BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

(All items are applicable to Grandfathered and Non-Grandfathered Insured Small 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. (Blue Star℠): _____ Customer No. (if different, for existing business only): _____

Employer's Legal 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 to be covered: _____

Affiliated Companies to be covered: _____

(Affiliated Companies must be required or permitted to be aggregated per IRS guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m), or (o), or under applicable law.)

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: _____ / _____ / _____

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*: _____

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
- ☐ 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

Employer has decided that Eligible Person means:

A Full-Time Employee of the Employer. Full-time Employee means an Employee of the Employer who is regularly scheduled to work a minimum of 30 hours per week.

The term "Employee" shall have the meaning set forth under ERISA and applicable law. Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("BCBSIL") reserves the right to audit Employer's initial and ongoing eligibility determinations.

2. Civil Union Partner Coverage:

A Civil Union partner, as defined in the Policy, 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 Employer elects "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 Insureds 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 BCBSIL. Yes ☐ No ☐ If yes, complete item 14 below.

B. Retiree means those persons who retire on or after the effective date of this Benefit Program Application:

Yes ☐ No ☐

If yes: Such retirees must be at least _____ years of age on the date of retirement with _____ years of continuous full-time employment with the Employer. Note: Minimum years of age is fifty-five (55); minimum years of continuous full-time employment is ten (10).

For existing groups, former employees who retired after the date the Employer initially purchased coverage from BCBSIL 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 substantive eligibility criteria and required waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

If a person is added to the Policy and it is later determined that the Policyholder reported a Coverage Date earlier than what would apply to the Employee or Dependent, based on the Waiting Period and eligibility conditions the Policyholder provided to BCBSIL, BCBSIL reserves the right to retroactively adjust the Coverage Date for such person.

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 91 calendar 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: _____

E. Substantive eligibility criteria.

Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, Employer is required to submit a new BPA to reflect that new information.

Check all that apply:

☐ An Orientation Period that:

1) Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
2) If used in conjunction with a waiting period, the waiting period begins on the first day after the orientation period.

☐ A Cumulative hours of service requirement that does not exceed 1200 hours

☐ An hours-of-service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:

1) Starts between the employee's date of hire and the first day of the following month;
2) Does not exceed 12 months; and
3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

☐ Other substantive eligibility criteria not described above; please describe: _____

6. Limiting Age for covered children:

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 (30) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so; provided, however, if a newborn is added as a dependent, such addition must be within thirty one (31) days. 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. 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 life and/or disability coverage and having less than one hundred dollars ($100.00) monthly combined life and disability 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
☐ One hundred percent (100%) of the Employee Coverage Premium will be applied toward the Family Coverage Premium.	☐ Other (specify): _____

(b) 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 BCBSIL due to other creditable coverage. In no event, however, shall the policy be renewed unless at least one (1) eligible employee has enrolled for coverage.

(c) The following applies to Non-Grandfathered Groups:
BCBSIL 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 25%, and at least a 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 25% minimum employer contribution is met and at least 70% participation of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify BCBSIL of any change in participation and Employer contribution.

(d) The following applies to both Grandfathered and Non-Grandfathered Groups:
BCBSIL 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.

(e) 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 BCBSIL medical due to having coverage elsewhere.

11. Reimbursement: It is understood and agreed that in the event BCBSIL makes a recovery on a third-party liability claim, BCBSIL will retain twenty five percent (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

12. Third Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services): BCBSIL engages with third party recovery vendors and law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.

13. Wellbeing Management (included): The undersigned representative authorizes the provision of alternative benefits rendered to Covered Persons in accordance with the provisions of the Policy.

14. BlueEdge FSA℠ (Vendor: Select Vendor) purchased: ☐ Yes ☐ No

15. 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

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.

This BPA is subject to acceptance by BCBSIL as to coverage it underwrites. We certify that all the information and all attestations provided to BCBSIL is correct and complete. Upon acceptance of this BPA, BCBSIL 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 BCBSIL 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 producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if BCBSIL accepts this BPA and issues a Policy to the Employer, BCBSIL may pay the Employer's 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 producer by BCBSIL in connection with the issuance of a Policy, the Employer should contact its 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 BCBSIL except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by BCBSIL.

With respect to Life and/or Short-Term Disability coverage applied for:

We agree to comply with and participate in all provisions of the Group Policy providing the coverage applied for. We understand that BCBSIL intends to rely on this information in determining whether the enrolling employees may become insured.

