BlueCross BlueShield of Oklahoma

NATIONAL ASSOCIATION OF SONIC DRIVE-IN FRANCHISEES

SONIC

Certification of Enrollment Eligibility

Group Contact: _____ **Telephone:** _____

Billing Address: _____

_____

Store #(s): _____

Plan Options:

Deductible Option: **$500** _____ **$1000** _____ **$2000** _____ **$5000** _____

Dental: **Yes** _____ **No** _____

Locations (please list city, state):

1. _____ **6.** _____

2. _____ **7.** _____

3. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

A. Total number of *eligible employees: _____

(*owners, managers, salaried assistant managers, salaried supervisors and office staff who works at least 30 hours per week)

B. The following number of employees are not counted as eligible for health insurance through your group for the reasons listed below:

1. Employees who have other health coverage: _____

2. New employees who have not yet met the waiting period: _____

Total Number Ineligible Employees (B1 + B2): _____

C: Total number of employees enrolling in plan: _____

D: Employer contribution (amount of premium that employer pays toward employee contracts): _____

Minimum 50%

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT. I UNDERSTAND THAT INFORMATION GIVEN IN ERROR MAY RESULT IN THE TERMINATION OF THE GROUP BENEFIT MASTER AGREEMENT WITH BLUE CROSS BLUE SHIELD OF OKLAHOMA.

_____ _____

Group Administrator Date