue Service (IRS) guidelines linked at the end of this page or discuss with your tax or legal advisor.
- **Use whole numbers only**—no decimals, fractions or ranges. Use the number of employees at the end of the month.
- Make sure to count all employees, including those in different locations or divisions. A **full-time** employee is one who works an average of 30 or more hours per week. A **part-time** employee is one who works less than 30 hours per week. A **seasonal worker** is one who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including retail workers employed only during the holiday season.
- Be sure to use FTE data from the calendar year prior to your upcoming effective date. For example, if you are renewing in 2025, use FTE data between 1/1/2024 to 12/31/24. You may need to estimate the number of anticipated full-time employees and the anticipated part-time hours for the remainder of 2024.
  1. For each month during the calendar year, count all full-time employees.
  2. For each month during the calendar year, count all hours worked by part-time employees and divide by 120.
  3. Add the number from line (1) to the number from line (2) and **divide by 12**.
  4. **Enter that number as a whole number below. This is your group's total FTEs for the appropriate calendar year.**

IMPORTANT: PLEASE COMPLETE ALL OF THE REQUIRED INFORMATION BELOW. A GROUP OR BROKER REPRESENTATIVE MUST SIGN THIS DOCUMENT TO ATTEST THAT THE INFORMATION IS CORRECT.

I am a duly authorized representative and confirm in writing that the information entered here is true, correct and complete to the best of my knowledge or belief. Signature ◯ By checking this box, I consent to use this as my electronic signature for this document.	Date

Print Name:		Print Title:
Group Name:		Group Number:
Total FTEs:	Calendar year (Example: 2025):	*FTE data must be calculated using employee count from the calendar year prior to your upcoming effective date.*

The **Internal Revenue Service** and **Federal Register** websites may be helpful to you. You should consult your tax or legal advisor if clarification/direction is needed.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

MEDICARE SECONDARY PAYER (MSP) CALCULATION FORM

Medicare Secondary Payer (MSP) Calculation Form

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INSTRUCTIONS

The collection and reporting of the total number of group employees is required under federal mandate. The MSP calculation is required for all medical business regardless of rating arrangement.* Please review the instructions below and submit this form to your broker or to CareFirst BlueCross BlueShield (CareFirst) along with your other paperwork.

CALCULATING MSP (GENERAL INSTRUCTIONS)

The MSP calculation equals: the total number of full-time and part employees working in the United States carried under the payroll of the employer, working 20 or more calendar weeks in the preceding calendar year, regardless of the number of hours worked per employee, and regardless of whether the weeks worked were consecutive, whether they are eligible or not for group health coverage, whether they are members of a CareFirst plan or any other plan, or have declined coverage.

- **Groups of 1–199 enrollees:** The calculation rules described in this document must be followed to calculate the number of employees.
- **Group of 200+ enrollees:** The calculation can be an estimate provided by the group based on the most recent statistics. For example, a group has 5,000 enrollees but their employee count is around 8,500. The number submitted to CareFirst should be 8,500.

Calculate the number of all employees (not just the number of covered lives) who worked for your company in the prior calendar year by completing the worksheet on the following page. If the employer was not in business during the prior calendar year, calculate the data based on estimates for the current calendar year.

Include the following types of employees even though they are not all specifically listed in the worksheet on the following page:

- The total number of employees in an organizational structure (include all employees in the parent, subsidiary, and sibling organizations) rather than just the number of employees in the particular subsidiary being reported.
- All employees, whether full-time, part-time or seasonal.
- All owners, partners and employees of the company, even if no W-2 or 1099 was issued regardless of whether they have coverage with CareFirst, coverage with another company, or no coverage at all.

Independent contractors, such as subcontractors, who received a 1099 from your company, are excluded and should not be counted as employees.

In most cases, MSP data is calculated using employee data for the prior calendar year. New or renewing groups effective or renewing January 1 or February 1 will submit renewal information in November or December of the current calendar year, and the data calculation must be based on the current calendar year average number of employees. For example, a group that renews January 1, 2025 will submit renewal information in November or December 2024. For a January 1, 2025 renewal, the prior calendar year to be considered for reporting purposes is calendar year 2024.

MEDICARE SECONDARY PAYER (EXAMPLE)

The employer has the following mix of employees who worked more than 20 weeks in the prior calendar year.

The Medicare Secondary Payer employee total = 63

A	What was the total number of full-time employees including owners and partners who were employed for the entire period from January 1, YYYY to December 31, YYYY?	52
B	What was the total number of employees who worked 20 or more weeks from January 1, YYYY to December 31, YYYY by employees who fall into these categories?	
	Full-time employees who did not work a full year	3
	Part-time workers	3
	Seasonal workers	5
C	Employer size calculation (add lines A and B).	63

Calendar year: 2024

* MSP data is not required for ancillary only groups sold independently of a medical product.