ADDITIONAL PROVISIONS:

A. Grandfathered Health Plans: Policyholder shall provide BCBSIL 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 BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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 BCBSIL with any requested grandfathered health plan information, BCBSIL 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 BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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. Religious Employer Exemption and Eligible Organization Accommodation: Although federal regulations describe a limited exemption for certain group health plans from the Affordable Care Act requirement to cover contraceptive services under guidelines supported by the Health Resources and Services Administration (HRSA), your insurance Policy must comply with applicable state requirements regarding contraceptive coverage. Accordingly, your Policy currently includes coverage for contraceptives consistent with the state and federal coverage requirements and applicable exemptions. Some contraceptives may be covered without additional cost to the Covered Employee.

D. Policyholder shall indemnify and hold harmless BCBSIL 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 BCBSIL 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-D (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.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSIL 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 BCBSIL 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-D (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."

The following one (1) paragraph applies to Non-Grandfathered Groups:

BCBSIL reserves the right to restrict new business enrollment in health insurance coverage to open or special enrollment periods 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.

_____

Producer Agency Representative

Signature of Employer/Authorized Purchaser

Signature of Producer Agency Representative

Title

Producer Agency Name

Date

Producer Address

Witness

Producer Phone No.

Producer Number

Contracted Producer Tax ID No.

$ _____ Amount Submitted (for initial enrollment only)

Other Information: _____

BCBSIL Sales Representative District / Cluster

	UNDERWRITING AUTHORIZATION
INTERNAL USE ONLY	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 is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked either 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.

HCSC pays indemnification or advances expenses to its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

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

BENEFIT PLAN SELECTION (BPS) - ACA SMALL GROUP

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

Section 1- Account Information:

A. Employer Name:				B. SIC Code	
C. Account #:		D. Effective Date:		E. Anniversary Date:	

- Only Individual cost shares are listed out for each plan.
- A group may select up to six health plan options.
- A group may select one dental plan or two dental plans if 10 or more are enrolled.
- For additional product detail, please utilize Summary of Benefits and Coverage (SBC) and Product Plan Grids

Billing Method Selection

Please select one of the following billing methods.
(For Existing Accounts: If no selection is made, your plans will default to their current billing method.)

☐ Composite Billing
☐ Age Billing

Section 2a- Renewing Groups Only: (*New Business update to Section 4)

Current Plan: Please list current plan(s) below	Retaining Plan:		Replacing Plan: Please list replacement plan in space below.
1.	☐ **Yes**	☐ **No**	
2.	☐ **Yes**	☐ **No**	
3.	☐ **Yes**	☐ **No**	
4.	☐ **Yes**	☐ **No**	
5.	☐ **Yes**	☐ **No**	
6.	☐ **Yes**	☐ **No**	
7.	☐ **Yes**	☐ **No**	
8.	☐ **Yes**	☐ **No**	

Section 2b- Renewing Groups Only: (*New Business update to Section 4)

Adding Plan (Medical and/or Dental)**:**
Please list new plan(s) below

1.
2.
3.
4.
5.
6.
7.
8.

Section 3- HSA

HSA Vendor: *** If HSA is selected, a vendor will need to be selected.** (If no HSA selection is made, HSA Vendor will default to Other / None.)	☐ **Option A:** BenefitWallet® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option B:** HSA Bank® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option C:** FlexHSA® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option D:** Other HSA Vendor / None (Select this option if using an HSA Vendor other than above or are not offering an employer sponsored HSA vendor.)

Section 4- New Business

Group Number:

Please select plan designs (Up to a maximum of 6 plans)

A. Blue Choice Preferred							
2021 Plan ID	**Deductible (In/Out)**	**Office Visit/ Specialist**	**Coins (In/Out)**	**OPX (In/Out)**	**ER Copay*1**	**Urgent Care Copay**	**Non-Preferred Pharmacy****
Platinum							
☐P5E2BCE	$250/$500	$30/$60	80%/50%	$1250/Unlimited	$400	$60	$10/$20/$55/$95/$150/$250
☐P5E1BCE	$500/$1000	$20/$40	90%/60%	$1500/Unlimited	$400	$75	$10/$20/$70/$120/$150/$250
Gold							
☐G532BCE	$1500/$3000	$40/$60	80%/50%	$5500/Unlimited	$400	$75	$15/$25/$70/$120/$250/$350
☐G531BCE	$2500/$5000	$20/$60	80%/50%	$5000/Unlimited	$400	$75	$10/$20/$55/$95/$150/$250
☐G530BCE	$3750/$7500	$35/$55	100%/100%	$3750/$7500	$400	$75	$10/$20/$55/$95/$150/$250
Silver							
☐S532BCE*2	$3250/$6500	$50/$70	60%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S501BCE	$4500/$9000	80%/80%	80%/50%	$7900/Unlimited	NA	NA	$10/$20/$70/$120/$150/$250
☐S531BCE	$4700/$9400	$45/$65	80%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S535BCE	$7550/$15100	$30/$50	100%/100%	$7550/$15100	$500	$75	$10/$20/$70/$120/$150/$250

