BlueCross BlueShield of Illinois

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:

- ✓ 2-150 Benefit Program Application (BPA)
- ✓ 2-150 Benefit Plan Selection Form (BPS)
- ✓ Employer Group Information Form
- ✓ Illinois Standard Health Employee Application for Small Employers Form (Enrollment Application)
- ✓ HMO / CPO Provider Selection Enrollment and Change Form
- ✓ Annual Medicare Secondary Payer (MSP) Employer Acknowledgement Form and Instructions
- ✓ Information Regarding the Medicare Secondary Payer Laws Brochure
- ✓ HCSC/Dearborn National Disclosure Forms
- ✓ 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.
- ⇒ Producer's printed name and signature.
- ⇒ The signed BPA will be returned to the employer group with the group policy after enrollment.
- ⇒ The Proxy may 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.
- ⇒ Include the Producer's printed name and signature (required for final rates).

☐ **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**

☐ **Illinois Standard Health Employee Application for Small Employers**

- ⇒ The employee enrollment application is used to enroll in medical, dental and life products (term life/AD&D/short-term disability). If the employee is waiving any coverage being offered, the Waiver of Coverage section (Section C) should be completed and signed.
- ⇒ Spousal and/or other coverage information is required including the policy number and carrier name.
- ⇒ **If Dearborn National** (life products) **is paid in full by the employer, the employee cannot waive this coverage.**
- ⇒ The Heath Statement (Section F) should be completed by each employee (and spouse, if applicable) for groups with 2-50 enrollees.

⇒ **Please note:** Enrollment could be delayed if the "Hire Date" (Section A), "Individuals Requesting Coverage" (Section D), "Health Statement" (Section F) and/or "Additional Information" (Section G) of the employee application are not completed properly. Please have employees pay close attention to these sections.

☐ **HMO / CPO Provider Selection Enrollment and Change Form**

⇒ This is a supplemental enrollment form used to enroll employees in HMO or CPO health benefit plan options offered by the employer. This form is required to obtain information not included on the employee application that BCBSIL requires to accurately enroll the employee.

⇒ **Please note:** Enrollment could be delayed if the "Medical Group/IPA Name and #" (for HMO enrollees) 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 Secondary Payer Laws

⇒ The Annual Medicare Secondary Payer (MSP) Employer Acknowledgement Form collects employer size and other critical information in order to determine whether the employer's group health plan coverage should be considered primary to Medicare.

⇒ The client **must** complete and return this form to BCBSIL within 45 days of the coverage effective date. If not received within 45 days of the coverage effective date, we will begin a follow-up process to request that this form be submitted. If the client does not return this form, the Medicare Secondary Payer guidelines 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, a listing on company letterhead of all the employees indicating their full or part-time status, and a copy of the first payroll listing.

⇒ 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 BCBSIL sales executive or General Agent for the proper documentation.

⇒ The individuals included on the Wage/Tax statement, billing statement and applications must be reconciled with employment status indicated, (e.g., FT, PT, Term, Union,) 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. For submission deadlines, please contact your Blue Cross and Blue Shield of Illinois sales executive or General Agent.

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

BlueCross BlueShield of Illinois

Dearborn National®
A Subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company

BENEFIT PROGRAM APPLICATION ("BPA")

(All items are applicable to 51-150 Grandfathered and Non-Grandfathered Insured Group Accounts unless otherwise specified.)
(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

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"): _____

Wholly Owned 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, attached to the BPA, and is made a part of the Policy.)

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: _____ / _____ / _____
Month Day Year

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health Plan*: Yes ☐ No ☐

If Yes, specify ERISA Plan Year*: Beginning Date: ___/___/___ End Date: ___/___/___ (month/day/year)

ERISA Plan Sponsor*: _____

(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: _____

Please provide your Non-ERISA Plan Month/Year: ___/___

If you contend ERISA is inapplicable to your group health plan, please give legal reason for exemption*:

- ☐ Federal Governmental Plan (e.g., the government of the United States or agency of the United States)
- ☐ Non-Federal Governmental Plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
- ☐ Church Plan (complete and attach a Medical Loss Ratio Assurance form)
- ☐ Other, please specify: _____

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations.

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. **Civil Union Partner Coverage:**

   A Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union Partners.

3. **Domestic Partner Coverage:** Yes ☐ No ☐

   If Yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Covered Employees with Domestic Partner Coverage.

   Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but are eligible for continuation coverage similar to that available to spouses under COBRA continuation.

4. **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 14. below.

   B. Retiree means those persons who retire on or after the effective date of this BPA: 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 4.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 not available.

5. **Eligibility Date:** All current and new employees must satisfy the required waiting period indicated below before coverage will become effective. The waiting period must not result in an effective date that exceeds ninety (90) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

   A. For Health, Dental PPO and Life Coverage (If purchasing life or short term disability coverage, the account must have a first (1st) of the month effective date):

☐ The date of employment.	☐ The _____ day of employment. **Note:** This may not exceed 90 days	☐ The first day of the month following the date of employment.
☐ The _____ day (select 1st or 15th) of the month following _____ month(s) of employment (option of 1 or 2 months)		
☐ The _____ day (select 1st or 15th) of the month following _____ days of employment (option of up to 60 days)		
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 (1st) day of the month following the date of employment.
☐ The first (1st) day of the month following _____ month(s) of employment (option of 1 or 2 months)
☐ The first (1st) day of the month following _____ day(s) of employment (option of up to 60 days)
Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.

   C. Waive the Waiting Period on initial group enrollment? ☐ Yes ☐ No

   D. Number of employees serving Waiting Period: _____

6. **Limiting Age for covered children is twenty-six (26) years.** Hereafter, covered children means a natural child, a stepchild, an eligible foster child, an adopted child (including a child involved in a suit for adoption,) a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years 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.