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MEDICARE SECONDARY PAYER CALCULATION			
Group Name:		Group Number:	
Group Signature:		Date:	
Contact Name (Please Print):		Contact Title:	Contact Phone Number:
A	What was the total number of full-time employees including owners and partners who were employed for the entire period from January 1, YYYY to December 31, YYYY?		
B	What was the total number of employees who worked 20 or more weeks from January 1, YYYY to December 31, YYYY by employees who fall into these categories?		
	Full-time employees who did not work a full year		
	Part-time workers		
	Seasonal workers		
C	Employer size calculation (add lines A and B).		
Calendar year:			

GROUP CONTRACT APPLICATION (DENTAL AND VISION)

Required only for groups enrolling in a CareFirst Dental or Vision product, excluding DHMO. DHMO groups should use the DHMO form located in the Broker Portal under Apps & Forms–Dental.

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
1440 G Street, NW
Washington, DC 20005
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT APPLICATION

DENTAL AND VISION PRODUCTS

This form should be completed for a new Group, or an existing Group selecting a new dental or vision product or making a jurisdictional change at the annual renewal, if the Group does not have a health benefits program through CareFirst or another CareFirst affiliate. The Group is required to complete this Application in its entirety, in black ink, and sign, date and return it to the Group's CareFirst Sales Representative.

If the Group is an existing Group amending the current coverage or changing general information, the Group is required to complete, in black ink, *only* the sections in which the information is changing, sign and return this Application to the Group's CareFirst Sales Representative.

This Group Contract Application is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for dental and/or vision benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group such as the payment of premiums when they are due and the fulfillment of the Group's obligations stated in the Group Contract. The provisions of this Group Contract Application remain in effect at the Group's annual renewals, unless a revised Group Contract Application is submitted to CareFirst or if the Group Contract is amended or terminated in accordance with the terms of the Group Contract.

Do not alter this document except to fill in the blanks and check the boxes provided. This Application will not be accepted if any other changes are made.

GENERAL INFORMATION

CareFirst Group Number (if available): _____

Name of Organization: _____

Physical Location:

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Billing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Group Administrator (Person to Contact):

Name: _____ Telephone Number: _____

Title: _____

Email Address: _____

Chief Executive Officer/President

Name: _____ Telephone Number: _____

Title: _____

Email Address: _____

Type of Organization ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other _____

Nature of Business: _____

Federal Tax Identification Number: _____

GROUP MINIMUM ENROLLMENT REQUIREMENTS

It is understood and agreed that in order to be eligible for coverage and maintain such eligibility, the Group must meet the following requirements.

Minimum Enrollment Requirements for Freestanding Dental and Vision Products

The Group must enroll and maintain enrollment (unless otherwise approved by CareFirst) as stated below:

When a Group selects employer-sponsored freestanding dental and/or vision benefit coverage, the Group must enroll and maintain enrollment of at least 75% of all eligible employees for the employer-sponsored dental and/or vision coverage. If at any time there are less than 75% enrolled in the employer-sponsored dental and/or vision products; CareFirst reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement.

For Groups with 50 or fewer eligible employees, when a Group selects Voluntary dental benefit coverage, the Group must enroll and maintain enrollment of the lesser of ten (10) eligible employees or 35% of all employees eligible for the Voluntary dental coverage. If at any time there are less than ten (10) eligible employees or 35% enrolled in the Voluntary dental coverage, CareFirst reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate the product that does not meet the requirements, or refuse to renew the product that does not meet the requirements.

For Groups with more than 50 eligible employees, when a Group selects Voluntary dental benefit coverage, the Group must enroll and maintain enrollment of 20% of all employees eligible for the Voluntary dental coverage. If at any time there are less than 20% enrolled in the Voluntary dental coverage, CareFirst reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate the product that does not meet the 20% requirement, or refuse to renew the product that does not meet the 20% requirement.

For Groups that select Voluntary vision benefit coverage, there are no minimum enrollment requirements for the Voluntary vision benefit coverage.

If the Group offers dental or vision benefits only and at any time total enrollment increases or decreases by 10% or more, CareFirst reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate this Group Contract, or refuse to renew this Group Contract.

The basis for determining whether an enrollment increase or decrease has occurred will be the total enrollment:

1. On the effective date or contract renewal date versus the total enrollment proposed at the time the rates were developed; and

2. On the first day of any month during the contract period versus the total enrollment proposed at the time the rates were developed.

At least one employee must be employed full-time and enrolled under the Group's dental or vision coverage on the first day of the plan year. (Note: Those employees with complementary to Medicare coverage do not count toward the one employee minimum enrollment requirement.). Enrolled Groups that drop to less than one full-time employee at this time should contact their CareFirst Sales Representative to arrange for individual direct pay coverage.

Exclusions from Requirement Calculations (Applicable to All Products)

The following eligible employees will be excluded from any count of eligible employees for purposes of calculating compliance with any minimum enrollment requirement above:

1. Those eligible employees who have coverage under their spouse's or parent's group coverage, TRICARE, Medicare as primary under TEFRA, or their prior employer's plan under COBRA.

2. Those eligible employees enrolled in other CareFirst coverage or covered under any CareFirst affiliate.

3. Those employees who obtain coverage through the Individual Exchange where the employer does not offer affordable coverage and minimum essential coverage as defined under the Affordable Care Act.

Former employees, if eligible below, will not be included in the total number of eligible employees or the total number of enrolled employees for purposes of calculating compliance with any minimum enrollment requirement.