Blue Choice Preferred HSA Plans								
2021 Plan ID	**HSA Contr.**	**Deduct (In/Out)**	**Office Visit/ Specialist**	**Coins (In/Out)**	**OPX (In/Out)**	**ER Copay**	**Urgent Care Copay**	**Non-Preferred Pharmacy****
Gold								
☐G533BCE*3	$180-$280	$2800/$5600	90%/90%	90%/60%	$3500/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
☐G535BCE	$475-$625	$2800/$5600	80%/80%	80%/50%	$5000/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
Silver								
☐S534BCE	$0-$115	$4800/$9600	100%/100%	100%/100%	$4800/$9600	NA	NA	100%
☐S5J1BCE	$150-$400	$6000/$12000	100%/100%	100%/100%	$6000/$12000	NA	NA	100%
Bronze								
☐B536BCE	$0	$6650/$13300	80%/80%	80%/50%	$6900/Unlimited	$250	NA	80%/80%/70%/60%/60%/50%
☐B535BCE	$0	$6900/$13800	100%/100%	100%/100%	$6900/$13800	$250	NA	100%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
Virtual Visits are available from a participating provider for certain non-emergency services
**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy, then a lower copay may apply.
*1 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.
*2 $500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.
*3 Select HDHP-HSA preventive prescription drugs will be covered with no member cost share

B. Blue Precision HMO

2021 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay*1	Urgent Care Copay	Pharmacy
Platinum							
☐P506PSN*2	$0	$10/$45	100%	$1500	$300	$45	$0/$10/$50/$100/$150/$250
☐P5J1PSN*3	$0	$20/$30	100%	$2000	$300	$30	$0/$10/$50/$100/$150/$250
☐P5E1PSN*4	$1000	$25/$50	80%	$3000	$400	$50	$0/$10/$50/$100/$150/$250
Gold							
☐G5J2PSN*5	$0	$50/$70	100%	$5000	$500	$70	$10/$20/$50/$100/$250/$350
☐G532PSN*4	$2500	$55/$75	70%	$8550	$1000	$75	$10/$20/$50/$100/$250/$350
Silver							
☐S531PSN*6	$3000	$40/$60	80%	$8550	$1000	$60	$10/$20/$50/$100/$250/$350
☐S530PSN*7	$7000	$55/$75	70%	$7900	$700	$75	$0/$10/$50/$100/$150/$250

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.

*1 - ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.

*2 - $250 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). $45 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

*3 - $250 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). $60 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

*4 - No deductible/coinsurance on capitated services: Imaging, Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

*5 - $400 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). $100 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

*6 - $750 copay on Imaging (CT/PET/MRI) $250 copay on other capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient surgery.

*7 - $400 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply. $70 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery

C. Blue Options
Tiered Network (Blue Options – BCO / PPO – PPO / OON – Out of Network)

2021 Plan ID	Deductible (BCO/ PPO/ OON	PCP Copay (BCO/ PPO)	SPC Copay (BCO/ PPO)	Coins (BCO /PPO/ OON)	OPX (BCO/ PPO/ OON)	ER Copay*1	Urgent Care Copay	Non-Preferred Pharmacy**
Gold								
☐G506OPT	$750/ $1750/ $3500	$40/$60	$60/$100	80%/ 70%/ 50%	$5000/ $7000/ Unlimited	$600	$75	$20/$30/$70/$120/$250/$350
☐G508OPT	$1500/ $3250/ $6500	$30/$55	$45/$95	90%/ 70%/ 50%	$4100/ $6100/ Unlimited	$600	$75	$20/$30/$70/$120/$250/$350
☐G507OPT	$2000/ $3500/ $7000	$35/$60	$50/$100	90%/ 70% 50%	$3500/ $6500/ Unlimited	$400	$75	$10/$20/$55/$95/$150/$250
Silver								
☐S506OPT	$4850/ $5850/ $11700	$40/60	$60/$100	80%/ 60%/ 50%	$6850/ $8550/ Unlimited	$600	$75	$20/$30/$70/$120/$250/350