7. **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. In the case of a Special Enrollment event due to loss of coverage under Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

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 one hundred percent (100%). If the employer contributes one hundred percent (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**.**

8. **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. In the event of Total Disability at the time the group policy is terminated, an Extension of Benefits will be provided for a period of no more than twelve (12) months from the date of termination, to the extent required, and 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.

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

☐ First (1st) 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 (15th) day of each calendar month through the fourteenth (14th) 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 Dearborn National ® Life Insurance Company ("Dearborn National") Life coverage and having less than one hundred dollars ($100.00) monthly premium will be billed on a quarterly basis.

10. **Employer Contribution:**
    (a) **The following elections apply to both Grandfathered and Non-Grandfathered Groups: 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): _____

(b) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**
Employer contribution:

☐ One hundred percent (100%) of the Individual Coverage Premium and an amount equal to one hundred percent (100%) of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
☐ _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
☐ Other (please specify): _____.

(c) **The following applies to both Grandfathered and Non-Grandfathered Groups:**
HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

(d) **The following applies to Grandfathered Groups:**
The required minimum employer contribution is twenty five percent (25%). No policy will be issued or renewed unless at least seventy percent (70%) of eligible employees have enrolled for coverage. This applies to health and dental business separately. 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 two (2) eligible employees have enrolled for coverage.

(e) **The following applies to Non-Grandfathered Groups:**
HCSC reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of twenty five percent (25%), and at least a seventy percent (70%) participation of eligible employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the twenty five percent (25%) minimum employer contribution is met and at least seventy percent (70%) of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify HCSC of any change in participation and Employer contribution.

(f) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**
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 one hundred percent (100%) toward the cost of coverage, no policy will be issued or renewed unless at least one hundred percent (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 seventy five percent (75%) of eligible employees have enrolled for that coverage. Eligible employees are those who meet the definition of an Eligible Person, regardless of if an eligible employee waives coverage under HCSC medical due to having coverage elsewhere.

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. BlueEdge FSA (Vendor: ConnectYourCare) purchased: ☐ Yes ☐ No

13. 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, to the extent required by applicable law. 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.

14. Eligible Persons: If applicable, list the names of persons of the group who are eligible retirees as described in Item 4.A. above.

Name of Retiree	Name of Retiree

15. 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.

16. **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.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this 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. 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. No coverage will begin until receipt of the first premium by HCSC.

This BPA is subject to acceptance by HCSC and by Dearborn National as to coverage it underwrites. We certify that all the information and all attestations provided to HCSC and Dearborn National is correct and complete. Upon acceptance of this BPA, Dearborn National 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 Dearborn National except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC and Dearborn National.

With respect to coverage applied for under Dearborn National:
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 Dearborn National 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 sixty (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, (d) any provision of inaccurate information, (e) the SBC, and/or (f) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder. 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.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or "Health Insurer Fee"; and (2) the Transitional Reinsurance Program Contribution Fee or "Reinsurance Fee". Both the Reinsurance Fee and Health Insurer Fee go into effect in 2014.

Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish the fee at $5.25 per member, per month for 2014. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

Beginning with your bill for January 2014 coverage, your premium will be adjusted to reflect the effects of the Health Insurer Fees and Reinsurance Fees.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, HCSC reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or

guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require HCSC to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

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 BPA to eligible dependents may include Domestic Partners or Civil Union partners, but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, 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 as described in the certificate booklet.

Any reference in this BPA to the "Employee plus one dependent" rate structure means "Employee plus one spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one or more children."

_____

Producer Agency Representative	Signature of Employer/Authorized Purchaser
Signature of Producer Agency Representative	Title
Producer Agency Name	Date
Producer Address	Witness
Producer Phone No.	
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

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 (BPS)

(To Be Used for Non-Regulated Small Group Accounts)

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 / Non-Regulated Benefit Plan Selection:

- The OPX in all plans listed below will not exceed $6,350 for individual and $12,700 for family. The OPX is inclusive of all deductibles, copays and coinsurance costs incurred on in-network benefits.
- There are four health product categories which include multiple products (i.e., Blue Choice PPO) and their applicable benefit plans.
- A group may select up to six health plan options.
- The Outpatient Prescription Drug Card may vary between products.

	GROUP NUMBER:	