CareFirst will notify the Group of any rate adjustments no later than 45 days prior to the effective date of the rate change. If, however, the proposed premium rate increase exceeds thirty-five percent (35%) of the annual premium charged, CareFirst will give the Group prior written notice of no less than sixty (60) days.

Annual Enrollment Certification

CareFirst reserves the right to inspect the records of the Group after 60 days from the effective date of the Group coverage in order to verify the eligibility of employees and their dependents. In addition, the Group agrees to complete and return to CareFirst an eligibility audit and/or census report annually.

EMPLOYER CONTRIBUTION

To be eligible for CareFirst Group dental and/or vision benefits coverage, the employer must identify the contribution level that applies to the dental and/or vision benefits coverage in the checkboxes below. If the employer's contribution for enrolled employees is an amount equal to at least 50% of the cost of the Individual Coverage for enrolled employees, then the employer should select employer-sponsored below. If the employer's contribution is less than 50% of the cost of the Individual Coverage, the plan will be

considered Voluntary, and the employer should select Voluntary below. If the employee or participant in the Group agrees to pay the entire premium for the coverage to the Group, then the employer should select Voluntary below.

If the Group selects dental benefit coverage, the Group must specify if the coverage will be:

Employer-sponsored or

☐ Voluntary.

If the Group selects vision benefit coverage, the Group must specify if the coverage will be:

☐ Employer-sponsored or

☐ Voluntary.

EMPLOYEE ENROLLMENT ELIGIBILITY REQUIREMENTS

The following individuals identified below ("Subscribers") are eligible to enroll themselves (and any dependents), as long as they meet the additional eligibility and enrollment requirements stated in the Evidence of Coverage and any attachments thereto.

Full-Time Employees: All employees (including owners and partners) who are regularly employed on a full-time basis working at least 30 hours a week on a regular basis are eligible to enroll. Seasonal employees and independent contractors, such as subcontractors, who received a 1099, are not eligible to enroll. The IRS has issued guidance on when individuals could be treated as either an employee or independent contractor. Employers are encouraged to review this guidance and consult with an attorney or accountant, if needed.

All former employees (and any dependents), enrolled under the Group's prior health coverage, whose eligibility for group coverage has been extended due to COBRA requirements, are eligible to enroll.

Specify the following additional Subscribers that the Group wishes to cover, even if the Group does not currently have such individuals in the Group. NOTE: These individuals cannot be included in the total number of Eligible Employees for the Group.

- ☐ Part-time employees who work at least 17.5 hours per week on a regular (not seasonal or temporary) basis for more than six months each year.
- ☐ All Retirees in accordance with the provisions of the Group's retirement program, as amended from time to time, who retired prior to the effective date of this coverage. (Available only if the Group covered retirees under the Group's prior health coverage.)
- ☐ All Retirees in accordance with the provisions of the Group's retirement program, as amended from time to time, who retire on or after the effective date of this coverage.
- ☐ All former employees who terminated employment due to disability prior to the effective date of this coverage may enroll for a period of not more than two years. (Available only if covered under the Group's prior health coverage.)
- ☐ All eligible individuals who terminate employment due to disability after the effective date of this coverage may enroll for a period of not more than two years. (Available only if covered under the Group's current coverage with CareFirst prior to disability.)
- ☐ All individuals, not described above, who are defined as being eligible for coverage as a Subscriber in the Group's written employee benefit policies, as amended from time to time. *NOTE: The Group's written employee benefits policies must comply with all applicable federal, state and local laws and regulations. CareFirst reserves the right to review, prior to the effective date, the Group's written employee benefit policies applicable to the product selected for compliance with all applicable laws.*

Note: No individual is eligible to enroll under the Group's coverage both as a Subscriber and as a dependent. If the Group employs both spouses of a family (or both Domestic Partners, if applicable), they may <u>not</u> both select a Type of Coverage that is Individual and Adult Coverage or Family Coverage.

CareFirst may at reasonable times examine the Group's pertinent records (including payroll records) with respect to eligibility and premium payments. CareFirst may establish reasonable requirements of proof to confirm the eligibility of Members. The Group agrees to provide, within 31 days of request, any information that verifies its compliance with the enrollment guidelines.

DOMESTIC PARTNER ELIGIBILITY

Specify below whether Domestic Partners of Subscribers will be eligible to enroll as dependents:

☐ YES ☐ NO Domestic Partners of Subscribers are eligible.