Blue Options HSA Plans

2020 Plan ID	HSA Cont.	Deductible (BCO/ PPO/ OON	PCP Copay (BCO/ PPO)	SPC Copay (BCO/ PPO	Coins (BCO /PPO/ OON)	OPX (BCO/ PPO/ OON)	ER Copay	Urgent Care Copay	Non-Preferred Pharmacy**
Silver									
☐S507OPT	$0-$50	$4000/ $4750/ $9500	100%/80%	100%/80%	100%/ 80%/ 50%	$4000/ $6900/ Unlimited	NA	NA	100%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
Virtual Visits are available from a participating provider for certain non-emergency services.
**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy then a lower copay may apply
*1 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.

D. PPO (Participating Provider Options)

2021 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay*1	Urgent Care Copay	Non-Preferred Pharmacy**
Platinum							
☐P503PPO	$250/$500	$30/$60	80%/50%	$1250/Unlimited	$400	$60	$10/$20/$55/$95/$150/$250
☐P5E1PPO	$500/$1000	$20/$40	90%/60%	$1500/Unlimited	$400	$75	$10/$20/$70/$120/$150/$250
Gold							
☐G534PPO	$1000/$2000	$50/$70	80%/50%	$6750/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐G532PPO	$1500/$3000	$40/$60	80%/50%	$5500/Unlimited	$400	$75	$15/$25/$70/$120/$250/$350
☐G536PPO	$2000/$4000	$45/$65	90%/60%	$5000/Unlimited	$500	$75	$15/$25/$70/$120/$250/$350
☐G531PPO	$2500/$5000	$20/$60	80%/50%	$5000/Unlimited	$400	$75	$10/$20/$55/$95/$150/$250
☐G537PPO	$2600/$5200	100%/100%	100%/100%	$2600/$5200	NA	NA	100%
☐G530PPO	$3750/$7500	$35/$55	100%/100%	$3750/$7500	$400	$75	$10/$20/$55/$95/$150/$250
Silver							
☐S532PPO*2	$3250/$6500	$50/$70	60%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S501PPO	$4500/$9000	80%/80%	80%/50%	$7900/Unlimited	NA	NA	$10/$20/$70/$120/$150/$250
☐S531PPO	$4700/$9400	$45/$65	80%/50%	$8550/Unlimited	$500	$75	$10/$20/$70/$120/$150/$250
☐S535PPO	$7550/$15100	$30/$50	100%/100%	$7550/$15100	$500	$75	$10/$20/$70/$120/$150/$250

PPO HSA Plans

2021 Plan ID	HSA Contr.	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay*1	Urgent Care Copay	Non-Preferred Pharmacy**
Gold								
☐G533PPO*3	$180-$280	$2800/ $5600	90%/90%	90%/ 60%	$3500/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
☐G535PPO	$475-$625	$2800/ $5600	80%/80%	80%/ 50%	$5000/Unlimited	NA	NA	80%/80%/70%/60%/60%/50%
Sliver								
☐S534PPO	$0-$115	$4800/ $9600	100%/100%	100%/ 100%	$4800/$9600	NA	NA	100%
☐S5J1PPO	$150-$400	$6000/ $12000	100%/100%	100%/ 100%	$6000/$12000	NA	NA	100%
Bronze								
☐B536PPO	$0	$6650/ $13300	100%/100%	80%/ 50%	$6900/Unlimited	$250	NA	80%/80%/70%/60%/60%/50%
☐B535PPO	$0	$6900/ $13800	100%/100%	100%/ 100%	$6900/$13800	$250	NA	100%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
Virtual Visits are available from a participating provider for certain non-emergency services.
**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy, then a lower copay may apply
*1 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.
*2 $500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.
*3 Select HDHP-HSA preventive prescription drugs will be covered with no member cost share

Section 5- Ancillary Product Selection:

A. Dental Products

Blue Care Dental

Plan Pairings (Groups 10+ enrolled)		Participation Requirements	
Contributory Group	**Voluntary**	**Contributory Group**	**Voluntary**
Any one contributory high option can be paired with any one contributory low option. Exceptions: **DILHM57** can be paired with **DILHR33**. **DILHM59** can be paired with **DILHR43**.	Any one voluntary high option can be paired with any voluntary low option. Voluntary plans and contributory plans may not be offered together. **DILHM42** can be paired with any contributory plan. **DILHM46** can be paired with any voluntary plan.	>70% Participation >50% Employer contribution	>25% Participation Employers are not required to contribute to Voluntary Dental plans

