BlueAdvantage Entrepreneur/BluePrint (2-150) Producer/Employer New Business Checklist

We want to help ensure that your group enrollments are processed as quickly as possible. The checklist below will help start the process out right. If you have any questions or require additional forms, please contact your General Agent or Blue Cross and Blue Shield of Illinois (BCBSIL) sales executive. For your immediate convenience, we have enclosed the following materials in your BlueAdvantage Entrepreneur/BluePrint producer/employer kit: a 2-150 Benefit Program Application (BPA,) a 2-150 Benefit Plan Selection Form (BPS,) an Employer Group Information Form, Employee Application/Medical Questionnaire/Waiver of Coverage forms (Enrollment Applications,) an Annual Medicare Secondary Payer (MSP) Employer Acknowledgement Form and Instructions, an "Information Regarding the Medicare as Secondary Payer Statute" brochure, HCSC/FDL Disclosure forms and HIPAA Notice of Privacy Practices forms.

NOTE: If a section in any document does not apply, "N/A" should be indicated.

☐ **2-150 Benefit Program Application (BPA)**

- ⇒ Combined BPA applies to medical, dental and life/AD&D/short term disability coverage.
- ⇒ Fill out all sections.
- ⇒ The signed BPA will be returned to the employer group with the group policy after enrollment.
- ⇒ The Proxy must be filled out and signed. DO NOT DETACH from the BPA.
- ⇒ Please note: Enrollment could be delayed if the "Eligibility Date" section is not completed properly.

☐ **2-150 Benefit Plan Selection Form (BPS)**

- ⇒ Combined BPS applies to medical, dental and life/AD&D/short term disability coverage.

☐ **Employer Group Information Form**

☐ **Employee Application/Medical Questionnaire/Waiver of Coverage**

This employee enrollment application is used to enroll in medical, dental and life/AD&D/short term disability products. If the employee is waiving any coverage being offered, the Waiver of Coverage form should be completed and signed. Spousal and/or other coverage information is required including the policy number and carrier name for other coverage.

If FDL is paid in full by the employer, the employee cannot waive this coverage.

- ⇒ The medical questionnaire should be completed, signed and dated by each employee (and spouse, if applicable) for groups with 2-50 enrollees.
- ⇒ Please note: Enrollment could be delayed if the "Date of Employment", "Family Coverage Information" (when applicable) and "Medical Group/IPA Name and #" (for HMO) sections of the Application and the "Personal Data/Health Questions" sections of the Medical Questionnaire (when applicable) are not completed properly. Please have employees pay close attention to these sections.

☐ **Annual Medicare Secondary Payer (MSP) Employer Acknowledgement Form**
Instructions – Completing the MSP Employer Acknowledgement Form
Information Regarding the Medicare as Secondary Payer Statute

The Annual Medicare Secondary Payer (MSP) Employer Acknowledgement Form collects employer size information required to make MSP order of payment determination. The client **must** complete and return this form to BCBSIL within 90 days of the coverage effective date. If this information is not provided, the Centers for Medicare & Medicaid (CMS) regulations require that **the client's group health plan coverage be considered primary to Medicare**. "Instructions – Completing the MSP Employer Acknowledgement Form" provides guidance in completing the Employer Acknowledgement Form. "Information Regarding the Medicare as Secondary Payer Statute" provides general information about the MSP statute, employer obligations and the MSP data match process.

In addition to the above, the following information is required for new group enrollments:

- ☐ **Employer check for first month's estimated premium**
- ☐ **BlueAdvantage Entrepreneur/BluePrint proposal**
- ☐ **Most recent Quarterly Wage and Tax Statement** (indicating any changes to current statement) –
  - ⇒ For start-up companies without a wage/tax statement, we require a copy of the Articles of Incorporation and a copy of the first payroll listing all eligible employees. Please ensure that all full-time, part-time and recently terminated employees are included and new hires are added to the list. It is important that this information is current and provided in the proper format. If a wage/tax statement is not available on a company in business for more than three months, consult your general agent or BCBSIL sales executive for the proper documentation.
  - ⇒ The individuals included on the wage/tax statement, billing statement and application must be reconciled so that every person is accounted for.

If the employer group had prior coverage, the following documents will also be required.

- ☐ **Prior carrier's renewal notification**
- ☐ **Prior carrier's most recent billing (indicating any changes to current statement)**
  - ⇒ Enrollment could be delayed if the most recent bill is not supplied and/or if the bill and renewal notification letter are missing.

IMPORTANT: PLEASE CHECK ALL DOCUMENTS TO MAKE SURE THAT ALL REQUIRED SIGNATURES AND DATES ARE INCLUDED. All documents must be submitted to BCBSIL as quickly as possible, but no later than the 1st of the month for which the group is applying for coverage.

If voluntary life or voluntary dental coverage is being purchased, please contact your General Agent or BCBSIL sales executive for the appropriate forms. BCBSIL forms can also be downloaded from our Web site at **www.bcbsil.com**.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Illinois

FORT DEARBORN LIFE* *Insurance Company®'*

BENEFIT PROGRAM APPLICATION ("BPA")

Employer Group No.(s): _____ Section No.(s):_____
Account No. (BlueStar): _____ Customer No. (if different, for existing business only): _____
Employer Name: _____
(Specify the employer applying for coverage and list the names of any subsidiary or affiliated companies to be covered below.)
Address: _____ City: _____ State: _____ Zip Code: _____
Billing Address (if different from above) : _____ City: _____ State: _____ Zip Code: _____
Employer Identification Number ("EIN"): _____
Subsidiaries: _____
Affiliated Companies: _____
(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to the BPA.)
Administrative Contact: _____ Phone: _____ Fax: _____ Email: _____
Blue Access for Employers (BAE) Contact: _____
(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE)
Title: _____ Phone: _____ Fax: _____ Email: _____
Policy Effective Date: _____ Policy Anniversary Date: _____
ERISA Plan: Yes ☐ No ☐ If Yes, specify ERISA Plan Year: _____
(If the Employer is required to file Form 5500 Schedule A with the IRS, the following ERISA items must be completed):
ERISA Plan Administrator: _____
ERISA Plan Administrator's Address: _____ City: _____ State: _____ Zip Code: _____
ERISA Plan Administrator's Email: _____

1. **Eligible Person:** Means a full-time Employee of the Employer. Part-time and Seasonal employees are not eligible. Full-time Employee means a person who is regularly scheduled to work a minimum of thirty (30) hours per week and who is on the permanent payroll of the Employer.

2. **Domestic Partner Coverage:** Yes ☐ No ☐ If yes, a Domestic Partner as defined in the Policy shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner coverage.

3. **Retiree Coverage:** Yes ☐ No ☐ If yes, complete the following, as applicable:

   A. Retiree means those persons covered as retirees under the Employer's health care plan prior to the date the Employer initially purchased coverage from Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Yes ☐ No ☐ If yes, complete item 13. below.

   B. Retiree means those persons who retire on or after the effective date of this Benefit Program Application: Yes ☐ No ☐ If yes: Such retirees must be at least _____ years of age on the date of retirement with _____ years of continuous full-time employment with the Employer. Note: Minimum years of age is fifty-five (55); minimum years of continuous full-time employment is ten (10).

   For existing groups, former employees who retired after the date the Employer initially purchased coverage from HCSC and prior to the initial effective date of the retiree coverage specified in item 3.B. above are not eligible. An Employer may only elect or change retiree coverage on the Policy Effective Date or Policy Anniversary Date. For Life Plans, retiree coverage is available on a limited basis. For retiree eligibility information, refer to the Life Class Description on the Benefit Plan Selection Form and to item 13. below.

*Fort Dearborn Life is a separate company that does not provide Blue Cross and Blue Shield of Illinois products or services. Fort Dearborn Life is solely responsible for the life and disability coverage provided.

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4. Eligibility Date: All current and new employees must satisfy the required waiting period indicated below before coverage will become effective.

A. For Health, Dental PPO and Life Coverage:

☐ The date of employment.	☐ The _____ day of employment.	☐ The first day of the month following the date of employment.
☐ The _____ day of the month following _____ month(s) _____ days of employment (if purchasing life or short term disability coverage, all coverages must be the first day of the month).		
Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.		

B. For Dental HMO Coverage:

☐ The first day of the month following the date of employment.
☐ The _____ day of the month following _____ month(s) _____ days of employment
Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.

5. Limiting Age for covered unmarried dependent children: Twenty-six (26) years; thirty (30) years if eligible military personnel as described in the Certificate Booklet. For health and dental Plans, coverage will terminate at the end of the period for which premium has been accepted. For Life Plans, coverage will terminate on the birthday. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

6. Enrollment:

Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person’s Coverage Date, Family Coverage Date, and/or dependent’s Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage.

Annual Open Enrollment: For Health and Dental Plans only, an Eligible Person, who did not enroll under Timely Enrollment, may apply for Individual coverage, Family coverage or add dependents during the Employer’s Annual Open Enrollment Period. The Open Enrollment Period is to be held thirty (30) days prior to the Policy Anniversary Date of the program. Such person's Individual Coverage Date, Family Coverage Date and/or dependent's Coverage Date will be the Policy Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

Late Enrollment: For Non-Voluntary Life, Accidental Death and Dismemberment (AD&D) and Short Term Disability Plans only, an Eligible Person who did not apply under Timely Enrollment may apply for Individual coverage, Family coverage or add dependents. Late enrollees must furnish acceptable evidence of insurability if the employer contributes less than 100%. If the employer contributes 100%, such person’s effective date will be a date mutually agreed to by the insurance company and the employer. For Voluntary Life Plans only, employees applying for or increasing coverage after their initial eligibility period can only enroll during the employer's annual enrollment period. Satisfactory evidence of insurability will be required for Voluntary Life coverages in these circumstances**.**

7. Extension of Benefits: An Extension of Benefits will be provided for a period of thirty (30) days in the event of Temporary Layoff, Disability or Leave of Absence. However, benefits shall be extended for the duration of an Eligible Person’s leave in accordance with any applicable federal or state law. For Life Plans, an extension of benefits will be provided as follows: Due to Disability - until the end of the twelfth month following the month in which the disability began; Due to Layoff and Leave of Absence - until the end of the month following the month during which the layoff or leave of absence began. The extension will apply, provided all premiums are paid when due.