ENROLLMENT EFFECTIVE DATES

Coverage of the following eligible individuals becomes effective on the date that the Group Contract becomes effective:

1. Existing eligible individuals who are currently enrolled under the Group's prior dental and/or vision health coverage if selected above;

2. Former employees, who are currently enrolled under the Group's prior dental and/or vision health coverage, whose eligibility for group coverage has been extended due to COBRA requirements; and

3. Eligible individuals who enroll during an open enrollment period prior to the effective date of the Group Contract.

Coverage for an individual newly eligible to enroll as a Subscriber, and any eligible and enrolled dependents, is effective as stated below:

Select one:

☐ On the first day of the month following employment or eligibility, whichever is later
☐ On the date of employment or eligibility, whichever is later
☐ On the day after the Subscriber satisfies the Group's Waiting Period of ____ days after employment or eligibility, whichever is later. (Day range cannot exceed a total of ninety (90) days.)
☐ On the first day of the month following the date the Subscriber satisfies the Group's Waiting Period of _____ days after employment or eligibility, whichever is later. (Day ranges cannot exceed a total of sixty (60) days to ensure compliance with applicable law).
☐ Coverage will be effective at the time stated in the Group's written employee benefit policies, as amended from time to time.
NOTE: The Group's written benefits policies must comply with all applicable federal, state and local laws and regulations. CareFirst reserves the right to review, prior to the effective date, the Group's written benefit policies applicable to the product selected for compliance with all applicable laws.

TERMINATION OF COVERAGE

Coverage for enrolled Subscribers or any enrolled Dependents who are no longer eligible (other than on the basis of a dependent child's limiting age) terminates on the date stated below:

Select One:

☐ The date on which the Subscriber's employment or eligibility or the Dependent's eligibility terminates.
☐ The last day of the month in which the Subscriber's employment or eligibility or the Dependent's eligibility terminates.

☐ The time stated in the Group's written employee benefit policies, as amended from time to time. *NOTE: The Group's written employee benefits policies must comply with all applicable federal, state and local laws and regulations. CareFirst reserves the right to review, prior to the effective date, the Group's written benefit policies applicable to the product selected for compliance with all applicable laws.*

AGE LIMITS FOR DEPENDENT CHILDREN

Groups with 50 or fewer enrolled employees:

Dependent children are covered until: The last day of the month of their 26th birthday.

Groups with more than 50 enrolled employees:

Dependent children are covered until:

Select One:

☐ The last day of the month of their 26th birthday.
☐ The last day of the calendar year of their 26th birthday.
☐ On the date of their 26th birthday.
☐ The last day of the month of their _____ birthday. (Specify an age over the age of 26.)
☐ On the date of their _____ birthday. (Specify an age over the age of 26.)
☐ The last day of the calendar year of their _____ birthday. (Specify an age over the age of 26.)
☐ The time stated in the Group's written benefit policies, as amended from time to time. (All dependent children must be covered to at least age 26.)
NOTE: The Group's written employee benefits policies must comply with all applicable federal, state and local laws and regulations. CareFirst reserves the right to review, prior to the effective date, the Group's written benefit policies applicable to the product selected for compliance with all applicable laws.

If the Group elects not to cover Dependent children who are full-time students beyond the Limiting Age defined above, skip the following section.

Dependent children may remain eligible after the age selected above as long as they are enrolled as full-time students in a public or private high school, college, university, graduate school, trade school, or other school and have a student certification on file with CareFirst until:

Select One:

☐ The last day of the month of their _____ birthday. (Specify an age of 27 or over.)
☐ The date of their _____ birthday. (Specify an age of 27 or over)
☐ The last day of the calendar year of their _____ birthday. (Specify an age of 27 or over.)
☐ The last day of the month of the student dependent's graduation or the end of the month of their _____ birthday, whichever occurs last. (Specify an age of 27 or over.)
☐ The date of their graduation or on his or her _____ birthday, whichever occurs last. (Specify an age of 27 or over.)
☐ The last day of the calendar year of their graduation or the last day of the calendar year of their _____ birthday, whichever occurs first. (Specify an age of 27 or over.)
☐ The time stated in the Group's written benefit policies, as amended from time to time. (All dependent children must be covered to at least age 26.)
NOTE: The Group's written employee benefits policies must comply with all applicable federal, state and local laws and regulations. CareFirst reserves the right to review, prior to the effective date, the Group's written benefit policies applicable to the product selected for compliance with all applicable laws.

CareFirst has the right to verify student dependent eligibility status.

Note: Dependent eligibility must end in the same manner for dependent children and dependent students, i.e. at the end of the year, or the end of the month, or on the birthday. For example, the Group may not select end of the month for dependent children and end of the year for dependent students.

GROUP'S RESPONSIBILITY TO EMPLOYEES

In any case in which the employee is responsible for a portion of the monthly premiums, the Group must:

1. Advise the employee of his/her eligibility for coverage under the Group Contract;

2. Advise the employee when s/he may enroll for such coverage in accordance with the provisions stipulated in this Application and the Group Contract including the Evidence of Coverage;

3. Advise the employee when coverage will commence based on the aforementioned provisions and the date of completion of the enrollment form;

4. Advise the employee of the cost of such coverage to the employee and the method in which payment is to be made; and

5. Obtain from the employee a completed enrollment form and a signed agreement by the employee to pay the applicable portion of the monthly rates.

GROUP STATEMENTS

The Group agrees that in the making of this Application, it is acting for and on behalf of itself and as the agent representative of its employees and COBRA participants, and their dependents, if any; and it is agreed and understood that the Group is not the agent or representative of CareFirst for any purpose of this Application or any Group Contract issued pursuant to this Application.