A. BlueChoice PPO SM						
Plan ID	Deductible (In/Out)	CoIns (In/Out)	OPX (In/Out)	PCP Copay	ER Copay	Rx Plan Network
☐ NBP42324	$250/$500	90% / 60%	$1,250/$2,500	$20	$150	$15/35%/50%
☐ NBP42326	$250/$500	90% / 60%	$1,250/$2,500	$20	$150	$10/$40/$60
☐ NBP43434	$250/$500	80% / 50%	$2,250/$4,500	$30	$150	$15/35%/50%
☐ NBP43436	$250/$500	80% / 50%	$2,250/$4,500	$30	$150	$10/$40/$60
☐ NBP72326	$500/$1,000	90% / 60%	$1,500/$3,000	$20	$150	$10/$40/$60
☐ NBP7232C	$500/$1,000	90% / 60%	$1,500/$3,000	$20	$150	$8/$35/$75/150
☐ NBP73436	$500/$1,000	80% / 50%	$2,500/$5,000	$30	$150	$10/$40/$60
☐ NBP7343C	$500/$1,000	80% / 50%	$2,500/$5,000	$30	$150	$8/$35/$75/150
☐ NBP82326	$1,000/$2,000	90% / 60%	$2,000/$4,000	$20	$150	$10/$40/$60
☐ NBP8232C	$1,000/$2,000	90% / 60%	$2,000/$4,000	$20	$150	$8/$35/$75/150
☐ NBP83436	$1,000/$2,000	80% / 50%	$3,000/$6,000	$30	$150	$10/$40/$60
☐ NBP8343C	$1,000/$2,000	80% / 50%	$3,000/$6,000	$30	$150	$8/$35/$75/150
☐ NBP92326	$1,500/$3,000	90% / 60%	$2,500/$5,000	$20	$150	$10/$40/$60
☐ NBP9232C	$1,500/$3,000	90% / 60%	$2,500/$5,000	$20	$150	$8/$35/$75/150
☐ NBP93436	$1,500/$3,000	80% / 50%	$3,500/$7,000	$30	$150	$10/$40/$60
☐ NBP9343C	$1,500/$3,000	80% / 50%	$3,500/$7,000	$30	$150	$8/$35/$75/150
☐ NBPC2324	$2,500/$5,000	90% / 60%	$3,500/$7,000	$20	$150	$15/35%/50%
☐ NBPC2326	$2,500/$5,000	90% / 60%	$3,500/$7,000	$20	$150	$10/$40/$60
☐ NBPC3434	$2,500/$5,000	80% / 50%	$4,500/$9,000	$30	$150	$15/35%/50%
☐ NBPC3436	$2,500/$5,000	80% / 50%	$4,500/$9,000	$30	$150	$10/$40/$60
BlueEdge SM Select HSA						
HSA Vendor: ☐ **Option A:** ACS/ BNY Mellon ☐ **Option B:** HSA Bank ☐ **Option C:** FlexHSA Plan ☐ Other / None						
☐ NBSM1A05	$1,250/$2,500	100% / 70%	$2,400/$4,800	100%	100%	80%
☐ NBSM3A05	$1,250/$2,500	80% / 50%	$2,400/$4,800	80%	80%	80%
☐ NBS91505	$1,500/$3,000	100% / 70%	$3,000/$6,000	100%	100%	80%
☐ NBS93505	$1,500/$3,000	80% / 50%	$3,000/$6,000	80%	80%	80%
☐ NBEC1807	$2,500/$5,000	100% / 70%	$2,500/$5,000	100%	100%	100%
☐ NBEC3805	$2,500/$5,000	80% / 50%	$5,000/$10,000	80%	80%	80%
☐ NBSC1807	$2,500/$5,000	100% / 70%	$2,500/$5,000	100%	100%	100%
☐ NBSC3805	$2,500/$5,000	80% / 50%	$5,000/$10,000	80%	80%	80%
Blue Choice PPO SM Value Choice						
☐ NBV43705	$250/$500	80% / 50%	$2,750/$5,500	80%	80%	80%
☐ NBV43805	$250/$500	80% / 50%	$5,250/$10,500	80%	80%	80%
☐ NBV73805	$500/$1,000	80% / 50%	$5,500/$11,000	80%	80%	80%
☐ NBV83705	$1,000/$2,000	80% / 50%	$3,500/$7,000	80%	80%	80%
☐ NBV83805	$1,000/$2,000	80% / 50%	$6,000/$12,000	80%	80%	80%

(excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

CPO-This Product is not available in all geographic areas (Network: Blue Choice/PPO/OUT)						
☐ NCP7242C	$500	90%	$2,500	$20	$150	$8/$35/$75/$150
	$1,000	80%	$5,000	$20	$150	$8/$35/$75/$150
	$2,000	60%	$14,000	60%	$150	$8/$35/$75/$150
Initial Employee Enrollment by CPO Network			CO_____# of Ees_____			
			CO_____# of Ees_____			
			CO_____# of Ees_____			
			Total # of Employees Enrolled:_____			
BlueEdge℠ HSA						
HSA Vendor: ☐ **Option A:** ACS/ BNY Mellon ☐ **Option B:** HSA Bank ☐ **Option C:** FlexHSA Plan ☐ Other / None						
☐ NPSM1A05	$1,250	100% / 80%	$2,400/$2,400	100%	100%	80%
☐ NPSM3A05	$1,250/$2,500	80% / 60%	$2,400/$4,800	80%	80%	80%
☐ NPS91605	$1,500	100% / 80%	$3,000/$3,000	100%	100%	80%
☐ NPS93505	$1,500/$3,000	80% / 60%	$3,000/$6,000	80%	80%	80%
☐ NPEC1807	$2,500/$5,000	100% / 80%	$2,500/$10,000	100%	100%	100%
☐ NPSC1807	$2,500	100% / 80%	$5,000/$5,000	100%	100%	100%
☐ NPEC3805	$2,500/$5,000	80% / 60%	$5,000/$10,000	80%	80%	80%
☐ NPSC3805	$2,500/$5,000	80% / 60%	$5,000/$10,000	80%	80%	80%
☐ NPEE3A05	$3,500/$7,000	80% / 60%	$5,800/$11,600	80%	80%	80%
☐ NPSE3A05	$3,500/$7,000	80% / 60%	$5,800/$11,600	80%	80%	80%
PPO Value Choice						
☐ NPV43705	$250/$500	80% / 60%	$2,750/$5,500	80%	$0	80%
☐ NPV44708	$250/$500	70% / 50%	$2,750/$5,500	70%	$0	70%
☐ NPV43805	$250/$500	80% / 60%	$5,250/$10,500	80%	$0	80%
☐ NPV44808	$250/$500	70% / 50%	$5,250/$10,500	70%	$0	70%
☐ NPV74708	$500/$1,000	70% / 50%	$3,000/$6,000	70%	$0	70%
☐ NPV73805	$500/$1,000	80% / 60%	$5,500/$11,000	80%	$0	80%
☐ NPV74808	$500/$1,000	70% / 50%	$5,500/$11,000	70%	$0	70%
☐ NPV83705	$1,000/$2,000	80% / 60%	$3,500/$7,000	80%	$0	80%
☐ NPV84708	$1,000/$2,000	70% / 50%	$3,500/$7,000	70%	$0	70%
☐ NPV83805	$1,000/$2,000	80% / 60%	$6,000/$12,000	80%	$0	80%
☐ NPV84808	$1,000/$2,000	70% / 50%	$6,000/$12,000	70%	$0	70%
☐ NPVC3705	$2,500/$5,000	80% / 60%	$5,000/$10,000	80%	$150	80%
CPO Value Choice -This Product is not available in all geographic areas (Network: CPO/PPO/OUT)						
☐ NCV82305	$1,000	90%	$2,000	90%	$150	80%
	$2,000	80%	$4,000	90%	$150	80%
	$4,000	50%	$8,000	90%	$150	80%
Initial Employee Enrollment by CPO Network			CO_____# of Ees_____			
			CO_____# of Ees_____			
			CO_____# of Ees_____			
			Total # of Employees Enrolled:_____			
BlueAdvantage® HMO						
☐ NHHB106	N/A	N/A	$1500	$20	$150	$10/$40/$60
☐ NHHB10C	N/A	N/A	$1500	$20	$150	$8/$35/$75/$150
☐ NHHB136	N/A	N/A	$1500	$20	$150	$10/$40/$60
☐ NHHB13C	N/A	N/A	$1500	$20	$150	$8/$35/$75/$150
☐ NHHB166	N/A	N/A	$1500	$30	$150	$10/$40/$60
☐ NHHB16C	N/A	N/A	$1500	$30	$150	$8/$35/$75/$150
☐ NHHB196	N/A	N/A	$1500	$30	$150	$10/$40/$60
☐ NHHB19C	N/A	N/A	$1500	$30	$150	$8/$35/$75/$150
BlueAdvantage HMO® Value Choice						
☐ NHVBV026	N/A	N/A	$3000	$40	$250	$10/$40/$60
☐ NHVBV02C	N/A	N/A	$3000	$40	$250	$8/$35/$75/$150
☐ NHVBV036	N/A	N/A	$3000	$50	$300	$10/$40/$60
☐ NHVBV03C	N/A	N/A	$3000	$50	$300	$8/$35/$75/$150
BluePrint® PPO						
☐ NPP11123	$0	100% / 80%	$0/$1200	$20	$150	$15/$30/$50
☐ NPP43323	$250/$500	80% / 60%	$1,250/$2,500	$20	$150	$15/$30/$50
☐ NPP71126	$500/$1,000	100% / 80%	$500/$1,000	$20	$150	$10/$40/$60
☐ NPP7112C	$500/$1,000	100% / 80%	$500/$1,000	$20	$150	$8/$35/$75/150
☐ NPP72226	$500/$1,000	90% / 70%	$1,000/$2,000	$20	$150	$10/$40/$60
☐ NPP7222C	$500/$1,000	90% / 70%	$1,000/$2,000	$20	$150	$8/$35/$75/150
☐ NPP72326	$500/$1,000	90% / 70%	$1,500/$3,000	$20	$150	$10/$40/$60
☐ NPP7232C	$500/$1,000	90% / 70%	$1,500/$3,000	$20	$150	$8/$35/$75/150
☐ NPP72426	$500/$1,000	90% / 70%	$2,500/$5,000	$20	$150	$10/$40/$60
☐ NPP7242C	$500/$1,000	90% / 70%	$2,500/$5,000	$20	$150	$8/$35/$75/150
☐ NPP73326	$500/$1,000	80% / 60%	$1,500/$3,000	$20	$150	$10/$40/$60
☐ NPP7332C	$500/$1,000	80% / 60%	$1,500/$3,000	$20	$150	$8/$35/$75/150
☐ NPP73336	$500/$1,000	80% / 60%	$1,500/$3,000	$30	$150	$10/$40/$60
☐ NPP7333C	$500/$1,000	80% / 60%	$1,500/$3,000	$30	$150	$8/$35/$75/150
☐ NPP73426	$500/$1,000	80% / 60%	$2,500/$5,000	$20	$150	$10/$40/$60