8. Premium Period: The Premium Period must be consistent with the Policy Effective Date and/or Policy Anniversary Date.

☐ First day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO coverage.)
☐ Fifteenth day of each calendar month through the fourteenth day of the following calendar month. (This option is not available for any coverage if the Employer has BlueCare Dental HMO coverage.)
Note: Groups with Fort Dearborn Life coverage and having less than $100.00 monthly premium will be billed on a quarterly basis.

9. **Employer Contribution:**

Health and Dental Plans

☐ _____% for Employee Coverage	☐ _____% for Employee plus Spouse Coverage
☐ _____% for Employee plus Child(ren) Coverage	☐ _____% for Family Coverage
☐ 100% of the Employee Coverage Premium will be applied toward the Family Coverage Premium.	☐ Other (specify): _____

The required minimum employer contribution is 25%. No policy will be issued or renewed unless at least 75% of eligible employees have enrolled for coverage. This does not include those eligible employees waiving coverage under HCSC due to other group coverage. In no event, however, shall the policy be issued or renewed unless at least 50% of all eligible employees have enrolled for coverage.

Life, Accidental Death & Dismemberment (AD&D) and Short Term Disability Plans

☐ _____% for Group Life, AD&D	☐ _____% for Dependent Life	☐ _____% for Short Term Disability

If the employer contributes 100% toward the cost of coverage, no policy will be issued or renewed unless at least 100% of eligible employees have enrolled for that coverage. If both the employer and employee contribute toward the cost of coverage, no policy will be issued or renewed unless at least 75% of eligible employees have enrolled for that coverage.

10. **Reimbursement:** It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery, after attorneys' fees, if any, have been paid.

11. **Blue Care Connection® ("BCC"):** The undersigned representative authorizes the provision of alternative benefits rendered to Covered Persons in accordance with the provisions of the Policy.

12. **Certificate of Creditable Coverage:** It is understood and agreed that HCSC will issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Policy and information provided to HCSC by the Employer.

13. **Eligible Persons:** If applicable, list the names of persons of the group who are eligible retirees as described in Item 3.A. above.

Name of Retiree	Name of Retiree

14. **Electronic Issuance:** (Non-HMO Health and Dental Plans only) The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

15. **Massachusetts Health Care Reform Act**: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this Benefit Program Application ("BPA") and, on behalf of the Employer, offers to purchase the benefit program as outlined in the proposal document submitted to the Employer by the Sales Representative. The funding arrangements are outlined in this BPA. It is understood and agreed that the actual terms and conditions are those contained in the Policy. It is further understood and agreed that the terms of the BPA may be subject to change. The final terms may be specified in a benefit program and premium notification letter or the applicable rate summary (ies) for the plan number(s) selected which may be attached hereto and made a part of the BPA. Payment of the first premium due under the Policy constitutes acceptance of such terms.

This BPA is subject to acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and by Fort Dearborn Life Insurance Company ("FDL") as to coverage it underwrites. We certify that all the information provided to HCSC and FDL is correct and complete. Upon acceptance of this BPA, FDL shall issue this BPA to the Employer. Upon acceptance of this BPA, HCSC shall issue a Policy to the Employer and this BPA and the benefit program and premium notification letter or the applicable rate summary (ies) for the plan number(s) selected shall be incorporated and made a part of the Policy. Upon acceptance of this BPA by HCSC and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the proposal document and the Policy, the provisions of the Policy shall prevail.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other

compensation paid to the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, (“ERISA”) establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term “employee welfare benefit plan” includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities there under. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Employer is effective with respect to or accepted by HCSC and FDL except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC and FDL.

With respect to coverage applied for under Fort Dearborn Life Insurance Company (“FDL”):

We agree to comply with and participate in all provisions of the Small Group Employer Benefits Program, the Group Policy providing the coverage applied for and the Trust to which the policy is issued. We understand that FDL intends to rely on this information in determining whether the enrolling employees may become insured.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans: Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations.** Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a “plan”) qualifying as a “grandfathered health plan” under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form (“Form”), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an “exempt plan status”). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan’s exempt plan status or any representation regarding any plan’s past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys’ fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against HCSC in connection with (a) any plan’s grandfathered health plan status, (b) any plan’s exempt plan status, (c) any directions, actions and interpretations of the Policyholder, and/or (d) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

Renewals Only: If this BPA is blank, it is intentional and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the *Policyholder's* first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this Benefit Program Application to eligible dependents may include Domestic Partners, but will include dependent covered children under the Limiting Age of twenty-six (26).

Any reference in this Benefit Program Application to the Limiting Age for covered children means twenty-six (26) years, regardless of presence or absence of a child’s financial dependency, residency, student status, employment, marital status or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years.

Any reference in the eligibility section of this Benefit Program Application to the waiting period means the waiting period an Employee must satisfy in order for coverage to become effective. Covered family members do not have to satisfy a waiting period.

Any reference in this Benefit Program Application to the “Employee plus Child(ren) Coverage” employer contribution means “Employee plus one or more children Coverage.”

Producer Agency Representative	Signature of Employer/Authorized Purchaser
Producer Agency Name	Title
Producer Address	Date
Producer Phone No.	Witness
Contracted Producer Tax ID No.	$ _____ Amount Submitted (for initial enrollment only)
HCSC Sales Representative District / Cluster	Other Information: _____

	UNDERWRITING AUTHORIZATION
INTERNAL USE ONLY	Date BPA approved by Underwriting: _____ Underwriter: _____ Benefit program and premium notification letter included: ☐ Yes ☐ No Date of Letter:_____

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No(s).: ______________ By: ____
Print Signer's Name Here

➡ ____
Signature and Title

Group Name: ____________________________
Address: ____________________________
City: ____________________________ State: ____________ Zip Code: ___________

Dated this ________________ day of ______, ____________________
Month Year

BlueCross BlueShield of Illinois

Dearborn National™*

Underwritten by Fort Dearborn Life Insurance Company®

BENEFIT PLAN SELECTION FORM (BPS) FOR HEALTH PLANS

Please complete & return this form in its entirety, including the required signatures

Account Information:

Employer Name: ______________________________

BlueSTAR Account #: ______________ Policy Effective Date: ______________ Policy Anniversary Date: ______________

Health Products / Benefit Plan Selection:

- There are four health product categories which include multiple products (i.e., Blue*Choice* Select) and their applicable benefit plans.
- One benefit plan can be selected from each of the categories, not to exceed a total of three health benefit plans.
- The Outpatient Prescription Drug Card may vary between products.
- Some benefit plans have multiple Plan IDs to identify availability for specific group sizes. Please refer to your Proposal or Renewal Alternatives document for the applicable Plan ID for your group.
- BlueAdvantage Entrepreneur (2 – 50 lives) are represented with an “R” for Regulated plans and BluePrint (51+ lives) are represented with an “N” for Non-regulated plans.

Category 1 - Select Network Products

GROUP NUMBER:

The following proposed benefit programs are not considered “grandfathered health plans.”

A. Blue*Choice* Select℠

90%/60% Coinsurance (in/out) - $1,000/$2,000 OPX (in/out) - $20 Office Visit Copayment (OV) $150 Emergency Room Copayment (ER)

Outpatient Prescription Drug Card	Deductible Options (in/out)					
	$250 / $500	$500 / $1,000	$1,000 / $2,000	$1,500 / $3,000	$2,500 / $5,000	$3,500 / $7,000
$15 / $30 / $50	☐ RBP42323 ☐ NBP42323	☐ RBP72323 ☐ NBP72323	☐ RBP82323 ☐ NBP82323	☐ RBP92323 ☐ NBP92323	☐ RBPC2323 ☐ NBPC2323	☐ RBPE2323 ☐ NBPE2323
$10 / $40 / $60	☐ RBP42326 ☐ NBP42326	☐ RBP72326 ☐ NBP72326	☐ RBP82326 ☐ NBP82326	☐ RBP92326 ☐ NBP92326	☐ RBPC2326 ☐ NBPC2326	☐ RBPE2326 ☐ NBPE2326
$15 / 35% / 50%	☐ RBP42324 ☐ NBP42324	☐ RBP72324 ☐ NBP72324	☐ RBP82324 ☐ NBP82324	☐ RBP92324 ☐ NBP92324	☐ RBPC2324 ☐ NBPC2324	☐ RBPE2324 ☐ NBPE2324

80% / 50% Coinsurance (in/out) - $2,000/$4,000 OPX (in/out) - $30 OV $150 ER

Outpatient Prescription Drug Card	Deductible Options (in/out)					
	$250 / $500	$500 / $1,000	$1,000 / $2,000	$1,500 / $3,000	$2,500 / $5,000	$3,500 / $7,000
$15 / $30 / $50	☐ RBP43433 ☐ NBP43433	☐ RBP73433 ☐ NBP73433	☐ RBP83433 ☐ NBP83433	☐ RBP93433 ☐ NBP93433	☐ RBPC3433 ☐ NBPC3433	☐ RBPE3433 ☐ NBPE3433
$10 / $40 / $60	☐ RBP43436 ☐ NBP43436	☐ RBP73436 ☐ NBP73436	☐ RBP83436 ☐ NBP83436	☐ RBP93436 ☐ NBP93436	☐ RBPC3436 ☐ NBPC3436	☐ RBPE3436 ☐ NBPE3436
$15 / 35% / 50%	☐ RBP43434 ☐ NBP43434	☐ RBP73434 ☐ NBP73434	☐ RBP83434 ☐ NBP83434	☐ RBP93434 ☐ NBP93434	☐ RBPC3434 ☐ NBPC3434	☐ RBPE3434 ☐ NBPE3434