The Group agrees to receive on behalf of its eligible employees and their dependents and COBRA participants, the Evidence of Coverage including all attachments, and all relevant notices furnished by CareFirst, and to forward such materials to these individuals.

The Group agrees that in the making of this Application, it has provided CareFirst with information regarding the eligibility of enrollees that is accurate and consistent with the requirements and provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (as amended and codified).

The Group understands and agrees that, unless the Notice of Intent of Grandfathered Status is completed and returned to CareFirst at each renewal, the health plan(s) selected by the Group in this Application will not be considered grandfathered plans under the Patient Protection and Affordable Care Act.

This Group Contract Application is part of the Agreement between the Group and CareFirst.

IMPORTANT NOTE: The Group's rate sheet, which describes the benefits and corresponding rates for the CareFirst coverage selected must be signed by the Group before coverage can be made effective. CareFirst reserves the right to revise the rates if the actual enrollment varies substantially from that used in the original rating or if applicable law or regulatory authority requires such revisions.

For Groups with more than 50 enrolled employees: The quoted rates and plan designs assume a Full Time Equivalent (FTE) employee count of 51 or greater. A current, completed FTE form indicating an FTE employee count of at least 51 must be submitted to CareFirst prior to implementation of the quoted plan designs and rates.

Warning: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia state law.

CareFirst may terminate the Group Contract immediately if the Group has performed an act or a practice that constitutes fraud; and/or if the Group has failed to comply with a material plan provision in the Group Contract relating to the employer contributions or group participation rules; and/or if the Group has made an intentional misrepresentation of material fact under the terms of the CareFirst coverage.

If the Group has any questions concerning the benefits and services that are provided by or excluded under the coverage for which the Group is applying, please contact a customer services representative before signing this Application.

ACCEPTED FOR:

_____
(Name of Organization)

BY: _____
(Printed Name of Authorized Officer)

_____
(Signature of Authorized Officer)

Title: _____ Date: _____

Broker (if applicable)

_____
(Printed Name of Broker)

_____
(Signature of Broker)

Email Address: _____

ID#: _____ Date: _____

Effective Date of Group Contract: _____

STOP LOSS INSURANCE DISCLOSURE

STOP LOSS INSURANCE DISCLOSURE

Required by

Group Hospitalization and Medical Services, Inc.

doing business as

CareFirst BlueCross BlueShield

1440 G Street, NW

Washington, DC 20005

202-479-8000

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.
which are independent licensees of the Blue Cross and Blue Shield Association.

Please complete this disclosure in entirety, then sign and return to your CareFirst account executive, CareFirst account manager, or producer.

APPLICANT INFORMATION		
Legal Name of Applicant/Plan Sponsor (to appear on Policy)		**Key Contact Person**
		Name:
		Phone Number:
PRODUCER (Agent/Broker) INFORMATION		
Name:	**Phone Number:**	**License Number(s):**

FRAUD NOTICE (please read carefully)
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I. DEFINITIONS

For the purposes of this disclosure, the following terms shall have the meanings provided below:

Catastrophic Claim means any Known Claim Information under the applicant's plan providing hospital/surgical/medical and pharmacy/prescription drug benefits incurred and/or actually paid, or expected to be incurred by an individual that may reasonably be assumed will result in a significant medical expense in that would exceed 50% of the requested Specific Deductible the next 24 months.

Claim Information means to provide Complete Details following a Diligent Review of the data requested by CareFirst in connection with the application for, or renewal of, the CareFirst Stop Loss Insurance Policy on any claim incurred, paid, or pended prior to the effective date of the CareFirst Stop Loss Insurance Policy including, but not limited to, Catastrophic Claims and Shock Losses.

Complete Details means detailed information including, but not limited to, the individual's name and social security number, date of birth, diagnosis, prognosis (unless prognosis cannot be obtained due to reasons beyond the applicant's or its representative's control) and provider name, on any individual covered by, or eligible for coverage, under the applicant's plan.

Diligent Review means a complete review by the applicant or its representative(s) of the applicant's plan prior to Disclosure, or the initial underwriting, effective date, or renewal of the CareFirst Stop Loss Insurance Policy for Known potential large claimants. A claimant is Known if prior to, or at the time Disclosure is requested, the applicant or its representative(s) had actual information about the claim, or could have reasonably been assumed to have had such information, had they conducted a Diligent Review.

Disclosure or Disclosed means to provide Complete Details following a Diligent Review, and to provide CareFirst with all documentation requested including, but not limited to, the information requested on the stop loss Disclosure form, in connection with the quote/proposal or a renewal offer, census information and Claim Information within the time period(s) specified by CareFirst in writing, prior to the:

1. Initial underwriting of the CareFirst Stop Loss Insurance Policy;

2. Effective date of the CareFirst Stop Loss Insurance Policy;

3. Date an affiliate/subsidiary is acquired, or another class of employees established; or

4. Date of renewal following the end of any CareFirst Stop Loss Insurance Policy.

Known means information affecting the administration or underwriting of the CareFirst Stop Loss Insurance Policy, which can be reasonably assumed that the applicant or its representative(s) had knowledge of prior to, or at the time of, a request for Disclosure of Claim Information.

