



An Independent Licensee of the Blue Cross and Blue Shield Association

**Application For Group Insurance**

Please type or print. Must be completed in full. Indicate "NA" if item does not apply.

**1. General Information**

City of Rapid City

Full Legal Name of Group	<u>46-6000380</u>	( <u>605</u> ) <u>394-4136</u>
Tax I.D. Number	<u>300 Sixth Street</u>	Business Telephone Number
Address	<u>Rapid City SD</u>	( <u>605</u> ) <u>394-6621</u>
City, State	<u>www.rcgov.org</u>	Fax Number
Internet Address	<u>City Government</u>	<u>57701</u>
Nature of Business		Zip Code
		<u>tammie.krumm@rcgov.org</u>
		E-Mail Address
		<u>9111</u>
		SIC Code

**2. Requested Effective Date:** 07/01/2012

**3. Number of Eligible Employees:** \_\_\_\_\_ **Number of Participating Employees:** 820

**4. Stop Loss Benefits / Premiums:**  **New Group**  **Renewal**

**Aggregate Coverage**

Aggregate Stop Loss: Yes (Yes / No)  
 Aggregate Contract: 24/12 (15/12, 12/18, other)  
 Employee Benefit Plan expenses will be Incurred from 7/1/2011 through 6/30/2013, and Paid from 7/1/2012 through 6/30/2013  
 Aggregate Stop Loss Eligible Expenses Include:  Health  Dental  Prescription  Other  
 Aggregate Stop Loss Deductible: 125%  
 Aggregate Stop Loss Premium (per contract per month): \$1.65 Premium Amount  
\$0.00 Broker Fee / Commission  
\$1.65 Total Aggregate Premium

Aggregate Attachment Points:

Benefit Description/Plan	Single		Family		EE/Sp		EE/Ch	
	Amount	Enrollment	Amount	Enrollment	Amount	Enrollment	Amount	Enrollment
	466.31	531	1165.78	289				

Annual Minimum Aggregate Deductible: **Calculated upon execution of agreement**

Maximum Aggregate Reimbursement: **Unlimited**

Aggregate Run-in, if applicable:

**Individual Coverage**

Individual Stop Loss: Yes (Yes / No)  
 Individual Contract: 24/12 (15/12, 12/18, other)  
 Employee Benefit Plan expenses will be Incurred from 7/1/2011 through 6/30/2013, and Paid from 7/1/2012 through 6/30/2013  
 Individual Stop Loss Eligible Expenses Include:  Health  Dental  Prescription  Other  
 Individual Stop Loss Deductible (per person): \$100000.00  
 Aggregating Individual Deductible (if applicable): \$0.00  
 Individual Stop Loss Premium (per contract per month): \$40.30 Premium Amount  
\$5.95 Broker Fee / Commission  
\$46.25 Total Individual Premium  
 Individual Stop Loss Lifetime Maximum (per person): \$

**5. Policy Limitations:**

Individuals requiring separate Individual Stop Loss Deductible (please list by Social Security number and relationship to employee)

Social Security Number	Relationship	Individual Stop Loss Deductible	Excluded? Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Policy Limitations:

Claims in excess of the group's Individual Stop Loss deductible level will not be covered under the Aggregate Stop Loss coverage.

Reimbursement of Third Party Fees, related to negotiation of out of network bills, is limited to 30% of the amount saved.

Advanced Funding:      Yes      (Yes / No)

**6. Administration**

Case Management:      Wellmark Blue Cross Blue Shield of Iowa

Ship to:      Stop Loss Policy      FAI

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I represent the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand they form the basis for Wellmark Blue Cross Blue Shield of Iowa's approval of the coverage requested.

\_\_\_\_\_  
Name of Applicant's Authorized Representative

\_\_\_\_\_  
Signature of Applicant's Authorized Representative

\_\_\_\_\_  
Title      Date

\_\_\_\_\_  
Signature of Witness and/or Agent  
Rapid City SD

\_\_\_\_\_  
Location, City/State  
Jennifer Herz

\_\_\_\_\_  
Name of Resident Agent

\_\_\_\_\_  
Signature of Resident Agent  
40090404

\_\_\_\_\_  
Resident Agent License Number