BluePrint PPO® (cont.)						
Plan ID	Deductible (In/Out)	CoIns (In/Out)	OPX (In/Out)	PCP Copay	ER Copay	Rx Plan Network
☐ NPP7342C	$500/$1,000	80% / 60%	$2,500/$5,000	$20	$150	$8/$35/$75/150
☐ NPP73436	$500/$1,000	80% / 60%	$2,500/$5,000	$30	$150	$10/$40/$60
☐ NPP7343C	$500/$1,000	80% / 60%	$2,500/$5,000	$30	$150	$8/$35/$75/150
☐ NPP73526	$500/$1,000	80% / 60%	$3,500/$7,000	$20	$150	$10/$40/$60
☐ NPP7352C	$500/$1,000	80% / 60%	$3,500/$7,000	$20	$150	$8/$35/$75/150
☐ NPP73536	$500/$1,000	80% / 60%	$3,500/$7,000	$30	$150	$10/$40/$60
☐ NPP7353C	$500/$1,000	80% / 60%	$3,500/$7,000	$30	$150	$8/$35/$75/150
☐ NPP82226	$1,000/$2,000	90% / 70%	$1,500/$3,000	$20	$150	$10/$40/$60
☐ NPP8222C	$1,000/$2,000	90% / 70%	$1,500/$3,000	$20	$150	$8/$35/$75/150
☐ NPP82326	$1,000/$2,000	90% / 70%	$2,000/$4,000	$20	$150	$10/$40/$60
☐ NPP8232C	$1,000/$2,000	90% / 70%	$2,000/$4,000	$20	$150	$8/$35/$75/150
☐ NPP82426	$1,000/$2,000	90% / 70%	$3,000/$6,000	$20	$150	$10/$40/$60
☐ NPP8242C	$1,000/$2,000	90% / 70%	$3,000/$6,000	$20	$150	$8/$35/$75/150
☐ NPP83326	$1,000/$2,000	80% / 60%	$2,000/$4,000	$20	$150	$10/$40/$60
☐ NPP8332C	$1,000/$2,000	80% / 60%	$2,000/$4,000	$20	$150	$8/$35/$75/150
☐ NPP83336	$1,000/$2,000	80% / 60%	$2,000/$4,000	$30	$150	$10/$40/$60
☐ NPP8333C	$1,000/$2,000	80% / 60%	$2,000/$4,000	$30	$150	$8/$35/$75/150
☐ NPP83426	$1,000/$2,000	80% / 60%	$3,000/$6,000	$20	$150	$10/$40/$60
☐ NPP8342C	$1,000/$2,000	80% / 60%	$3,000/$6,000	$20	$150	$8/$35/$75/150
☐ NPP83436	$1,000/$2,000	80% / 60%	$3,000/$6,000	$30	$150	$10/$40/$60
☐ NPP8343C	$1,000/$2,000	80% / 60%	$3,000/$6,000	$30	$150	$8/$35/$75/150
☐ NPP83526	$1,000/$2,000	80% / 60%	$4,000/$8,000	$20	$150	$10/$40/$60
☐ NPP8352C	$1,000/$2,000	80% / 60%	$4,000/$8,000	$20	$150	$8/$35/$75/150
☐ NPP83536	$1,000/$2,000	80% / 60%	$4,000/$8,000	$30	$150	$10/$40/$60
☐ NPP8353C	$1,000/$2,000	80% / 60%	$4,000/$8,000	$30	$150	$8/$35/$75/150
☐ NPP92326	$1,500/$3,000	90% / 70%	$2,500/$5,000	$20	$150	$10/$40/$60
☐ NPP9232C	$1,500/$3,000	90% / 70%	$2,500/$5,000	$20	$150	$8/$35/$75/150
☐ NPP92426	$1,500/$3,000	90% / 70%	$3,500/$7,000	$20	$150	$10/$40/$60
☐ NPP9242C	$1,500/$3,000	90% / 70%	$3,500/$7,000	$20	$150	$8/$35/$75/150
☐ NPP93326	$1,500/$3,000	80% / 60%	$2,500/$5,000	$20	$150	$10/$40/$60
☐ NPP9332C	$1,500/$3,000	80% / 60%	$2,500/$5,000	$20	$150	$8/$35/$75/150
☐ NPP93336	$1,500/$3,000	80% / 60%	$2,500/$5,000	$30	$150	$10/$40/$60
☐ NPP9333C	$1,500/$3,000	80% / 60%	$2,500/$5,000	$30	$150	$8/$35/$75/150
☐ NPP93426	$1,500/$3,000	80% / 60%	$3,500/$7,000	$20	$150	$10/$40/$60
☐ NPP9342C	$1,500/$3,000	80% / 60%	$3,500/$7,000	$20	$150	$8/$35/$75/150
☐ NPP93436	$1,500/$3,000	80% / 60%	$3,500/$7,000	$30	$150	$10/$40/$60
☐ NPP9343C	$1,500/$3,000	80% / 60%	$3,500/$7,000	$30	$150	$8/$35/$75/150
☐ NPP93526	$1,500/$3,000	80% / 60%	$4,500/$9,000	$20	$150	$10/$40/$60
☐ NPP9352C	$1,500/$3,000	80% / 60%	$4,500/$9,000	$20	$150	$8/$35/$75/150
☐ NPP93536	$1,500/$3,000	80% / 60%	$4,500/$9,000	$30	$150	$10/$40/$60
☐ NPP9353C	$1,500/$3,000	80% / 60%	$4,500/$9,000	$30	$150	$8/$35/$75/150
☐ NPPC2324	$2,500/$5,000	90% / 70%	$3,500/$7,000	$20	$150	$15/35%/50%
☐ NPPC2326	$2,500/$5,000	90% / 70%	$3,500/$7,000	$20	$150	$10/$40/$60
☐ NPPC3324	$2,500/$5,000	80% / 60%	$3,500/$7,000	$20	$150	$15/35%/50%
☐ NPPC3326	$2,500/$5,000	80% / 60%	$3,500/$7,000	$20	$150	$10/$40/$60
☐ NPPC3334	$2,500/$5,000	80% / 60%	$3,500/$7,000	$30	$150	$15/35%/50%
☐ NPPC3336	$2,500/$5,000	80% / 60%	$3,500/$7,000	$30	$150	$10/$40/$60
☐ NPPC2424	$2,500/$5,000	90% / 70%	$4,500/$9,000	$20	$150	$15/35%/50%
☐ NPPC2426	$2,500/$5,000	90% / 70%	$4,500/$9,000	$20	$150	$10/$40/$60
☐ NPPC3424	$2,500/$5,000	80% / 60%	$4,500/$9,000	$20	$150	$15/35%/50%
☐ NPPC3426	$2,500/$5,000	80% / 60%	$4,500/$9,000	$20	$150	$10/$40/$60
☐ NPPC3434	$2,500/$5,000	80% / 60%	$4,500/$9,000	$30	$150	$15/35%/50%
☐ NPPC3436	$2,500/$5,000	80% / 60%	$4,500/$9,000	$30	$150	$10/$40/$60
☐ NPPC3524	$2,500/$5,000	80% / 60%	$5,500/$11,000	$20	$150	$15/35%/50%
☐ NPPC3526	$2,500/$5,000	80% / 60%	$5,500/$11,000	$20	$150	$10/$40/$60
☐ NPPC3534	$2,500/$5,000	80% / 60%	$5,500/$11,000	$30	$150	$15/35%/50%
☐ NPPC3536	$2,500/$5,000	80% / 60%	$5,500/$11,000	$30	$150	$10/$40/$60
☐ NPPE3424	$3,500/$7,000	80% / 60%	$5,500/$11,000	$20	$150	$15/35%/50%
☐ NPPE3426	$3,500/$7,000	80% / 60%	$5,500/$11,000	$20	$150	$10/$40/$60