B. BlueEdge℠ Select HSA

HSA Vendor: ☐ **Option A:** ACS/Mellon Bank ☐ **Option B:** HSA Bank ☐ **Option C:** FlexHSA ☐ Other / None

Coinsurance (in/out	Office Visit (after deductible)	Outpatient Prescription Drugs (after deductible	Deductible & OPX Options (in/out)			
			$1,200 / $2,400 Deductible with $2,400 / $4,800 OPX	$1,500 / $3,000 Deductible with $3,000 / $6,000 OPX	$2,500 / $5,000 Deductible OPX 100%/70% $2,500 / $5,000 OPX 80%/50% $5,000 / $10,000	$2,500 / $5,000 Embedded Deductible OPX 100%/70% $2,500 / $5,000 OPX 80%/50% $5,000 / $10,000
100% / 70%	100%	100%	This space intentionally left blank		☐ RBSC1807 / NBSC1807	☐ RBEC1807/NBEC1807
100% / 70%	100%	80%	☐ RBSL1A05 ☐ NBSL1A05	☐ RBS91505 / NBS91505	This space intentionally left blank	
80% / 50%	80%	80%	☐ RBSL3A05 ☐ NBSL3A05	☐ RBS93505 / NBS93505	☐ RBSC3805 / NBSC3805	☐ RBEC3805/NBEC3805

C. BlueEdge℠ Select Direct HCA

100% / 70% Coinsurance (combined in & out) - OV & Outpatient Prescription Drugs covered at 100% after deductible	**90% / 60% Coinsurance** (combined in & out) - OV covered at 90% after deductible - Outpatient Prescription Drugs covered at 80% after deductible		**80% / 50% Coinsurance** (combined in & out) - OV & Outpatient Prescription Drugs covered at 80% after deductible	
$1,500 Deductible & $0 OPX	$1,500 Deductible & OPX	$2,000 Deductible & OPX	$1,500 Deductible & OPX	$2,000 Deductible & OPX
☐ RBD91127 / NBD91127 – $750 HCA ☐ RBD91137 / NBD91137 – $1,000 HCA	☐ RBD92615 / NBD92615 – $500 HCA ☐ RBD92625 / NBD92625 – $750 HCA ☐ RBD92635 / NBD92635 – $1,000 HCA	☐ RBDA2435 / NBDA2435 – $1,000 HCA	☐ RBD93615 / NBD93615 – $500 HCA ☐ RBD93625 / NBD93625 – $750 HCA	☐ RBDA3435 / NBDA3435 – $1,000 HCA

D. Blue*Choice* Select℠ Value Choice

80% / 50% Coinsurance – 80% ER

	$250/$500 Deductible(in/out)	**$500/$1,000 Deductible(in/out)**	**$1,000/$2,000 Deductible(in/out)**
Outpatient Prescription Drugs covered at 80%	☐ RBV43705 / NBV43705 $2,500/$5,000 **OPX** (in/out)	☐ RBV73805 / NBV73805 $5,000/$10,000 **OPX** (in/out)	☐ RBV83705 / NBV83705 $2,500/$5,000 **OPX** (in/out)
	☐ RBV43805 / NBV43805 $5,000/$10,000 **OPX** (in/out)		☐ RBV83805 / NBV83805 $5,000/$10,000 **OPX** (in/out)

E. CPO - This product is not available in all geographic areas

90% / 80% / 60% Coinsurance (CPO/PPO/out) - $20 OV $15O ER

Outpatient Prescription Drug Card	**Deductible & OPX Options** (CPO)	**Initial Employee Enrollment by CPO Network**
	$500 Deductible with $2,000 OPX	CO _____ # of Ees. _____ CO _____ # of Ees. _____ CO _____ # of Ees. _____
$15 / $30 / $50 $10 / $40 / $60 $15/35%/50%	☐ RCP72423 / NCP72423 ☐ RCP72426 / NCP72426 ☐ RCP72424 / NCP72424	TOTAL # OF EMPLOYEES ENROLLED: _____

Category 2 – Consumer Value Products

GROUP NUMBER:

A. BlueEdge℠ HSA

HSA Vendor: ☐ **Option A:** ACS/Mellon Bank ☐ **Option B:** HSA Bank ☐ **Option C:** FlexHSA ☐ Other / None

100% / 80% Coinsurance – OV covered at 100% & Outpatient Prescription Drugs covered at 80%, both after deductible	
☐ RPSL1A05 / NPSL1A05	$1,200 Deductible (combined in & out) with $2,400 OPX (combined in & out)
☐ RPS91605 / NPS91605	$1,500 Deductible (combined in & out) with $3,000 OPX (combined in & out)
100% / 80% Coinsurance – OV & Outpatient Prescription Drugs covered at 100% after deductible	
☐ RPSC1807 / NPSC1807	$2,500 Deductible (combined in & out) with $5,000 OPX (combined in & out)
☐ RPEC1807 / NPEC1807	$2,500 / $5,000 Embedded Deductible (in/out) with $2,500 / $10,000 OPX (in/out)
☐ RPSE1A07 / NPSE1A07	$3,500 Deductible (combined in & out) with $5,800 OPX (combined in & out)
☐ RPEE1907 / NPEE1907	$3,500/$7,000 Embedded Deductible (in/out) with $3,500/$14,000 OPX (in/out)
☐ RPSH1807 / NPSH1807	$5,000 Deductible (combined in & out) with $5,800 OPX (combined in & out)
☐ RPEH1807 / NPEH1807	$5,000/$10,000 Embedded Deductible (in/out) with $5,000 / $20,000 OPX (in/out)
80% / 60% Coinsurance – OV & Outpatient Prescription Drugs covered at 80% after deductible	
☐ RPSL3A05 / NPSL3A05	$1,200 / $2,400 Deductible (in/out) with $2,400 / $4,800 OPX (in/out)
☐ RPS93505 / NPS93505	$1,500 / $3,000 Deductible (in/out) with $3,000 / $6,000 OPX (in/out)
☐ RPSC3805 / NPSC3805	$2,500 / $5,000 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
☐ RPEC3805 / NPEC3805	$2,500 / $5,000 Embedded Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
☐ RPSE3A05 / NPSE3A05	$3,500/ $7,000 Deductible (in/out) with $5,800/ $11,600 OPX (in & out)
☐ RPEE3A05 / NPEE3A05	$3,500/ $7,000 Embedded Deductible (in/out) with $5,800 / $11,600 OPX (in/out)

B. BlueEdge℠ Direct HCA

100% / 80% Coinsurance (combined in & out) – OV & Outpatient Prescription Drugs covered at 100% after deductible	**90% / 70% Coinsurance** (combined in & out) - OV covered at 90% after deductible - Outpatient Prescription Drugs covered at 80% after deductible		**80% /60% Coinsurance** (combined in & out) - OV & Outpatient Prescription Drugs covered at 80% after deductible	
$1,500 Deductible & $0 OPX	$1,500 Deductible & OPX	$2,000 Deductible & OPX	$1,500 Deductible & OPX	$2,000 Deductible & OPX
☐ RPD91127 / NPD91127 – $750 HCA ☐ RPD91137 / NPD91137 – $1,000 HCA	☐ RPD92615 / NPD92615 – $500 HCA ☐ RPD92625 / NPD92625 – $750 HCA ☐ RPD92635 / NPD92635 – $1,000 HCA	☐ RPDA2435 / NPDA2435 – $1,000 HCA	☐ RPD93615 / NPD93615 – $500 HCA ☐ RPD93625 / NPD93625 – $750 HCA	☐ RPDA3435 / NPDA3435 – $1,000 HCA

C. PPO Value Choice

80% / 60% Coinsurance (in / out) – OV, ER & Outpatient Prescription Drugs covered at 80% after deductible	
☐ RPV43705 / NPV43705	$250 / $500 Deductible (in/out) with $2,500 / $5,000 OPX (in/out)
☐ RPV43805 / NPV43805	$250 / $500 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
☐ RPV73805 / NPV73805	$500 / $1,000 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
☐ RPV83705 / NPV83705	$1,000 / $2,000 Deductible (in/out) with $2,500 / $5,000 OPX (in/out)
☐ RPV83805 / NPV83805	$1,000 / $2,000 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
80% / 60% Coinsurance (in / out) - OV & Outpatient Prescription Drugs covered at 80% after deductible $150 ER	
☐ RPVC3705 / NPVC3705	$2,500 / $5,000 Deductible (in/out) with $2,500 / $5,000 OPX (in/out)
☐ RPVE3905/ NPVE3905	$3,500 / $7,000 Deductible (in/out) with $3,500 / $7,000 OPX (in/out)
☐ RPVH3805 / NPVH3805	$5,000 / $10,000 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
70% / 50% Coinsurance (in / out) – OV, ER & Outpatient Prescription Drugs covered at 70% after deductible	
☐ RPV44708 / NPV44708	$250 / $500 Deductible (in/out) with $2,500 / $5,000 OPX (in/out)
☐ RPV44808 / NPV44808	$250 / $500 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
☐ RPV74708 / NPV74708	$500 / $1,000 Deductible (in/out) with $2,500 / $5,000 OPX (in/out)
☐ RPV74808 / NPV74808	$500 / $1,000 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)
☐ RPV84708 / NPV84708	$1,000 / $2,000 Deductible (in/out) with $2,500 / $5,000 OPX (in/out)
☐ RPV84808 / NPV84808	$1,000 / $2,000 Deductible (in/out) with $5,000 / $10,000 OPX (in/out)

D. CPO Value Choice - This product is not available in all geographic areas

90%/80%/50% Coinsurance(CPO/ PPO/ out) - OV covered at 90% Outpatient Rx covered at 80% after deductible $150 ER			
Deductible & OPX Options (CPO)			**Initial Employee Enrollment by CPO Network**
$1,000 Deductible with $1,000 OPX	**$2,500 Deductible with $2,500 OPX**	**$5,000 Deductible with $5,000 OPX**	CO _____ # of Ees. _____ CO _____ # of Ees. _____ CO _____ # of Ees. _____
☐ **RCV82305 /** NCV82305	☐ **RCVC2705 /** NCVC2705	☐ **RCVG2805 /** NCVG2805	TOTAL # OF EMPLOYEES ENROLLED: ______

