



Independent licensees of the Blue Cross and Blue Shield Association

Group Underwriting Roster Payroll Register (See Back for Instructions)

Person Completing This Form	Phone Number
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Check Applicable Coverage(s): BCBSM BCN

Group Name		BCN Group No./Suffix(s) (If applicable)				BCBSM Group No./Suffix(s) (If applicable)						
Date of your Current Payroll Information (Month/Day/Year)						BCBSM Marketing Representative/Agent Name (If applicable)						
1 List All Employees Currently On Your Payroll	2 (*See Key Below)					3 Social Security Number	4 Year Born	5 Title or Job Description Must Be Completed (If retired, please indicate)	6 Avg. No. of hours worked	7 Date of Hire	8 If Employee Has Selected Alternate Group Health Plan, Provide Carrier Name	9 If Employee Has Other BCN or BCBSM Coverage, Indicate Contract No. Below
	1	2	3	4	5							
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25.												
*Key: 1 = Enrolling in BCBSM; 2 = Enrolling in BCN; 3 = Has other coverage complete section 8 or 9); 4 = Employee waived all group coverage; 5 = Employee is ineligible for coverage												
IMPORTANT: THIS AREA MUST BE SIGNED BY CHIEF EXECUTIVE (Must be original signature)												
I certify this information is complete and accurate. BCBSM and BCN have the right to a confidential audit of our payroll records to verify this information.								Signature of Chief Executive (Must be original)				Date

If this document is not complete, it will be returned

INSTRUCTIONS

Please list your name and phone number at the top of this Form. BCBSM or BCN Underwriting may need to contact you.

Check off applicable coverage (either BCBSM or BCN or both).

Fill in your employer group name.

If currently enrolled with BCN/BCBSM, fill in the group number(s) / suffix number(s).

Fill in the date of your current payroll including month, day and year.

Fill in the BCBSM Marketing Representative and/or your Insurance Agent's name.

Refer to your current payroll records to complete the following: (Fields are numbered for your convenience)

1. List all employee's names that are currently on the payroll regardless of number of hours worked (list retirees eligible for health care benefits)
2. Check the applicable box
 - (1) – Enrolling in BCBSM
 - (2) – Enrolling in BCN
 - (3) – Has other coverage, please complete #8 or #9
 - (4) –Employee waived all group coverage
 - (5) –Employee is ineligible for coverage, i.e., part-time or new hire waiting period
3. Social Security Number
4. Year born
5. Title or job description. If retired, indicate "retired"
6. Average number of hours worked weekly
7. Date of hire (mm/dd/yy)
8. Carrier name, if employee has selected alternate health plan (#3 is checked off)
9. Contract number, if employee is enrolled in BCN or BCBSM as dependent / spouse (#3 is checked off)

Obtain original signature of a Chief Executive and complete the date it is signed.

Note: Both BCBSM and BCN require original signatures. If enrolling in both BCBSM and BCN, make two copies of the roster and obtain the Chief Executive signature on both copies.