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	☐ DHUF04 - $1,500/$1,500 - U&C	☐ DLSF11 - $1,000/$1,000 – SMA	☐ DLUF19 - $1,000/N/C – U&C
☐ DHUF02 - $2,000/$1,500 -U&C	☐ DHUF05 - $1,500/$1,000 - U&C	☐ DLSF20 - $1,000/N/C - SMA	☐ DLUF23 - $1,250/N/C – U&C
☐ DHUF03 - $1,500/$1,500 - U&C	☐ DHUF07 - $1,000/$1,000 - U&C	☐ DLUF08 - $1,000/$1,000 –U&C	☐ DLUF24 - $1,250/$1,000 – U&C
☐ DHUF06 - $1,000/$1,000 - U&C	☐ DHSF10 - $1,000/$1,000 -SMA	☐ DLUF16 - $1,000/N/C – U&C	☐ DLUF25 - $1,500/$1,000 – U&C
☐ DHUF12 - $1,500/N/C - U&C	☐ DHUF13 - $1,500/N/C - U&C	☐ DLUF18 - $750/N/C – U&C	
☐ DHUF14 - $1,000/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		

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**
☐ DHUC02 - $1,000 / $1,000 - $1,000 / $1,000 - U&C	**$50 / $150 Deductible (ind/fam)**
☐ 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

Choose a Benefit:	Choose a Reduction Method:
	(Only available to groups with 10 or more enrolled lives)
☐ Flat Benefit of **$**_____ per Employee	☐ 35% of the original amount at age 65 / 50% of the original amount at age 70
☐ _____ 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	☐ 50% of the original amount at age 70
	(Only applicable to groups with 2 - 9 enrolled lives) ☐35% of the original amount at age 65/ 50% of the original amount at age 70 75% of the original amount at age 75/ 85% of the original amount at age 80

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 Fort Dearborn Life 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 14 days	Children – age 14 days to 6 months	Children – age 6 months to 26 years / student 26
Choose a Plan:	☐ Option 1	$10,000	$0	$100	$5,000
	☐ Option 2	$5,000	$0	$100	$5,000
	☐ Option 3	$5,000	$0	$100	$2,000

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 Benefit:

☐ Flat **$**_____ weekly (not o exceed $250)

☐ Salary Based (select one) - ☐ 50% ☐ 60% ☐ 66 2/3% of Basic Weekly Salary up to a maximum of **$**_____

Choose a Plan: Accident/Sickness/Duration

☐ 1 / 8 / 13 weeks	☐ 8 / 8 / 13 weeks	☐ 15 / 15 / 13 weeks	*☐ 31 / 31 / 13 weeks *Only available to groups with 10 or more lives enrolled
☐ 1 / 8 / 26 weeks	☐ 8 / 8 / 26 weeks	☐ 15 / 15 / 26 weeks	*☐ 31 / 31 / 26 weeks

D. Classes

Please complete this chart if Term Life or Short Term Disability benefits vary by class (3 Max 2 – 9 lives) (6 Max 10+ lives)

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
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

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 grey boxes.

Question #	Name (optional)	Employee, Spouse, Child	Age	Sex	Condition/ Diagnosis	Treatment Medications	Treatment Date	Date of Recovery
3A	Spouse	Employee, Spouse, Child	36	☒ M ☐ 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

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. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Fax or email completed form to 312-946-3688; smgrp1@bcbsil.com. A response is required for every question. For help in completing this form, refer to the *Instructions – Completing the Annual MSP Employer Acknowledgement* located at the end of this document.**

New BCBSIL clients please check the applicable box:	☐ The client was **not** in business the preceding calendar year ☐ The client was in business during the preceding year		
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. 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, 2013, base your current year answers on 2013. Or, if your upcoming renewal is effective January 1, 2014, base your current year answers on 2014. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee **current year** 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	☐ 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. Questions 5 and 7 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) Preceding Year	☐ Yes ☐ Yes	☐ No ☐ 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) Preceding Year	☐ Yes ☐ Yes	☐ No ☐ 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

SECTION E

The Affordable Care Act (ACA) established medical loss ratio (MLR) standards for health insurers. Generally, the MLR is the percentage of earned premiums that the insurer spends on health care services and quality improvement activities. If the insurer's MLR is less than ACA's MLR standard for a group market of a state, the insurer may provide ACA-MLR rebates in that market.

This section and the information you provide will assist us in completing our ACA-MLR report and distributing any ACA-MLR rebates that may be provided for an ACA-MLR reporting year. Please complete the information requested below.

1. **Employer Size. (Required for new groups only)** For the purpose of determining employer size:

   - An "employee" is defined as any individual employed by an employer. An employee includes full-time, part-time and seasonal employees.
   - Persons treated as a single employer under Internal Revenue Code Section 414(b), (c), (m) or (o) should be treated as a single employer.

   Check the box that applies to your company (employer):

   ☐ My company (employer) **existed** during the preceding calendar year.

   What is the average number of employees that your company (employer) employed on business days during the calendar year (January 1 – December 31) preceding the effective date of coverage? For example, if your effective date is July 1, 2014 then you would base your answer on calendar year 2013. _____

   ☐ My company (employer) **did not exist** at any time during the preceding calendar year.