Category 3 – HMO Products

GROUP NUMBER:

A. BlueAdvantage® HMO

$150 ER					
Copayments	**Outpatient Prescription Drug Card**	**Plan ID**	**Copayments**	**Outpatient Prescription Drug Card**	**Plan ID**
$20/$40 (PCP/PSP) OV	$15 / $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RHHHB103 / NHHB103 ☐ RHHHB106 / NHHB106 ☐ RHHHB104 / NHHB104	$30/$50 (PCP/PSP) OV	$15 / $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RHHHB163 / NHHB163 ☐ RHHHB166 / NHHB166 ☐ RHHHB164 / NHHB164
$20/$40 (PCP/PSP) OV & $100 per day hospital deductible for first 5 days of confinement per Calendar Year	$15 / $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RHHHB133 / NHHB133 ☐ RHHHB136 / NHHB136 ☐ RHHHB134 / NHHB134	$30/ $50 (PCP/PSP) OV & $250 per day hospital deductible for first 5 days of confinement per Calendar Year	$15 / $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RHHHB193 / NHHB193 ☐ RHHHB196 / NHHB196 ☐ RHHHB194 / NHHB194

B. BlueAdvantage® HMO Value Choice

OV Copayment	ER Copayment	Wellness Copayment	Specialist Visit Copayment	Hospital Confinement Deductible	Outpatient Prescription Drug Card	Plan ID
$40	$250	$0	$60	$500 per day for first 3 days of confinement per Calendar Year	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RHVHV023 / NHVBV023 ☐ RHVHV026 / NHVBV026 ☐ RHVHV024 / NHVBV024
$50	$300	$0	$70	$750 per day for first 3 days of confinement per Calendar Year	$15 / $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RHVHV033 / NHVBV033 ☐ RHVHV036 / NHVBV036 ☐ RHVHV034 / NHVBV034

Category 4 – PPO Products

GROUP NUMBER:

BlueAdvantage® Entrepreneur PPO / BluePrint® PPO

100% / 80% Coinsurance - $20/$40 OV $150 ER

OPX (in/out)	Outpatient Prescription Drug Card	Deductible Options (in/out)	
		$0/ $200	This space intentionally left blank
$0/$1,000 OPX	$15/ $30 / $50	☐ RPP11123 / NPP11123	

OPX (in/out)	Outpatient Prescription Drug Card	Deductible Options (in/out)	
		$500 / $1,000	This space intentionally left blank
$0 / $1,000 OPX	$15/ $30 /$50 $10/$40/$60 $15/35%/50%	☐ NPP71123 ☐ NPP71126 ☐ NPP71124	

90% / 70% Coinsurance $20/$40 OV $150 ER

OPX (in/out)	Outpatient Prescription Drug Card	Deductible Options (in/out)	
		$500 / $1,000	$1,000 / $2,000
$500 / $1,500 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ NPP72223 ☐ NPP72226 ☐ NPP72224	☐ NPP82223 ☐ NPP82226 ☐ NPP82224

OPX (in/out)	Outpatient Prescription Drug Card	Deductible Options (in/out)	
		$500 / $1,000	$1,000 / $2,000
$1,000 / $2,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RPP72323 /NPP72323 ☐ RPP72326 /NPP72326 ☐ RPP72324 /NPP72324	☐ RPP82323/NPP82323 ☐ RPP82326/NPP82326 ☐ RPP82324/NPP82324
$2,000 / $4,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ NPP72423 ☐ NPP72426 ☐ NPP72424	☐ NPP82423 ☐ NPP82426 ☐ NPP82424

OPX (in/out)	Outpatient Prescription Drug Card	$1,500 / $3,000	$2,500 / $5,000	$3,500 / $7,000
$1,000 / $2,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ NPP92323 ☐ NPP92326 ☐ NPP92324	☐ NPPC2323 ☐ NPPC2326 ☐ NPPC2324	☐ NPPE2323 ☐ NPPE2326 ☐ NPPE2324
$2,000 / $4,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ RPP92423 / NPP92423 ☐ RPP92426 / NPP92426 ☐ RPP92424 / NPP92424	☐ RPPC2423 / NPPC2423 ☐ RPPC2426 / NPPC2426 ☐ RPPC2424 / NPPC2424	☐ RPPE2423 / NPPE2423 ☐ RPPE2426 / NPPE2426 ☐ RPPE2424 / NPPE2424

80% / 60% Coinsurance - $20 / $40 OV $150 ER

OPX (in/out)	Outpatient Prescription Drug Card	Deductible Options (in/out)	
		$250 / $500	This space intentionally left blank
$1,000 / $2,000 OPX	$15/ $30 / $50	☐ RPP43323 / NPP43323	

OPX (in/out)	Outpatient Prescription Drug Card	$500 / $1,000	$1,000 / $2,000	$1,500 / $3,000	$2,500 / $5,000	$3,500 / $7,000
$1,000 / $2,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ NPP73323 ☐ NPP73326 ☐ NPP73324	☐ NPP83323 ☐ NPP83326 ☐ NPP83324	☐ NPP93323 ☐ NPP93326 ☐ NPP93324	☐ NPPC3323 ☐ NPPC3326 ☐ NPPC3324	☐ NPPE3323 ☐ NPPE3326 ☐ NPPE3324
$2,000 / $4,000 OPX	$15/ $30 / $50	☐ RPP73423 / NPP73423	☐ RPP83423 / NPP83423	☐ RPP93423 / NPP93423	☐ RPPC3423 / NPPC3423	☐ RPPE3423 / NPPE3423
	$10 / $40 / $60	☐ RPP73426 / NPP73426	☐ RPP83426 / NPP83426	☐ RPP93426 / NPP93426	☐ RPPC3426 / NPPC3426	☐ RPPE3426 / NPPE3426
	$15 / 35% / 50%	☐ RPP73424 / NPP73424	☐ RPP83424 / NPP83424	☐ RPP93424 / NPP93424	☐ RPPC3424 / NPPC3424	☐ RPPE3424 / NPPE3424
$3,000 / $6,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ NPP73523 ☐ NPP73526 ☐ NPP73524	☐ NPP83523 ☐ NPP83526 ☐ NPP83524	☐ NPP93523 ☐ NPP93526 ☐ NPP93524	☐ NPPC3523 ☐ NPPC3526 ☐ NPPC3524	☐ NPPE3523 ☐ NPPE3526 ☐ NPPE3524

BlueAdvantage® Entrepreneur PPO / BluePrint® PPO (cont'd)

80% / 60% Coinsurance - $30 / $50 OV $150 ER

OPX (in/out)	Outpatient Prescription Drug Card	Deductible Options (in/out) $500 / $1,000	$1,000 / $2,000	$1,500 / $3,000	$2,500 / $5,000	$3,500 / $7,000
$1,000 / $2,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ NPP73333 ☐ NPP73336 ☐ NPP73334	☐ NPP83333 ☐ NPP83336 ☐ NPP83334	☐ NPP93333 ☐ NPP93336 ☐ NPP93334	☐ NPPC3333 ☐ NPPC3336 ☐ NPPC3334	☐ NPPE3333 ☐ NPPE3336 ☐ NPPE3334
$2,000 / $4,000 OPX	$15/ $30 / $50	☐ RPP73433 / NPP73433	☐ RPP83433 / NPP83433	☐ RPP93433 / NPP93433	☐ RPPC3433 / NPPC3433	☐ RPPE3433 / NPPE3433
	$10 / $40 / $60	☐ RPP73436 / NPP73436	☐ RPP83436 / NPP83436	☐ RPP93436 / NPP93436	☐ RPPC3436 / NPPC3436	☐ RPPE3436 / NPPE3436
	$15 / 35% / 50%	☐ RPP73434 / NPP73434	☐ RPP83434 / NPP83434	☐ RPP93434 / NPP93434	☐ RPPC3434 / NPPC3434	☐ RPPE3434 / NPPE3434
$3,000 / $6,000 OPX	$15/ $30 / $50 $10 / $40 / $60 $15 / 35% / 50%	☐ NPP73533 ☐ NPP73536 ☐ NPP73534	☐ NPP83533 ☐ NPP83536 ☐ NPP83534	☐ NPP93533 ☐ NPP93536 ☐ NPP93534	☐ NPPC3533 ☐ NPPC3536 ☐ NPPC3534	☐ NPPE3533 ☐ NPPE3536 ☐ NPPE3534

Ancillary Products Selection:

Dental Products

DENTAL PPO GROUP NUMBER:

DENTAL HMO GROUP NUMBER:

If Dental is a desired benefit, the Dental HMO (DHMO) product cannot be selected unless a Dental PPO (DPPO) product is also selected.