Shock Claim or Shock Loss means any loss that is reasonably likely to result in a potentially Catastrophic Claim, or any other loss due to the nature of the injury, illness or diagnosis that the applicant or it representative(s) reasonably assumes will result in a significant hospital/surgical/medical and pharmacy/prescription drug expense that would exceed 50% of the requested Specific Deductible in the next 24 months.

II. INSTRUCTIONS FOR COMPLETION OF THE STOP LOSS DISCLOSURE FORM

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as a part of "health care operations." CareFirst shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI collected except in performing this risk evaluation.

CareFirst will rely upon the information provided on the attached disclosure form, which will become part of the application for stop loss insurance. The purpose of the form is to allow CareFirst to take underwriting action on all Known risks in the categories listed below. It is the Plan Sponsor's responsibility, either directly or through their designated representative, to accurately report all claims known as of the date of this Disclosure by making a thorough review of all

applicable records. Such records shall include historical claims reports, disability records, current information from claims administrators, insurers, utilization management companies, managed care companies, and any producer of the Plan Sponsor. The attached disclosure form must be completed and signed by the appropriate parties no more than thirty (30) days prior to the proposed effective date of stop loss coverage and received by CareFirst within ten (10) days of completion.

Upon receipt of the completed Disclosure, CareFirst will assess all data, new and previously reported, and will inform the producer in writing within ten (10) days of any changes to the rates, factors or terms of coverage. CareFirst reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

List on the Disclosure form all risks Known to:

1. Be currently disabled or confined to a medical facility.

2. Have received hospital/surgical/medical and pharmacy/prescription drug services during the current plan year the cost of which exceeds $25,000, and for which bills have been received by the claims administrator and entered into their claims system.

3. Have been identified as a candidate for case management and as having the potential to exceed during the policy term, $25,000.

4. Have been diagnosed or treated for, during the current plan year, with a condition represented by any of the International Classification of Diseases (ICD) codes contained in the attached list(s) and have also received hospital/ surgical/medical and pharmacy/prescription drug services costing at least $5,000 during the same period.

If the Plan Sponsor fails to Disclose any risk to the best of their knowledge and belief Known to fall into one of the above categories, either intentionally or because a thorough review of all records was not conducted, then CareFirst will have no liability for claims on the risk not Disclosed.

III. Stop Loss Disclosure Form

Risk Identifier	DOB	Sex	EE, Sp or Ch	(A)ctive, (C)OBRA, (R)etiree, or (T)ermed	Term Date	Diagnosis	Most Recent Date of Service	Expenses Incurred This Plan Year

The Plan Sponsor named below represents that the above list accurately Discloses all potentially catastrophic risks in accordance with the instructions attached to this form and that it is the result of a Diligent Review in accordance with those instructions**. If there are no risks to report which meet the disclosure criteria above, please check this box.** ☐

Plan Sponsor: _____

Signature: _____

Name: _____

Title: _____

Date: _____

Producer: _____

Signature: _____

Name: _____

Title: _____

Date: _____

IV. ICD-10 Codes for Disclosure Notification

Please list all Plan participants who have been diagnosed with or treated for any of the codes listed under the following categories during the current benefit period.

ICD-10 diagnosis codes contain from three to seven digits (alpha or numeric) the first of which must be alpha, the second must be numeric, and digits three through 7 can be either alpha or numeric. For reporting purposes CareFirst adopted the following convention: If a single code is listed it includes all codes with one or more digits to the right of the rightmost digit in the listed code. For example, code F20 includes all codes from F20.0 through F20.9, code G82.5 includes all codes from G82.50 through the last code with a prefix of G82.5, which is G82.54. Similarly, where a range of codes is listed, such as C00-C96, that range includes all codes up through and including the last code in C96, which is C96.9.

This list may, from time to time, be updated to reflect code additions or deletions made by the Centers for Medicare & Medicaid Services (CMS) or some other governing body as well as subsequent versions of codes, to allow joint issue of two sets of codes for those times when codes are updated and claims history spans both sets of codes.

A00-B99	***Certain infectious and parasitic disease***
A40	Streptococcal sepsis
A41	Other Sepsis
B15-B19	Viral hepatitis
B20	Human immunodeficiency virus [HIV] disease
C00-D49	***Neoplasms***
C00-C96	Malignant neoplasms
D46	Myelodysplastic syndromes
D50-D89	***Diseases of the blood and blood-forming organs & disorders involving the immune mechanism***
D57	Sickle-cell disorders
D59	Acquired hemolytic anemia
D60-D64	Aplastic and other anemias
D65-D69	Coagulation defects, purpura and other hemorrhagic conditions
D70-D77	Other diseases of blood and blood-forming organs
D80-D89	Certain disorders involving the immune mechanism
E00-E89	***Endocrine, nutritional and metabolic diseases***
E10-E13	Diabetes mellitus
E15-E16	Other disorders of glucose regulation and pancreatic internal secretion
E65-E68	Obesity and other hyper alimentation
E70-E89	Metabolic disorders
F01-F99	***Mental, Behavioral and Neurodevelopmental disorders***
F10.1	Alcohol Abuse

