



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.

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

*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.

A. For Health, Dental PPO and Life Coverage:

<input type="checkbox"/> The date of employment.	<input type="checkbox"/> The day of employment.	<input type="checkbox"/> The first day of the month following the date of employment.
<input type="checkbox"/> 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:

<input type="checkbox"/> The first day of the month following the date of employment.
<input type="checkbox"/> 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.

<input type="checkbox"/> 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.)
<input type="checkbox"/> 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

<input type="checkbox"/> % for Employee Coverage	<input type="checkbox"/> % for Employee plus Spouse Coverage
<input type="checkbox"/> % for Employee plus Child(ren) Coverage	<input type="checkbox"/> % for Family Coverage
<input type="checkbox"/> 100% of the Employee Coverage Premium will be applied toward the Family Coverage Premium.	<input type="checkbox"/> 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

<input type="checkbox"/> % for Group Life, AD&D	<input type="checkbox"/> % for Dependent Life	<input type="checkbox"/> % for Short Term Disability
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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: _____

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)		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">HCSC Sales Representative</td> <td style="width: 50%;">District / Cluster</td> </tr> </table>	HCSC Sales Representative	District / Cluster	Other Information:
HCSC Sales Representative	District / Cluster		

UNDERWRITING AUTHORIZATION	
INTERNAL USE ONLY	Date BPA approved by Underwriting: _____ Underwriter: _____ Benefit program and premium notification letter included: <input type="checkbox"/> Yes <input type="checkbox"/> 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.: _____ By: _____
Print Signer's Name Here

➔ _____
Signature and Title

Group Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____,
Month Year