A. BlueCare Dental Freedom PPO

Selection content contains: Plan ID - Annual Benefit Maximum / Orthodontia Lifetime Maximum – Out-of-Network Reimbursement

High Coverage Allocation		Low Coverage Allocation	
$25 / $75 Deductible (ind./fam.)	**$50 / $150 Deductible (ind/fam)**	**$50 / $150 Deductible (ind/fam)**	
☐ DHUF01 - $2,000/$2,000 - U&C ☐ DHUF02 - $2,000/$1,500 -U&C ☐ DHUF03 - $1,500/$1,500 - U&C ☐ DHUF06 - $1,000/$1,000 - U&C ☐ DHUF12 - $1,500/N/C - U&C ☐ DHUF14 - $1,000/N/C - U&C	☐ DHUF04 - $1,500/$1,500 - U&C ☐ DHUF05 - $1,500/$1,000 - U&C ☐ DHUF07 - $1,000/$1,000 - U&C ☐ DHSF10 - $1,000/$1,000 -SMA ☐ DHUF13 - $1,500/N/C - U&C ☐ DHUF15 - $1,000/N/C - U&C ☐ DHUF21 - $1,250/N/C - U&C ☐ DHUF22 - $1,250/$1,000 - U&C	☐ DLSF11 - $1,000/$1,000 – SMA ☐ DLSF20 - $1,000/N/C - SMA ☐ DLUF08 - $1,000/$1,000 –U&C ☐ DLUF16 - $1,000/N/C – U&C ☐ DLUF18 - $750/N/C – U&C	☐ DLUF19 - $1,000/N/C – U&C ☐ DLUF23 - $1,250/N/C – U&C ☐ DLUF24 - $1,250/$1,000 – U&C ☐ DLUF25 - $1,500/$1,000 – U&C

B. BlueCare Dental Choice PPO

Selection content contains: Plan ID - Annual Benefit Maximum (in/out) - Orthodontia Lifetime Maximum (in/out) – Out-of-Network Reimbursement

High Coverage Allocation	High Coverage Allocation
$25 / $75 Deductible (ind./fam.)	**$50 / $150 Deductible (ind/fam) Continued**
☐ DHUC01 - $1,500 / $1,000 - $1,000 / $1,000 - U&C	☐ DHSC09 - $1,250 / $1,000 – N/C – SMA
$50 / $150 Deductible (ind/fam)	Low Coverage Allocation **$50 / $150 Deductible (ind/fam)**
☐ DHUC02 - $1,000 / $1,000 - $1,000 / $1,000 - U&C	
☐ DHUC04 - $1,250 / $1,000 - $1,000 / $1,000 - U&C	☐ DLUC08 - $1,000 / $1,000 – N/C - U&C
☐ DHUC05 - $1,000 / $1,000 - $1,000 / $1,000 - U&C	☐ DLSC10 - $1,000 / $1,000 – N/C – SMA

C. BlueCare Dental HMO

☐ BlueCare Dental HMO 710	☐ BlueCare Dental HMO 730

Life Products

GROUP NUMBER:

If Life is a desired benefit, the Group Term Life product must be selected in order to also select Dependent Life and Short Term Disability.

A. Group Term Life / Accidental Death & Dismemberment (AD&D)

☐ **Yes** ☐ **No**

Complete Item D below if Term Life benefits vary by class
Accidental Death & Dismemberment is not available for retirees

Choose a Benefit:	Choose a Reduction Method:
☐ $25,000 per Employee ☐ Flat Benefit of **$**______ per Employee ☐ ______ times Basic Annual Salary (rounded to the next higher multiple of $1,000, if not already a multiple), up to a Maximum benefit of **$**______ per Employee	☐ 65% of the original amount at age 65 / 50% of the original amount at age 70 (Standard Option – applicable to groups with less than 10 employees) ☐ 50% of the original amount at age 70

Excess Amounts of Life Insurance:

Evidence of Insurability will be required for individual life insurance amounts in excess of **$**______. Such excess insurance amounts shall become effective on the date Evidence of Insurability is approved by Dearborn National Insurance Company. Waiver of Premium, in the event of total disability, will terminate at age 65 or when no longer disabled, whichever is earlier. Being Actively at Work is a requirement for coverage. If an employee is not Actively at Work on the day his coverage would otherwise be effective, the effective date of his coverage will be the date of his return to Active Work. If an employee does not return to Active Work, he will not be covered.

B. Dependent Life

☐ **Yes** ☐ **No**		**Spouse**	**Children** – age birth to 6 months	**Children** – age 6 months to 19 years/student to age 25
Choose a Plan:	☐ Option 1	$2,000	$100	$1,000
	☐ Option 2	$5,000	$100	$2,500

C. Short Term Disability (STD)

☐ **Yes** ☐ **No**

Complete Item D below if Short Term Disability benefits vary by class
Benefit will not exceed 66 2/3% of Basic Weekly Salary and is payable for non-occupational disabilities only

Choose a Plan:	Choose a Benefit:
☐ 1 / 8 / 13 weeks	☐ Flat $______ weekly (not to exceed $250)
☐ 1 / 8 / 26 weeks	☐ Salary Based (select one) - ☐ 50% ☐ 60% ☐ 66 2/3% of Basic Weekly Salary up to a maximum of $______

D. Classes

Please complete this chart if Term Life or Short Term Disability benefits vary by class

Class Description	Term Life / AD&D	Short Term Disability

Electronic Issuance:

(Non-HMO Health and Dental Plans only) The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

Additional Provisions:

Use this section to indicate if the account is retaining any plan(s) not shown above, or need to indicate any other instruction or important information.

____

____

____

Signatures

Employer / Authorized Purchaser ______________ Title ______________ Date ______________

Underwriter ______________ Title ______________ Date ______________

EMPLOYER GROUP INFORMATION

Indicate N/A in any sections that do not apply to your group.

BlueCross BlueShield of Illinois

SECTION A

Employer Name____ Employer Tax ID #_______________________________

Type of Business____________________________SIC Code____________ Original Business Start-up Date_____/_____/__________

Parent Company Name ____

Prior Group Coverage with Blue Cross and Blue Shield of Illinois. a Division of Health Care Service Corporation, a Mutual Legal Reserve Company? ☐ Yes ☐ No **If Yes**, provide Cancellation Date_______________ & Group Number ____________________________

Is the Group's current funding arrangement fully insured? ☐ Yes ☐ No

What is the Group's current health coverage renewal date? _____/_____/___________

Number of Part-Time Employees:____________ Number of Full-Time Employees:____________ Number of Total Employees:_______________	Number of Out-of-State Resident Enrollees: ______________________ List: State ________ Number of Employees ____________ ________ ____________ ________ ____________	Total Number Enrolled: ____________ Number with Signed Waivers: ____________

List below the names and termination dates for Employees, Spouses and/or Children continuing coverage under the provisions of **COBRA, or Illinois Continuation** (will be referenced only as COBRA throughout remainder of this form).

Name of COBRA Continuee	Coverage Type (Individual or Family)	Projected COBRA Termination Date	Type of Coverage Extended
			☐ Health ☐ Dental
			☐ Health ☐ Dental
			☐ Health ☐ Dental

List below the names of **covered Employees not actively at work** due to: 1) layoff; 2) leave of absence; 3) confinement in a health care facility; 4) maternity leave; 5) disability; 6) worker's compensation; 7) illness; 8) injury; 9) other (specify)____________________________

Employee Name	Age	Reason for Absence (1-9)	Plan Type (PPO, HMO, etc.)	Date Last Worked	Family Coverage (Y or N)

List below all **disabled** Spouses and/or Children who are currently covered by the group health plan.

Spouse or Child Name	Age	Employee Name	Plan Type (PPO, HMO, etc.)	Date of Disability	Will BCBSIL be Primary or Secondary?	Medicare Eligible (Y or N)

SECTION B

This section is to be completed by groups with 51 or more employees *ONLY*.

MEDICAL QUESTIONNAIRE

YES	NO	# of members	Directions: Please check ☐ Yes or ☐ No. If any box is checked "Yes" (☒ YES) circle the condition, e.g., (STROKE), and give details below.
☐	☐		**1.** Has anyone had a claim of $5,000 or more in the past 12 months?
☐	☐		**2.** Has anyone been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years?
			3. Has anyone been advised, diagnosed or treated by a physician in the past 5 years for:
☐	☐		**A.** Stroke, heart, circulatory, vascular disease or disorder, or high blood pressure?
☐	☐		**B.** Cancer, tumors, leukemia, lupus or any other systemic disease?
☐	☐		**C.** Multiple sclerosis, paralysis, arthritis or bone/joint/back/muscle disorders?
☐	☐		**D.** Asthma, emphysema, respiratory or lung disorders?
☐	☐		**E.** Diabetes, pancreas, growth disorder or endocrine disorder?
☐	☐		**F.** AIDS, tested positive for HIV, immune system disorders or blood disorders?
☐	☐		**G.** Hepatitis/liver disorder, digestive system disease or disorder, colon disorder, kidney/prostate/reproductive organs disorder or infertility?
☐	☐		**H.** Nervous system or brain/seizure disorder, mental/emotional disorders, alcohol/drug/substance abuse or dependency?
☐	☐		**I.** Organ transplant or bone marrow transplant?
☐	☐		**J.** Other?____________________
☐	☐		**4.** Are any employees or dependents currently pregnant?

If you have answered "Yes" to any of the questions above, please provide details below. Use an additional page if needed.

DETAILS OF MEDICAL HISTORY

Example is shown in gray boxes

Question #	Name (optional)	Employee, Spouse, or Child	Age	Sex	Condition/ Diagnosis	Treatment Medications	Treatment Date	Date of Recovery
3A	Spouse	Employee, (Spouse), Child	36	M X F ___	Stroke	Surgery	5/3/2005	
		Employee, Spouse, Child		M___ F ___				
		Employee, Spouse, Child		M___ F ___				
		Employee, Spouse, Child		M___ F ___				
		Employee, Spouse, Child		M___ F ___				

The following information is needed to comply with Public Act 86-537, as amended, which regulates the Discontinuation and Replacement of Group Insurance policies. Each covered person will be given credit toward our participating provider program deductible for prior deductible and waiting periods satisfied under the prior carrier's coverage based on information provided to Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") by the group. HCSC reserves the right to accept or, where not prohibited by law, reject the entire group based on the information provided. HCSC further reserves the right to change the quoted rates or withdraw the proposal if any of the above information changes was omitted, or has been reported inaccurately.

What is the provision in the current insurance carrier's contract for **coverage during lay off, leave of absence and disability**?

____

What is the current carrier's **extension of benefits provision** for medical services in the event of employer group cancellation?

____

Has the Group's **medical coverage ever been cancelled**, or applications for coverage been declined or withdrawn? ☐ Yes ☐ No

If yes, explain. ____

If additional space is needed for any of the above, please attach a separate sheet with the required information.