F11.1	Opioid Abuse
F20	Schizophrenia
F31	Bipolar Disorder
F32.3	Major depressive disorder, single episode, severe with psychotic feature
F33.1-F33.3	Major Depressive Disorder, recurrent
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.5	Asperger's syndrome

G00-99	***Diseases of the nervous system***
G00	Bacterial Meningitis
G04	Encephalitis Myelitis and Encephalomyelitis.
G06-G07	Intracranial and intraspinal abscess and granuloma
G12.21	Amyotrophic Lateral Sclerosis
G35	Multiple Sclerosis
G36	Other Acute Disseminated Demyelination
G37	Other Demyelinating disease of central nervous system
G82.5	Quadraplegia
G83.4	Cauda Equina Syndrome
G92	Toxic Encephalopathy
G93.1	Anoxic Brain Injury

I00-I99	***Diseases of Circulatory System***
I20	Angina Pectoris
I21.09-I22	Acute myocardial infarction
I24	Acute and Subacute Ischemic Heart Disease
I25	Chronic ischemic heart disease
I26	Pulmonary embolism
I27	Other pulmonary heart disease
I28	Other diseases of pulmonary vessels
I33	Acute & Subacute Endocarditis
I34-I38	Heart Valve Disorders
I42-I43	Cardiomyopathy
I44-I45	Conduction Disorders
I46	Cardiac Arrest
I47-I49	Cardiac Dysrhythmias
I50	Heart Failure
I60-161	Subarachnoid Hemorrhage / Intercerebral Hemorrhage
I63	Cerebral infarction
I65.8-I66	Occlusion of Precerebral /Cerebral Arteries
I67	Other cerebrovascular disease
I70	Atherosclerosis / Aortic Aneurysm

J00-J99	***Diseases of Respiratory System***
J40-J44	Chronic Obstructive Pulmonary Disease (COPD)
J84.10-J84.89	Postinflammatory Pulmonary Fibrosis
J98.11-J98.4	Pulmonary Collapse / Respiratory Failure

K00-K95	***Diseases of Digestive System***
K22	Esophageal obstruction
K25-K28	Ulcers
K31	Other diseases of stomach & duodenum

K50	Crohn's disease
K51	Ulcerative colitis
K55-K64	Diseases of intestine
K65-K68	Diseases of peritoneum & retroperitoneum
K70-K77	Diseases of liver
K83	Diseases of biliary tract
K85-K86	Diseases of pancreatitis
K90-K95	Other diseases of digestive system/Complications of bariatric procedures

M00-M99	***Diseases of Musculoskeletal System & Connective Tissue***
M15-M19	Osteoarthritis
M32	Systemic lupus erythematosus
M34	Systemic sclerosis
M41	Scoliosis
M43	Spondylolysis
M50	Cervical disc disorders
M51	Thoracic, thoracolumbar & lumbosacral intervertebral disc disorders
M72.6	Necrotizing Fasciitis
M86	Osteomyelitis

N00-N99	***Diseases of the Genitourinary System***
N00-N01	Acute and Rapidly Progressive Nephritic Syndrome
N03	Chronic Nephritic Syndrome
N04	Nephrotic Syndrome
N05-N07	Nephritis and Nephropathy
N08	Glomerular Disorders classified elsewhere
N17	Acute Kidney Failure
N18	Chronic Kidney Disease (CKD)
N19	Renal Failure, Unspecified

O00-O9A	***Pregnancy, childbirth and the puerperium***
O09	High Risk Pregnancy
O11	Pre-Existing Hypertension with Pre-Eclampsia
O14-O15	Pre-Eclampsia and Eclampsia
O30	Multiple Gestation
O31	Other complications specific to Multiple Gestations

P00-P96	***Certain conditions originating in the perinatal period***
P07	Disorders of newborn related to short gestation and low birth weight
P10- P15	Birth Trauma
P19	Fetal distress
P23-P28	Other respiratory conditions of newborn
P29	Cardiovascular disorders originating in the perinatal period
P36	Bacterial sepsis of newborn
P52-P53	Intracranial hemorrhage of newborn
P77	Necrotizing enterocolitis of newborn
P91	Other disturbances of cerebral status newborn

Q00-Q99	***Congenital malformations, deformations and chromosomal abnormalities***
Q00-Q07	Congenital malformations of the nervous system
Q20- Q26	Congenital Cardiac malformations
Q41-Q45	Congenital Anomalies of Digestive system

Q85	hakomatoses, not classified elsewhere
Q87	Congenital malformation syndromes affecting multiple systems
Q89	Other Congenital malformations

R00-R99	***Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified***
R07.1-R07.9	Chest Pain
R40-R40.236	Coma
R57-R58	Shock, Hemorrhage
R65.2-R65.21	Severe sepsis

