

**CIGNA HealthCare of South Carolina, Inc.
GROUP MASTER DATA SHEET**



GENERAL GROUP INFORMATION

GROUP NAME: _____ Primary Enrollment Contact/Title: _____ Nature of Business: _____	Effective Date: _____ Plan Design: _____ Sic Code: _____
GROUP ADDRESS (Include multiple locations on attachment): Street Address: _____ City, State: _____ Zip Code: _____ County: _____ Phone Number: _____ Fax Number: _____	BILLING ADDRESS (if different): Street Address: _____ City, State: _____ Zip Code: _____ E-Mail Address: _____ Tax ID: _____

WAITING PERIOD:

_____ 1st of the Month Following	OR _____ Immediately after	OPEN ENROLLMENT PERIOD IS 30 DAYS PRIOR TO EFFECTIVE DATE
_____ Date of Hire	_____ 90 Days from Date of Hire	
_____ 30 Days from Date of Hire	_____ 180 Days from Date of Hire	
_____ 60 Days from Date of Hire		

1. Eligible employees must be active-at-work a minimum of 30 hours per week. Please list all employees who are not active-at-work on the effective date and the reason:

Name: _____	Reason: _____
Name: _____	Reason: _____

2. The Group adheres to the following participation requirements:

- 2-3 Eligible Employees: 100% Participation Required
- 4-7 Eligible Employees: 1 Waiver Allowed
- 8-50 Eligible Employees: 70% minimum participation

Number of Eligible Employees: _____

Number Employees Enrolled in the Plan: _____

Total Members = (employees + dependents) _____

3. 50% employer contribution to employee cost required.

Employer Contribution to Employee Cost: _____
 to Dependent Cost: _____