   What is the average number of employees that your company (employer) is reasonably expected to employ on business days during the current calendar year? _____

2. **Church Plan.** In order to provide an ACA-MLR rebate to a policyholder with a group health plan that is a church plan (within the meaning of Internal Revenue Code Section 414(e)), ACA requires that the insurer obtain a written assurance from the policyholder that any rebate provided to the policyholder be used for the benefit of enrollees as described in MLR regulations (45 C.F.R. 158.242). If such a written assurance is not provided, an insurer may not provide an ACA-MLR rebate to the policyholder.

   Will the health insurance coverage be provided in connection with a group health plan that is a church plan?

   ☐ No, our group health plan is NOT a church plan.

   ☐ Yes, our group health plan is a church plan. If so, check one of the following:

   ☐ We **WILL** use any rebate provided to the policyholder to benefit enrollees as described above.

   ☐ We **WILL NOT** use any rebate provided to the policyholder to benefit enrollees as described above.

If you have any general questions about this request, please contact our Health Care Reform Call Center at 855-756-4438, 7:30 a.m. to 4 p.m. MST, Monday through Friday. Should the employer's or plan's status change, please contact your account representative.

I, the undersigned, a duly authorized representative of policyholder represent and warrant that the information contained in this Section D is true, correct and complete to the best of my knowledge and belief.

_____ _____

Employer or Authorized Purchaser Signature and Title Date

_____ _____

Producer Signature Date

INSTRUCTIONS – COMPLETING THE ANNUAL MSP EMPLOYER ACKNOWLEDGEMENT

Important Note

Under federal law, it is the employer's responsibility to annually inform its insurer or third-party administrator, such as Blue Cross and Blue Shield of Illinois (BCBSIL), of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered **primary to Medicare.**

Background
When an individual is covered by both Medicare and an employer's group health plan (GHP), Medicare secondary payer (MSP) rules specify that the employer's total size, not group health plan enrollment size, is a factor in determining whether Medicare benefits are primary or secondary. Employer size is a factor in MSP order of payment determinations when the covered individual is Medicare-entitled due to either age ("working aged") or disability.

Employer information — Who is the Employer?
For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. In some situations, it may not be clear which corporation or individual is the employer for MSP purposes. In these cases, employers must use Internal Revenue Service aggregation rules provided in the Internal Revenue Code [IRC 26 U.S.C. Sections 52(a), 52(b), 414(n) (2)]. In general, these rules specify that single employers include:

- all employees of all corporations that are members of the same controlled group of corporations, and
- all employees of trades or business (whether incorporated or not), e.g., employees of partnerships, LLCs, proprietorships that are under common control.

The Centers for Medicare & Medicaid Service's (CMS) *MSP Manual* provides additional guidance about aggregation for affiliated service groups and religious orders, as well as authoritative information about employer size and other MSP topics. The *MSP Manual* is available online at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Question 1 — Did you file a separate Federal Tax Return?
If you filed a federal tax return that did not include information about any other individual or entity, check "Yes." If you filed a federal tax return consolidated with another individual or entity, check "No." If you are not required to file a federal tax return, check "N/A."

Question 2 — Employer Size from Your Federal Tax Return Information
How many employees did all the entities listed on the tax return have on the payroll (whether full-time, part-time, seasonal or partners) during the prior calendar year? It is important that you enter the total number of employees for all entities (including parent, subsidiaries and affiliated entities) listed on the tax return, since this may determine whether or not Medicare will be the primary payer of claims. Subsidiaries of foreign companies must count the number of employees of the organization worldwide.

Question 3 — Are you part of a multi-employer group health plan?
Authoritative guidance for determining multiple employer group health plan participation can be found in the Code of Federal Regulations at 29 CFR § 2510.3-37.

Questions 4 and 5 — Working Aged Rule & Employer Size
Under the MSP "working aged" rule, Medicare is secondary to the employer's GHP coverage if the employer's size equals 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. *(Question 4 refers to this standard as "the threshold.")* Note: The year of your upcoming renewal is the 'current' year. 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. This also applies to multi-employer and multiple employer group health plans in which at least one employer employs 20 or more employees.

- *Counting individuals for the "20-or-more" employer size*
  - -- Employees counted in the 20-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees and partners who work or who are expected to report for work on a particular day.
  - -- Those not counted in the 20-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer's group health plan.

- *Employer size increases to 20 or more during the year*

  If the employer's size was below 20 during the preceding year, the employer's GHP coverage becomes primary as soon as the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The 20 calendar weeks do not have be consecutive. Then, the employer's GHP coverage is primary for the remainder of the year and during the following year.

  For example, the employer's size meets the 20-or-more employee threshold as of October 1, 2013. The employer's GHP coverage becomes primary for services provided from October 1, 2013 through December 31, 2014.

Please note: If you check "No" for the current year in EAF **Question 4** and your answer changes to "Yes" at any time, you must promptly notify BCBSIL by completing a new EAF and indicating the date the change occurred in the space provided in **Question 4**.

- *Employer size fails to meet the threshold of '20 or more employees during 20 or more weeks' during the year*

  If the employer's size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks for the preceding year, but during the current calendar year the employer size never meets that threshold, the employer's group health plan remains primary until the end of the current year.

  For example, during 2013 the employer's size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks. However, during 2014 the employer's size never meets this threshold. The employer's group health plan coverage remains primary through December 31, 2014.

- *Individuals affected by the working aged rule*

  The "working aged rule" applies to individuals who are Medicare-entitled due to age (age-65 or older) and

  -- Are covered under their employer's GHP and have "current employment status" and the employer meets the "20-or-more" employer size requirements (above), or

  -- Are covered under their spouse's (of any age) employer's GHP and the spouse has current employment status and the employer meets the "20-or-more" employer size requirements (above).