S00-T88	***Injury, Poisoning and Certain Other Consequences of External Causes***
S02	Fracture of skull and facial bones
S06	Intracranial injury
S07	Crush injury to head
S08	Avulsion and traumatic amputation of part of head
S12-S13	Fracture and injuries of cervical vertebra and other parts of neck
S14.0-S14.15	Injury of nerves and spinal cord at neck level
S22.0	Fracture of thoracic vertebra
S24	Injury of nerves and spinal cord at thorax level
S25	Injury of blood vessels of thorax
S26	Injury of heart
S32.0-S32.2	Fracture of lumbar vertebra
S34	Injury of lumbar and sacral spinal cord and nerves
S35	Injury of blood vessels at abdomen, lower back and pelvis
S36-S37	Injury of intra-abdominal organs
S48	Traumatic amputation of shoulder and upper arm
S58	Traumatic amputation of elbow and forearm
S68.4-S68.7	Traumatic amputation of hand at wrist level
S78	Traumatic amputation of hip and thigh
S88	Traumatic amputation of lower leg
S98	Traumatic amputation of ankle and foot
T30-T32	Burns and corrosions of multiple body regions
T81.11-T81.12	Postprocedural cardiogenic and septic shock
T82	Complications of cardiac and vascular prosthetic devices, implants and grafts
T83-T85	Complications of prosthetic devices, implants and grafts
T86	Complications of transplanted organs and tissue
T87	Complications to reattachment and amputation

Z00-Z99	***Factors Influencing Health Status and Contact with Health Services***
Z37.5-Z37.6	Multiple births
Z38.3-Z38.8	Multiple births
Z48-Z48.298	Encounter for aftercare following organ transplant
Z49	Encounter for care involving renal dialysis
Z94	Transplanted organ and tissue status
Z95	Presence of cardiac and vascular implants and grafts
Z98.85	Transplanted organ removal status
Z99.1	Dependence on respirator
Z99.2	Dependence on dialysis

STOP LOSS INSURANCE DISCLOSURE

I represent that the statements contained in this Disclosure are true and complete to the best of my knowledge and belief, and I understand that they form the basis for CareFirst's approval of the requested stop loss insurance.

Applicant Signature	Producer Signature
Printed Name	Printed Name
Title	Title
Date	Date

APPLICATION FOR STOP LOSS INSURANCE

APPLICATION FOR STOP LOSS INSURANCE

From

Group Hospitalization and Medical Services, Inc.

doing business as

CareFirst BlueCross BlueShield

1440 G Street, NW

Washington, DC 20005

202-479-8000

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association.

Please complete this application in entirety, then sign and return to your CareFirst account executive, CareFirst account manager, or producer.

APPLICANT INFORMATION				
Legal Name of Applicant/Plan Sponsor (to appear on Policy)			**Key Contact Person**	
Tax ID Number	**Business Telephone Number**	**Fax Number**	**E-mail**	**Internet**
Address		**City**	**State**	**Zip Code + 4**
Nature of Business		**SIC Code**	☐ **Corporation** ☐ **Partnership** ☐ **Government** ☐ **Other*_____**	

*If an association, trust or charitable organization, a copy of the bylaws and/or trust is required with the submission of the application. If a union, or if union employees are covered, a copy of the collective bargaining agreement is required with the submission of the application.

APPLICATION FOR STOP LOSS INSURANCE

Subsidiary or affiliated companies to be insured? ☐ **No** ☐ **Yes**
If yes, complete the table below, attaching additional sheets if necessary. In the case of trusteeship or association, attach a list of contributing employers or employer-members.

[redacted]			
[redacted]			
[redacted]			
Group Hospitalization and Medical Services, Inc.			
[redacted]			

APPLICATION FOR STOP LOSS INSURANCE

FRAUD NOTICE (please read carefully)

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia state law.

APPLICANT UNDERSTANDS AND AGREES THAT

The stop loss insurance applied for herein shall not take effect until such insurance has been approved by CareFirst.

The stop loss insurance policy applied for herein is based on a quote prepared by CareFirst and reviewed by the applicant prior to execution of this Application for Stop Loss Insurance.

CareFirst's approval is subject to receipt of final census and any other information requested in connection with this application.

- Completion of CareFirst's Stop Loss Insurance Disclosure is required for new business only.

Failure to comply with the above will result in approval being denied or delayed until a later date.

Receipt of the application shall not constitute an acceptance of liability. In the event that CareFirst disapproves this application, its sole obligation shall be to refund any premium received by the applicant. **Coverage will not be in effect until notified in writing by CareFirst. Do not cancel prior coverage until so notified.**

APPLICATION FOR STOP LOSS INSURANCE

The basis of the underlying coverage shall be the "Plan" which means only that portion of the welfare benefit plan established by the applicant that provides for medically necessary benefits as determined by the Plan pursuant to the terms and conditions of the Plan and which are otherwise expressly stated as covered under the Plan, stated as a benefit within the Plan and not otherwise excluded from coverage under the Plan, and prescribed and/or rendered by providers within the scope of their license, schedules of coverage and any amendments, riders, and endorsements attached thereto on the Effective Date of the proposed stop loss insurance policy or as may be added thereafter and approved as provided in the proposed stop loss insurance policy.

The stop loss insurance which is the subject of this application is a reimbursement policy, and the applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this application.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for CareFirst's approval of the requested stop loss insurance.

Applicant Signature	Producer Signature
Printed Name	Printed Name
Title	Title
Date	Date

CareFirst

Family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

SUM7711-1E (7/26)