SECTION C

Insurance Company History (All Insurance Companies, including HMO, in the previous five years)

Insurance Company Name	Period Insured
Current:	
Previous:	

Current Carrier Premium Rates for:	Plan Type (HMO, PPO, other)	Current Policy	Renewal	Benefit Levels (Deductible and Coinsurance)
Employee	☐ HMO ☐ PPO ☐ Other (specify:)____________	$______ $______ $______	$______ $______ $______	Deductible: ________ Coinsurance: ________
Employee plus Spouse	☐ HMO ☐ PPO ☐ Other (specify:)____________	$______ $______ $______	$______ $______ $______	Deductible: ________ Coinsurance: ________
Employee plus Child(ren)	☐ HMO ☐ PPO ☐ Other (specify:)____________	$______ $______ $______	$______ $______ $______	Deductible: ________ Coinsurance: ________
Family	☐ HMO ☐ PPO ☐ Other (specify:)____________	$______ $______ $______	$______ $______ $______	Deductible: ________ Coinsurance: ________
Total Monthly Health Premium		$	$	

SECTION D

Medicare Secondary Payer (MSP) Employer Acknowledgement

Indicate below the total number eligible for Medicare in each category:

Active Employees _________ **Dependents** _________ **Retirees Under Age 65** _________ **Retirees Over Age 65** _________

As an officer of the above named Employer, I have been provided with a pamphlet entitled "Information Regarding the Medicare as Secondary Payer Statute." I understand that Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC,) will provide basic information about individuals who are both enrolled in the Employer group health insurance plans and are covered by Medicare to the Centers for Medicare and Medicare Services ("CMS") formerly known as Health Care Financing Administration ("HCFA"), which administers Medicare. The ability to make primary and secondary determinations involving such individuals and thus to assist CMS in processing MSP claims properly in the first instance depends on the breadth and accuracy of the information provided by the Employer to HCSC concerning individuals covered by our group health insurance plans. To ensure continuing accuracy, the Employer acknowledges its responsibility to notify HCSC promptly of any changes in the size of our work force or the status of employees or their dependents that might affect the order of payment under the MSP statute. Furthermore, the Employer has conducted a survey of all insured employees and retirees under age 65 and their dependents and represents that on this date, the information contained herein is correct.

I have read all the statements above and represent that they are true and complete to the best of my knowledge and belief.

____ ____________________

Employer or Authorized Purchaser Signature and Title **Date**

____ ____________________

Producer Signature **Date**

BLUE CROSS AND BLUE SHIELD OF ILLINOIS (BCBSIL) MEDICARE SECONDARY PAYER (MSP) EMPLOYER ACKNOWLEDGEMENT FORM (EAF)

BlueCross BlueShield of Illinois
Experience. Wellness. Everywhere.®

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the enclosed document titled "Instructions – Completing the MSP Employer Acknowledgement Form" for more details. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Please complete this form, sign, date and direct it to your BCBSIL Account Executive. A response is required for every question.**

Employer Name – Legal Name of Company:		Employer Identification Number (EIN):
Physical Address (number & street), City, State, ZIP:		
Account Number(s):	Group Number(s):	
⇨ New BCBSIL clients please check the correct box	☐ The client was **not** in business during the preceding calendar year	☐ The client was in business during the preceding calendar year
⇨ Current BCBSIL clients please check the correct box	☐ Submitting this EAF at renewal	☐ Submitting this EAF as an update ☐ Submitting this EAF as an error correction

Question			
Do you have any affiliates or subsidiaries? If "yes", list name of each.		☐ Yes	☐ No
Some of the following responses are based on the current calendar year, while others are based on the preceding year. Unless making an update or error correction, please use the year of your upcoming renewal as 'current year' when answering the following questions. For example, if your upcoming renewal is effective July 1, 2009, base your current year answers on 2009. Or, if your upcoming renewal is effective January 1, 2010, base your current year answers on 2010. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSIL if and when your status changes. **Please indicate the current calendar year for which the form is being completed:**		______ **Current year**	
1. In the year immediately prior to the current calendar year, did you file a separate federal tax return, that is, not consolidated with another individual or entity? If you are not required to file a federal tax return, please check N/A ☐		☐ Yes	☐ No
2. How many employees did all the entities on the preceding calendar year's tax return have on the payroll (whether full-time, part-time, seasonal, or partners) during the preceding calendar year? Enter number of employees.		______ (# of employees)	
3. Are you part of a multi-employer group health plan? The term "multi-employer group health plan" means any trust, plan, association or any other arrangement made by one or more employers or by employers and unions to offer, contribute to, sponsor, or directly provide health benefits. Question 5 must also be completed.		☐ Yes	☐ No
4. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ Check 'Yes' or 'No' for both the current and preceding calendar years ☐ If you checked "Yes" for the current calendar year, and the threshold was met during the current year, please check this box and enter the date the threshold was met in the following space. _______/_______/________. ☐ If you check "No" for the current year and your answer changes to "Yes" at any time, you must promptly notify BCBSIL by completing a new EAF, checking this box and entering the date the threshold was met in the space above.	Current year (See above.)	☐ Yes	☐ No
	Preceding year	☐ Yes	☐ No
5. If you are currently or were during the preceding year part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ If you answered 'Yes' to #3, then check 'Yes' or 'No' for both the current and preceding calendar years ⇨ If you answered 'No' to #3, then check 'Yes' or 'No' for the preceding calendar year only	Current year (See above.)	☐ Yes	☐ No
	Preceding year	☐ Yes	☐ No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No

I understand that BCBSIL is relying on my answers to the above questions to determine whether Medicare will be the primary payer of claims for my Medicare eligible insured(s). I certify that the answers are true to the best of my knowledge and belief. I also understand that I am responsible to promptly notify BCBSIL, as indicated above, if my answers to the above questions change because we have increased the number of employees.

Signature of company officer or authorized representative ____________________ Print Name ____________________

Title ____________________ Date ____________________

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting the Privacy Office or by using our Web site, www.bcbsil.com. If you receive this notice on our Web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services; see information at its Web site: www.hhs.gov. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Director, Privacy Office
Health Care Service Corporation
PO Box 804836
Chicago, IL 60680-4110
(800) 607-7418

a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

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Blue Cross and Blue Shield of Illinois

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

OUR RESPONSIBILITIES

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the employer who is the plan sponsor of a group health plan. We may also in our health care operations disclose PHI to business associates[1] with whom we have written agreements containing terms to protect the privacy of your PHI.

[1] A "business associate" is a person or entity who performs or assists Blue Cross and Blue Shield of Illinois with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.

We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

Personal Representatives: We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services: We may use your PHI to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities.

We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA-regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to avert a serious threat to health or safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization; and
- in connection with certain research activities.

Use and Disclosure of Certain Types of Medical Information: For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your PHI:

- **HIV Test Information.** We may not disclose the result of any HIV test or that you have been the subject of an HIV test unless required by law or the disclosure is to you or other persons under limited circumstances or you have given us wri ten permission to disclose.
- **Genetic Information.** We may not disclose your genetic information unless the disclosure is made as required by law or you provide us with written permission to disclose such information.
- **Mental Health Information Records.** We may not disclose your mental health information records except to you and anyone else authorized by law to inspect and copy your mental health information records or you provide us with written permission to disclose.
- **Alcoholism or Drug Abuse Information.** We may not disclose any alcoholism or drug abuse information related to your treatment in an alcohol or drug abuse program unless the disclosure is allowed or required by law or you provide us with written permission to disclose.

INDIVIDUAL RIGHTS

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access: You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A "designated record set" contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting: You have the right to receive a list of instances since April 14, 2003 in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Health Care Service Corporation, A Mutual Legal Reserve Company
Fort Dearborn Life Insurance Company, A Stock Life Insurance Company
Notice of Information Practices

This description of the Information Practices of Health Care Service Corporation (HCSC) a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company (FDL), a Stock Life Insurance Company, (collectively referred to herein as "we," "our" or "us"), is provided to you in accordance with the requirements of the Illinois Insurance Information and Privacy Protection Law.

Collection of Information

In order to properly underwrite and administer your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation, physical condition and health history.

You are our most important source of information, but we may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone or by personal contact.

Circumstances of Disclosure

In some circumstances, we may make disclosures of personal or privileged information to third parties without your authorization. Following is a description of the types of persons who may receive such information without your authorization and some of the circumstances that might give rise to such disclosures.

- We might use an unaffiliated organization or person to perform a professional, business or insurance function for us. If, for example, we hired an independent organization to assist in the administration of a group insurance plan of which you are a participant, information relating to your insurance coverage would be disclosed to that organization in order for it to adequately perform its function. This would also be the case with respect to any organization or person, which performs a professional, business or insurance function for us.
- We may disclose information concerning your coverage to our agents and producers in order to provide you with adequate service, including the updating and improvement of your insurance program.
- We may disclose information to other insurance institutions, agents, insurance-support organizations or self-insurers, which is necessary (a) to prevent criminal activity, fraud, material misrepresentation or material non-disclosure in connection with insurance transactions, or (b) for either of us or such company to perform its function in connection with an insurance transaction involving you or a member of your family insured under your coverage. For example, if you are a participant in an HCSC or FDL group insurance plan, and if you, your spouse or dependents are insured under other group plans, the companies involved may be required to share claims information pursuant to coordination of benefits provisions in their respective policies. The object, of course, is to make sure that you receive total benefits from all companies no greater than the cost of health care received.
- We may disclose information to the Illinois Insurance regulatory authority in connection with its regulation of our business.
- We may disclose information to a law enforcement or governmental authority to protect our interest in preventing or prosecuting the perpetration of fraud upon us, or if we reasonably believe that illegal activities have been conducted we will also disclose information when permitted or required by law to do so.
- Various industry and professional organizations conduct scientific and actuarial research studies to learn more about the risk experience of our insureds. Other organizations conduct studies relating to medical research. These studies are purely scientific in nature, never identify individuals in their reports, and always maintain information provided in a highly confidential manner. When asked to provide information to such organizations, we ordinarily will do so because the results of such studies are of benefit to our customers and the public at large. You will not be individually identified in any report that results from the research, and material that we give to the person or organization performing the research will be returned to us or destroyed when it is no longer needed.
- If you are covered under an HCSC and/or FDL group policy, we may disclose information as is reasonably necessary to the group for purposes of administration of the group policy and to permit the group to audit, review and evaluate the performance of HCSC and FDL under the group policy.
- We are sometimes approached by persons or organizations that are interested in the opportunity to market products or services to our customers. When this happens, we may provide some limited information. However, if we want to give information to persons not affiliated with us, we will give you an opportunity to indicate to us that you do want information to be disclosed for this purpose. We will give information to our affiliates so that our customers may be aware of the insurance products and services offered by our affiliates.