Questions 6 and 7 — Disability Rule & Employer Size
Under the MSP "disability" rule, Medicare benefits are secondary to an employer's large group health plan (LGHP) benefits when the employer size equals 100 or more full-time and/or part-time employees on 50 percent or more of the employer's business days during the previous calendar year. The business days do not have to be consecutive.

For multi-employer plans, Medicare is the secondary payer for all individuals enrolled in the plan as long as at least one of the employers employs 100 or more employees. The 100-employee threshold is not based on the aggregate number of employees of all employers. If you are a multi-employer, please keep this in mind when completing questions 6 and 7.

- *Counting individuals for the "100-or-more" employer size*

  -- Employees counted in the 100-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees and partners who work or are expected to report for work on a particular day.

  -- Those not counted in the 100-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer's group health plan.

- *Employer size increases to 100 or more during the year*

  If the employer's size meets the 100-or-more employee threshold at any time during the current year, the employer's group health plan coverage will be primary to Medicare during the following year.

  For example, an employer met the 100-or-more employee threshold on May 1, 2013. The employer's GHP coverage will be primary for services provided from January 1, 2014, through December 31, 2014.

  Please note: If you answer "No" to **Question 6**, you must promptly notify BCBSIL by completing a new EAF if your answer changes to "Yes" at the beginning of the next calendar year.

- *Employer size doesn't meet the threshold of '100 or more employees during 50 percent of business days' during the year*

  If the employer's size does not meet the 100-or-more employee threshold during the year, the employer's GHP coverage is secondary to Medicare during the following year.

  For example, during 2013 the employer's size never meets the threshold of 100 or more full-time and/or part-time employees on 50 percent or more of the employer's business days. The employer's group health plan coverage will be secondary to Medicare for services provided from January 1, 2014, through December 31, 2014.

- *Individuals affected by the disability rule*.

  The "disability rule" applies to individuals who are Medicare-entitled due a Social Security Administration determination of disability and

  -- Are covered under their employer's GHP and have "current employment status" and the employer meets the "100-or-more" employer size requirements (above), or

  -- Are covered under their spouse's (of any age) employer's GHP and the spouse has current employment status and the employer meets the "100-or-more" employer size requirements (above).

BlueCross BlueShield 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 THIS NOTICE CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain and safeguard the privacy of your Protected Health Information (PHI). PHI is information in any format (electronic, paper, or verbal), about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition or the payment or provision of 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 September 23, 2013 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 material change in our privacy practices, we will change this notice and make the new notice available to you as required under the law.

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.

Use and Disclosure of Your Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. The 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 federal law 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

[1] A "business associate" is a person or entity who performs or assists Blue Cross Blue Shield of Illinois with an activity or provides services to Blue Cross Blue Shield of Illinois involving the use or disclosure of PHI.

the privacy of your PHI. We may disclose your PHI to another entity that is subject to federal law 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 healthcare fraud and abuse.

Joint Operations: We may use and disclose your PHI connected with a group health plan maintained by your plan sponsor with one or more other group health plans maintained by the same plan sponsor, in order to carry out the payment and health care operations of such an organized health care arrangement.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person 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 written authorization, we cannot use or disclose your PHI for any reason including marketing and sale of your PHI except those described in this notice or as permitted by law. 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, such as refill reminders, 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 nominal promotional gifts.

Fundraising: We may contact you or disclose a limited amount of your PHI to a Business Associate or to an institutionally related foundation for the purpose of raising funds for our own benefit. If we do so, you will have the right to opt out of receiving such fundraising communications. Your decision will have no impact on the payment for services.

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;
- as authorized by and to the extent necessary to comply with state worker's compensation laws; and
- in connection with certain research activities.

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; and
- to an organ procurement organization.

Use and Disclosure of Certain Types of Medical Information. For certain types of PHI, state laws may provide greater protection for your privacy. For example, use and/or disclosure of PHI including, but not limited to HIV/AIDS, genetic information, mental health information, alcohol and substance abuse information may need to be specifically authorized by you or be required by law.

In such instances, we will follow the provisions of that state law. We are prohibited from using or disclosing your genetic information for underwriting purposes unless your policy is a long-term care policy.

Your Rights

You may contact us using the information at the end of this notice to obtain the forms described here, receive explanations on how to submit a request, or for 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 also have the right to receive an electronic copy of your PHI if it is maintained in an electronic designated record set. 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 for the 6-year period, but not before 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 the 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.

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.

Breach Notification: You have the right to be notified when it has been determined that a breach of your unsecured PHI has occurred.

Right to Receive a Copy of the Notice: You may request a copy of this notice at any time by contacting the Privacy Office or by using our website, **www.bcbsil.com**. If you receive this notice on our web site or by electronic mail (e-mail), you are also entitled to request and receive 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 website: 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: Divisional Vice President, Privacy Office
Blue Cross and Blue Shield of Illinois
P.O. Box 804836
Chicago, IL 60680-4110

You may also contact us using the toll-free number located on the back of your member identification card or the Privacy Office toll-free number 1-877-361-7594

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	Spouse/Domestic Partner: ☐ Yes ☐ No	Child(ren): ☐ Yes ☐ No
Plan Choice:	Plan Choice:	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? Due Date: _____/_____/_____ (MM/DD/YYYY) If yes, are multiples (twins, triplets, *etc.*) expected? Are there any known complications, or is a cesarean section planned?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
3 Within the past 12 months, have you or your spouse/domestic partner used any tobacco products? Employee: Spouse/Domestic Partner:	☐ Yes ☐ Yes	☐ No ☐ 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 <u>any</u> 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.