



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

CID _____

Customer Renewal Questionnaire (please fill out one per group customer)

Internal Use Only
**Number of
Employees**

Customer Name: _____

A1. Total number of employees on current payroll	_____ →		
	Less than 20	20-99	100+
A2. Total number of employees on last year's payroll	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A3. Total number of employees on payroll two years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Employees not enrolling with your BCBSM plan

1. Part time/seasonal
2. Employees covered as dependents on another plan or former employer's retirement plan
3. Employees covered under a BCBSM employer-contributed Health & Welfare Trust fund
Name of Fund: _____
4. Employees not offered or declined coverage
5. Employees who elect another coverage option (includes Blue Care Network) offered by the employer:

Carrier Name	Product Type	Employer Contributions Dollar/Percent
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. Total Individuals electing BCBSM coverage through your company

- | | Employer Contributions
Dollar/Percent |
|----------------------|--|
| 1. Employees | _____ |
| 2. Retiree enrollees | _____ |
| 3. COBRA enrollees | _____ |

List the group/suffix number(s) of segment(s) of your employees currently enrolled with BCBSM:

Signature _____ Date _____

**PLEASE SIGN AND SUBMIT THE ATTACHED QUESTIONNAIRE WITH THE APPROPRIATE
QUARTERLY WAGE DETAIL REPORTS, MEMBERSHIP ROSTER AND EMPLOYEE WAIVER FORMS.**

For BCBSM use only					
Total eligible enrolled:		Total eligible:		Customer Size:	

Please return this document to B614

Customer Renewal Questionnaire Definitions

Term	Definition
Customer Name	Full legal name of company.
A1. Total number of employees on current payroll.	Total number of employees on current payroll under a common federal tax ID. Includes full and part-time. This does not include COBRA or retirees.
A2. Total number of employees on prior year payroll.	Check the box for the average number of employees from the prior year (1 year ago).
A3. Total number of employees on prior/prior year payroll.	Check the box for the average number of employees from the prior/prior year (2 years ago).
B. Employees not enrolling with your BCBSM plan.	Ineligible or eligible, not enrolling.
B1. Part time/Seasonal	Part-time is defined by the operating agreement (the standard operating agreement defines part time as working less than 30 hours per week). Seasonal is less than 9 months per year.
B2 – B5 : Questions refer to full-time employees only	
B2. Employees covered as dependents on another plan or former employer's retirement plan.	Employees covered as dependents on another plan or former employer's retirement plan. Proof must be provided. (Waiver card, Copy of Medical ID card).
B3. Employees covered under a BCBSM employer-contributed Health & Welfare Trust Fund.	If your employees are covered under a BCBSM Health & Welfare Trust Fund, please provide a copy of the contract and a list of the employees.
B4. Employees not offered or decline coverage.	List the number of employees not offered or declining coverage.
B5. Employees who elect another coverage option (includes BCN) offered by the employer.	If covered elsewhere, including BCN, indicate the carrier name (Examples of product type HMO, PPO, POS, and TRAD).
C. Total individuals electing BCBSM coverage through your company.	The total number of enrolled employees in BCBSM.
C1. Employees	Employees working 30+ hours unless otherwise defined in the operating agreement.
C2. Retiree enrollees	Those members who are retired.
C3. COBRA enrollees	Number of members who have signed up for COBRA coverage.
C4. Group suffix numbers of current enrollees.	List all active group/suffix numbers.



CUSTOMER RENEWAL QUESTIONNAIRE

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CID: _____
(Internal Use Only)

**You must complete a separate questionnaire for each group/suffix.
This information is important to make sure our records are up-to-date for the
coming year and to remain in compliance with state and federal legislation.**

Please fill in the blank lines. To correct pre-printed information,
please cross out the incorrect information and print the correct information (as applicable).

Customer Name: _____

1. Group number and suffix: _____

2. Renewal Date: _____

3. Phone Number: _____

4. Physical building address (*not the mailing address*):

5. SIC code – Type of Business: _____

6. Federal Tax ID#: _____

7. Workers Compensation Carrier Name: _____

8. Workers Compensation Policy #: _____

9. If represented by an independent agent, please indicate agent name: _____

10. Are there BCBSM subscribers and/or dependent(s) currently enrolled in Medicare? Yes () No ()
If yes, please complete the section below – attach additional page if necessary

CONTRACT NUMBER	MEMBER NAME	RELATIONSHIP TO SUBSCRIBER	MEDICARE #	PART A EFF. DATE	PART B EFF. DATE	RETIREMENT DATE

11. Are there COBRA enrollees? Yes () No ()

If yes, please complete the section below – attach additional page if necessary

ENROLLEE NAME	QUALIFYING DATE OF EVENT	END DATE FOR COBRA

Please return this document to B614



CUSTOMER RENEWAL QUESTIONNAIRE

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Customer Renewal Questionnaire Definitions

Customer Name	Full Legal Name of Company
1. Group Number and Suffix	5 digit group number and 3 digit suffix number
2. Renewal Date	Your current rate renewal date
3. Phone number	Business Phone number (including area code)
4. Physical Building address	Physical address of the business location
5. SIC code – Type of Business	Type of Business
6. Federal Tax ID#	Federal Identification Number used for business tax purposes
7. Workers Compensation Carrier Name	Name of Carrier who provides your Workers Compensation Benefits.
8. Workers Compensation Policy #	Indicate policy number of Workers Compensation Policy
9. Agent Representation	If you are represented by an agent, please indicate his/her name.
10. Medicare Information	
Contract Number	9 digit subscriber BCBSM contract number (Social Security number)
Member Name	Name of member enrolled in Medicare
Relationship to Subscriber	i.e. Subscriber, Spouse, dependent, etc.
Medicare #	Number listed on the Medicare card
Part A effective date	Date entitled to Part A – the effective date is indicated on the Medicare card
Part B effective date	Date entitled to Part B – the effective date is indicated on the Medicare card
Retirement date	Date retired (if retired)
11. Are there COBRA enrollees?	
Enrollee Name	Person eligible for COBRA (this includes subscriber and eligible dependents)
Qualifying Date of Event	Loss of coverage date: i.e. termination of employment, death of subscriber, divorce, loss of dependent status
End Date for COBRA	COBRA eligibility period ends from 18 to 36 months, depending on type of qualifying event.