Please understand that the above is intended to describe some of the disclosures which might be made, not disclosures which are always or even often made, in any event, the information disclosed without your authorization will be only as much as reasonably necessary to accomplish the intended purpose.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Your Right to Access Personal Information
As an individual, you have certain rights in regards to access to recorded personal information, which is reasonably locatable and retrievable. In order to maintain the security of that information, access will be permitted only after proper identification has been submitted to us.

1. If you have any question about what information we may have on file about you, please write us at the address indicated at the end of this notice. We will need your complete name, address, date of birth and all policy numbers under which you are insured. Tell us what information you would like to receive. Within 30 days of our receipt of your written request, we will:
   a) Inform you of the nature and substance of the recorded personal information in writing, by telephone or by other communication;
   b) Permit you to see and copy, in person (by appointment only,) the recorded personal information which applies to you or provide you with copies of this information by mail;
   c) Any insurance-support organization that furnished the personal information that has been corrected, amended or deleted.
2. If you disagree with a refusal to correct, amend or delete recorded personal information, you may file a:
   a) Concise document setting forth what you think is the correct, relevant or fair information, and a
   b) Concise statement of the reasons why you disagree with the refusal to correct, amend or delete recorded personal information.
3. If you file either of the statements described above, we will:
   a) File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the statement and have access to it;
   b) In any subsequent disclosure of the recorded personal information that is the subject of disagreement, clearly identify the information in dispute and provide the statements along with the recorded personal information being disclosed;
   c) Furnish the statement to any of the three categories of persons and organizations covered in the preceding point "2."
4. Your rights to correct, amend or delete recorded personal information exist to the extent that the information is collected and maintained in connection with an insurance transaction. These rights do not extend to information about you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal processing.

Please understand that the above is intended to describe some of the disclosures which might be made, not disclosures which are always or even often made. In any event, the information disclosed without your authorization will only be as much as reasonably necessary to accomplish the intended purpose.

Your Privacy Is Our Concern
Should you have any questions about our procedures or information maintained about you, please contact us at the following address:

Health Care Service Corporation, (A Mutual Legal Reserve Company)
300 East Randolph
Chicago, IL 60601
Attn: SSD – Privacy Act Information

This Important Notice is for coverages provided by Fort Dearborn Life Insurance Company

Fort Dearborn's underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and to provide a mechanism by which policyholders and certificate holders pay their fair share of the cost. In considering your application, Fort Dearborn considers information from various sources, including your own statements, the results of your physical examination (if required), and any obtained from doctors or medical facilities where you have been treated.

Information regarding your insurability will be treated as confidential. Fort Dearborn, or its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc. a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such a company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange a disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Fort Dearborn, or its reinsurer(s) may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

The purpose of the Bureau is to protect its member and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increase premium or declined).

BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois Cover Page to the **Illinois Standard Health Employee Application for Small Employers**

(Groups sized 2 - 150)

The purpose of this document is to help you – an employee requesting coverage from Blue Cross and Blue Shield of Illinois (BCBSIL) – fill out the new standard enrollment application created by the State of Illinois Department of Insurance.

As a result of the Illinois Insurance Fairness Act (Public Act 96-0857), the Illinois Department of Insurance created standard enrollment applications that must be used by all insurance companies doing business in the small group and individual markets.

The attached standard application goes into effect January 1, 2011 and replaces the small group enrollment applications previously used by insurance companies.

Although all insurance companies must use this standard enrollment application, the business needs and practices of all insurance companies are not the same. Not all the information requested on the new standard enrollment application is required by BCBSIL. However, there is information BCBSIL needs for the enrollment process that is not on the standard enrollment application.

The information below will help you understand how to complete each section of the standard enrollment application for enrollment with BCBSIL.

1. Employer Information

Your employer can use the Illinois Standard Health Employee Application with one or more insurance companies to request quotes for employee health insurance. This standard enrollment application means you do not need to fill out different applications from each insurance company. For your benefit, space is provided on the standard enrollment application so your employer can list the different insurance companies that will receive your health information.

You will see references to "spouse/domestic partner" and "retiree" in the standard enrollment application. Domestic partners and retirees are eligible only if your employer chooses to cover them. Check with your employer if you are not sure.

2. Section B – Coverage Requested

Choose the type of health coverage/product you want based on the option(s) your employer has offered you.

- Some employers may offer only one type of coverage such as a PPO health benefit plan.
- Others may provide different options such as a PPO, an HMO, and/or a plan that includes a Health Savings Account (HSA) and/or a Health Care Account (HCA).
- You and your dependents (spouse/domestic partner and children) will all be enrolled in the same product. You cannot pick different products for each person.

BCBSIL offers the following products for small group business. If you are not sure which product(s) are available to you, please ask your employer.

PPO	HMO	HSA	HCA
• BlueAdvantage℠ Entrepreneur PPO • BluePrint PPO • Blue*Choice* Select® • PPO Value Choice • CPO • CPO Value Choice	• BlueAdvantage℠ HMO • HMO Value Choice	• BlueEdge℠ HSA • BlueEdge℠ Select HSA	• BlueEdge℠ Direct HCA • BlueEdge℠ Select Direct HCA

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Illinois

3. **Section C – Waiver of Coverage**

You may enroll yourself and your dependents (spouse/domestic partner and children) in any coverage that your employer makes available to you, and that BCBSIL offers. While the standard enrollment application may appear to suggest that you can waive enrolling yourself for coverage but still enroll your dependents, BCBSIL's policy requires that you (the employee) enroll in order to also enroll your dependents. If you choose to waive any coverage, your dependents cannot enroll in that coverage. However, you can enroll yourself in a coverage and choose to waive it for any of your dependents.

Please use this section to indicate if you do not wish to enroll yourself and/or any of your dependents in the following types of coverage:

- Medical
- Dental
- Basic Life
- Dependent Life
- Short-Term Disability (*BCBSIL offers only to employees*)
- Voluntary Life (*BCBSIL offers only to employees*)

While you may see these types of coverage on the standard application, they are not available from BCBSIL for small group business:

- Vision
- Long-Term Disability

For small group business, BCBSIL does not consider "*Individual Coverage*" (*the second option on the standard application*) as a valid reason to decline your employer-offered coverage.

4. **Section D – Individuals Requesting Coverage**

- **Weight and Height -** BCBSIL requires the weight and height for yourself and your spouse/domestic partner. BCBSIL also requests weight and height be provided for any dependent that is 18 or older.
- **Military Veteran Dependents -** If you have dependents that are military veterans, you must include their honorable discharge documentation (Form DD-214).
- **Disabled Dependents -** Medical certification must be provided for disabled dependents.
- **HMO Coverage -** If you have elected to enroll in HMO coverage, information about your Primary Care Physician (PCP) is needed. The standard enrollment application provides space for your PCP and his or her identification number. However, BCBSIL requires more information about your physician. To accommodate this, a separate *HMO / CPO Provider Selection Enrollment and Change Form* is also required for HMO enrollees. This form is used to collect the following information:
  - Independent Practice Association (IPA) / Medical Group Number – this is required for BCBSIL to correctly identify the location you have chosen to access care from your PCP.
  - PCP name and the identification number.
  - Female enrollees may also choose a Woman's Principal Health Care Provider (WPHCP), so there is space to list this provider's name and identification number as well.
- **CPO Coverage -** BCBSIL offers a Community Participating Option (CPO) health benefit plan. This is similar to a PPO health benefit plan, but the member can gain greater savings by using providers at specific hospitals in the CPO network. Therefore, if you have chosen the CPO product, please use the *HMO / CPO Provider Selection Enrollment and Change Form* to indicate the number of the CPO network you have selected.

5. **Section E – Current / Prior Coverage Information: Medicare**

For small group business, "Dual Enrollment" is not an applicable Medicare entitlement reason for BCBSIL.

6. **Sections F & G – Health Statement / Additional Information**

This section should be completed by employees of groups that have 2-50 enrolling employees. If you are not sure about completing this section, check with your employer.

- For health coverage, BCBSIL does not require the health statement questions to be completed by employees of groups that have more than 50 employees enrolling.
- For basic life coverage, the health statement questions must be completed by the employee if the group has two or more eligible employees AND is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment.
- Two pages are left blank so that information in these sections can be pulled out for underwriting (if applicable).

7. **Section H – Additional Coverage Options**

As stated in item #3, the following types of coverage are not available from BCBSIL for small group business:

- Vision
- Long-Term Disability

Illinois Standard Health Employee Application for Small Employers

INSURER USE ONLY
Policy/Group No.
Section No.
Effective Date
New Hire Waiting Period

For assistance in completing this application, please contact your employer or insurance agent. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies.

The information you provide in this application will be sent to the following insurance companies:
(To be completed by employer)
Insurer: ______________________________ Insurer: ______________________________ Insurer: ______________________________
Insurer: ______________________________ Insurer: ______________________________ Insurer: ______________________________

TO BE COMPLETED BY EMPLOYER

Employer Name: | Phone #:

Address:

Reason for Enrollment (Mark all that apply)

New Enrollment: ☐ New Group ☐ Open Enrollment ☐ New Hire (Date: _________________________) ☐ Late Enrollee

Special Enrollment: ☐ Adoption ☐ Court Order ☐ Dependent Addition ☐ Divorce ☐ Domestic Partner
☐ Loss of Coverage ☐ Marriage ☐ Newborn ☐ Other Date of Event: ________/_________/_________

Employment Status: ☐ Active ☐ Retiree (Retirement Date: _______/_______/_______)
☐ Illinois Continuation ☐ COBRA
☐ Employee ☐ Dependent
Qualifying Event: ______________________________
Start Date _______/_______/________ Projected End Date _______/_______/________

A Employee Information

Name (Last) | (First) | (MI)

Job Title: | Hire Date: | Hrs/Week:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Home Address: | Apt #:

City: | State: | Zip:

Home (or Cell) Phone: (   ) | Business Phone: (   )

Email Address (optional):

B Coverage Requested

Medical

Employee: ☐ Yes ☐ No
Plan Choice:

Spouse/Domestic Partner: ☐ Yes ☐ No
Plan Choice:

Child(ren): ☐ Yes ☐ No
Plan Choice:

If you are **waiving (declining)** coverage for yourself or any member of your family, you must complete Section C below.

