Payroll Census Form

For groups 100+ in size

CLEAR

BlueCross BlueShield of Kansas
www.bcbsks.com

Section 1

This form may be used in place of the standard group form for the second and third renewals.

Group Name Cobalt Boats LLC

Group Number 09216 MPN Number 96280 Employer Tax ID 800165425

NAICS on File 336612 If inaccurate, list correct code _____

Effective/Renewal Date 01/01/2011

Representative Name Lori Oleson Representative No. 543

Section 2

Did your employer group† have an average of 20 or more **full time equivalents** on the payroll for more than 50% of your working days in the preceding calendar year? ☐ Yes ☐ No
If you answered yes, COBRA applies to your group.

Did your employer group† have 20 or more full-time and part-time on the payroll for 20 or more calendar weeks in this year or the prior year? If yes, list year: _____ ☐ Yes ☐ No
If you answered yes, MSP (age based aka TEFRA) applies to your group.

Did your employer group† have 100 or more full-time and part-time on the payroll during 50% or more of last year? ☐ Yes ☐ No
If you answered yes, MSP (disability based aka OBRA) applies to your group.

Are you part of an association or MEWA (Multiple Employer Welfare Arrangement)? ☐ Yes ☐ No

If yes, what is the name of the association? _____

Section 3

Determining Quota:

A. Total number of employees (including owners) within your employer group† ..... _____

B. Non-eligible employees ..... _____

C. Eligibles (A minus B) ..... _____

D. Number of employees currently enrolled ..... _____

E. Number of employees being added ..... _____

F. Total employees enrolled ..... _____

G. Extended coverage code ..... _____

†Employer group: all affiliated companies/entities (ie., parent company, brother/sister or parent/subsidiary affiliates, etc.)

This listing is true and complete to the best of my knowledge. I acknowledge inaccuracies in this information may result in termination of coverage. It is the responsibility of the Contract Holder/Employer group's Plan Administrator to submit to the Company for enrollment only those employees and dependents who meet the eligibility criteria of the Contract Holder and the Company, and to ensure and verify the continued eligibility status of covered employees and dependents. The Company has the right to recover from Insureds and/or Providers any benefit payments made on behalf of ineligible persons.

I understand that Blue Cross and Blue Shield of Kansas (BCBSKS) will rely on this information in accepting this group for coverage, and I will promptly notify them of any changes herein. Should the actual enrollment of my group increase or decrease, I undestand BCBSKS reserves the right to re-evaluate and adjust premiums accordingly.

Name _____ Title _____
Please print

Your signature required _____ **Date**