Employer Name ______________________________ Employee Name ____

C Waiver of Coverage

Please complete this section only if **you are waiving (declining) coverage** for yourself or one or more of your family members.

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

- If I am declining coverage for myself, my spouse/domestic partner, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse/domestic partner, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.
- If I have a new spouse/domestic partner or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse/domestic partner or child provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- If I decide to request coverage in the future, for a reason other than the termination of other coverage or the addition of a new spouse/domestic partner or child, I may be considered a late enrollee, if applicable, or I may have to wait until the plan's next open enrollment period. I also understand that as a late enrollee, coverage for preexisting conditions may be excluded for up to a period of 18 months. This period may be offset by the time I, my spouse/domestic partner, or my dependent child(ren) was covered under a qualified health plan.

I certify that I was not pressured, forced, or unfairly induced by my employer, the agent, or the insurer(s) into waiving or declining the group coverage.

I DO NOT want, and hereby waive, coverage for (initial next to all that apply):

Medical for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Dental* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Vision* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Basic Life* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Dependent Life* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Voluntary Life* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Short-Term Disability* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Long-Term Disability* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)

* If offered.

I am **declining** group coverage for the following reason(s): (check all that apply)

☐ Spouse/Domestic Partner's Employer Plan ☐ Individual Coverage (Non-Group Plan)
☐ COBRA/State Continuation ☐ Medicare or other Government Program
☐ Other (please explain): ____

✪ **If you are declining ALL coverage for ALL persons, please skip to the Acknowledgement & Signature section on page 10 of this application.**

Employer Name ______________________________ Employee Name ____

D Individuals Requesting Coverage

List yourself and all eligible family members to be included under coverage.

- Please check with your employer or insurance agent about who may qualify as an eligible family member under the policy.
- Illinois' Young Adult Dependent Coverage law allows parents to cover children up to the age of 26, and up to age 30 for military veteran dependents, regardless of whether the child may be considered a dependent for tax or other purposes. For more information, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

HMO only (if/when applicable): Primary Care Physician: | Physician ID:

Spouse/Domestic Partner Name (Last) ________________________ (First) ________________________ (MI) ______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

HMO only (if/when applicable): Primary Care Physician: | Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: | Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: | Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: | Physician ID:

Employer Name ______________________________ Employee Name ____

Dependent Name (Last) ________________ (First) ________________ (MI) _______		
Social Security Number:		Date of Birth: / /
Weight: lbs.	Height: ft. in.	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No		
HMO only (if/when applicable): Primary Care Physician:		Physician ID:

E Current/Prior Coverage Information

Please indicate for EACH person listed on this application any health coverage, including Medicare or Medicaid, in effect within **24 months** prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the **past 24 months**, please indicate **NONE.** If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation showing who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. You will be subject to an automatic PEC Waiting Period of up to 12 months until the insurer receives evidence of prior coverage.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) ______________________________ (First) ______________________________ (MI) _______

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________

Spouse/Domestic Partner Name (Last) ______________________ (First) ______________________ (MI) ______

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________

Dependent Name (Last) ______________________________ (First) ______________________________ (MI) _______

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________

Employer Name ________________________________ Employee Name ____

Dependent Name (Last) _______________________________ (First) _______________________________ (MI) _______

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ___________________________________ Insurer Name: ___________________________________
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ___________________________________ Insurer Name: ___________________________________

Dependent Name (Last) _______________________________ (First) _______________________________ (MI) _______

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ___________________________________ Insurer Name: ___________________________________
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ___________________________________ Insurer Name: ___________________________________

Dependent Name (Last) _______________________________ (First) _______________________________ (MI) _______

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ___________________________________ Insurer Name: ___________________________________
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ___________________________________ Insurer Name: ___________________________________

Medicare: If you or any family members listed on this application have Medicare coverage, please complete the following information.

Enrolling Individual Name (Last) ___________________________ (First) ___________________________ (MI) _______

Medicare ☐ Part A ☐ Part B ☐ Part D
Effective Date: ________/________/________
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

Medicare Number (please include alpha prefix):

Enrolling Individual Name (Last) ___________________________ (First) ___________________________ (MI) _______

Medicare ☐ Part A ☐ Part B ☐ Part D
Effective Date: ________/________/________
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

Medicare Number (please include alpha prefix):

Employer Name ______________________________ Employee Name ____

F Health Statement

Instructions:

1. The information you provide in this application is confidential. You should discuss with your employer if you prefer to submit the completed health statement directly to the insurance company or insurance broker.
2. The health information you provide below will be used by the insurance company to determine the price to charge your group for the coverage applied for and whether a Pre-Existing Condition Waiting Period(s) will apply to your coverage. Coverage for pre-existing conditions cannot be limited or excluded for dependents under the age of 19.
3. Each medical question below applies to all persons requesting coverage.
4. Answer the questions below with either Yes or No. If you answer Yes to any question, you must provide additional information in Section G below.
5. Do not leave any question unmarked.
6. Neither your employer nor your insurance agent can waive these requirements or may authorize you to provide anything less than a complete and accurate response to each of the questions.
7. After you submit this application, the insurance company may call you to obtain additional confidential information needed to evaluate and aid the processing of your application.

1 For the following conditions, **within the past 5 years**, have you or any dependents for whom you are requesting coverage:

- Been tested for or diagnosed with;
- Had medical treatment recommended;
- Received medical treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition related to any of the categories listed below?

A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other disease or disorder of the heart, arteries, blood, or blood vessels?	☐ Yes	☐ No
B. Cancer or cancerous tumor?	☐ Yes	☐ No
C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system?	☐ Yes	☐ No
D. Diabetes? If yes, check all that apply: ☐ Non-Insulin Dependent ☐ Insulin Dependent ☐ Insulin Pump	☐ Yes	☐ No
E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines?	☐ Yes	☐ No
F. Growth disorder or a disorder of the pancreas?	☐ Yes	☐ No
G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder?	☐ Yes	☐ No
H. Reproductive organ disorders or infertility?	☐ Yes	☐ No
I. Arthritis, or any other disorder of the joints, muscles, back, or bones?	☐ Yes	☐ No
J. Mental or emotional disorder?	☐ Yes	☐ No
K. Seizures/epilepsy, paralysis, or any other disorder of the brain or nervous system?	☐ Yes	☐ No

Employer Name ______________________________ Employee Name ____

L. HIV positive, AIDS, diseases associated with AIDS, lupus, or other disorder of the immune system?	☐ Yes	☐ No
M. Alcohol, drug, or substance use or dependency?	☐ Yes	☐ No
N. Organ or bone marrow transplant?	☐ Yes	☐ No
2 Are you, your spouse/domestic partner, or any dependent for whom you are requesting coverage currently pregnant?	☐ Yes	☐ No
Due Date: _____/_____/_________ (MM/DD/YYYY)		
If yes, are multiples (twins, triplets, *etc.*) expected?	☐ Yes	☐ No
Are there any known complications, or is a cesarean section planned?	☐ Yes	☐ No
3 **Within the past 12 months,** have you or your spouse/domestic partner used any tobacco products? Employee:	☐ Yes	☐ No
Spouse/Domestic Partner:	☐ Yes	☐ No
4 **Within the past 12 months**, has any applicant been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application?**	☐ Yes	☐ No
5 **Within the past 5 years**, has any person applying for coverage been tested for or diagnosed with, had medical treatment recommended, received medical treatment, including prescription medications, or been hospitalized for **any illness, injury or health condition not indicated above?**	☐ Yes	☐ No

G Additional Information

If you answered "Yes" to any of the questions above, you must complete this section.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Question Number: _________ Name of Individual: ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ________________________________

Surgery, additional tests or treatment recommended? ________________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ Name of Individual: ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ________________________________

Surgery, additional tests or treatment recommended? ________________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Employer Name ______________________________ Employee Name ____

Question Number: _________ **Name of Individual:** ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ **Name of Individual:** ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ **Name of Individual:** ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ **Name of Individual:** ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ **Name of Individual:** ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Employer Name ______________________________ Employee Name ____

H Additional Coverage Options

You should complete this section only if your employer offers any of the additional coverage options below.

Employee

▶ ☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): ______________________________

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $____________________

☐ Short-Term Disability ☐ Long-Term Disability

▶ Employee Class (employer will provide you with this information if needed): ____________________________________

▶ Salary (if requesting life or disability coverage): $__________________________

☐ Hourly ☐ Weekly ☐ Monthly ☐ Semi-monthly ☐ Annually

Spouse/Domestic Partner

▶ ☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): ______________________________

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $____________________

☐ Short-Term Disability ☐ Long-Term Disability

Child(ren)

▶ ☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): ______________________________

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $____________________

☐ Short-Term Disability ☐ Long-Term Disability

Beneficiary Information (if requesting life insurance)

Primary Beneficiary Name (Last, First, MI) ____

Relationship ____ Benefit % ______________________________

Secondary Beneficiary Name (Last, First, MI) ____

Relationship ____ Benefit % ______________________________

Employer Name ______________________________ Employee Name ____

I Acknowledgement & Signature

I understand, agree, and represent that:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section B and Section H of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature ____Date ________________________

✪ For assistance in completing this application, please contact your employer or insurance agent.
For information about your health care rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.