IL Plan ID	Plan Type	Deductible (In/Out) (3x Family Limit)	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance		Ortho Life Maximum	Allocation
					In-Network (Class I/ II/ III/ IV)	Out-of-Network (Class I/ II/ III/ IV)		
Contributory Group*2								
☐ DILHR31	Passive	$25/$25	$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DILHR32	Passive	$50/$50	$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DILHR33	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DILHR34	Active	$50/$75	$1500/$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	$1000	High
☐ DILLR36	Passive	$50/$50	$1000	90th R&C	100%/80/50%/NA	100%/80%/50%/NA	NA	Low
☐ DILLR37	Passive	$75/$75	$1000	90th R&C	90%/70%/50%/NA	90%/70%/50%/NA	NA	Low
☐ DILHM38	Passive	$50/$50	$1000	MAC	100%/80/50%/50%	100%/80%/50%/50%	$1000	High
☐ DILHM40	Active	$50/$50	$1500/$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	NA	High
☐ DILLM41	Active	$75/$75	$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	NA	Low
☐ DILHM42	Passive	$25/$75	$750	MAC	100%/80*3/NA/NA	100%/80%*3/NA/NA	NA	High
☐ DILHR50	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High
☐ DILLM51	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
☐ DILHM57	Passive	$50/$50	$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	$1500	High
☐ DILLR58 *4	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
Voluntary*2								
☐ DILHR43 *1	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DILHM44 *1	Active	$50/$50	NA	MAC	100%/80%/50%/NA	80%/60%/40%/NA	$1500/$1000	High
☐ DILHM46	Passive	$25/$75	NA	MAC	100%/80%*3/NA/NA	100%/80%*3/NA/NA	$750	High
☐ DILHR52 *1	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	High
☐ DILHR53 *1	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High
☐ DILLR54 *1	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low
☐ DILLM55*1	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
☐ DILLM56 *1	Active	$50/$100	NA	MAC	100%/80%/50%/NA	100%/50%/50%/NA	$750	Low
☐ DILHM59 *1	Passive	$50/$50	$1500	MAC	100%/100%/60%/50%	100%/50%/60%/50%	$1500	High
☐ DILLR60*1*4	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low

Coinsurance Type - I: Exams/Cleanings/X-Rays (both High & Low Coverage).
Coinsurance Type - II: Fillings/Non-Surgical Perio/Non-Surgical Extractions (both High & Low), Endo/Perio/Oral Surgery (High).
Coinsurance Type - III: Inlays/Onlays/Crowns/Dentures (both High & Low), Endo/Perio/Oral Surgery (Low).
Coinsurance Type - IV: Ortho (both High & Low Coverage).
R&C: Reasonable & Customary - Out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSIL to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses
MAC: Out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSIL to accept he maximum Allowable amount paid to Contracting Dentist as payment in full for Eligible Dental Expenses.
Passive: Plans have the same benefits In and Out of Network
Active: Plans have a richer In Network Benefit
*1 Waiting Period 12 month applicable for Surgical Perio/Major Restorative/Prosthodontics/Misc Rest & Prosth Services.
*2 Waived Deductible applies to all Class I services and plans include 3x Family Deductible Limit.
*3 Only Basic Restorative Services are covered.
*4 Preventive/Diagnostic services do not count toward annual max.

B. Life Products

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

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

☐ **Yes** ☐ **No**	Complete Item 4 below if Term Life benefits vary by class
Choose a Benefit:	**Choose a Reduction Method:**
☐ Flat Benefit of **$**_____ per Employee	(Only available to groups with 10 or more enrolled lives) ☐ 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. 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 coverage would otherwise be effective, the effective date of coverage will be the date of return to Active Work. If an employee does not return to Active Work, he/she will not be covered

2. 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 / students 26
Choose a Plan:	☐ Option1	$10,000	$100	$100	$5,000
	☐ Option 2	$5,000	$100	$100	$5,000
	☐ Option 3	$5,000	$100	$100	$2,000

3. Short Term Disability (STD)

☐ **Yes** ☐ **No**	Complete Item 4 below if Short Term Disability benefits vary by class (3 Max 2 – 9 lives) (6 Max 10+ lives) 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 to 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

4. Classes

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

Class Description	**Term Life / AD&D**	**Short Term Disability**

Section 6 - Additional Provisions:

Use this section to indicate any other instruction or important information.

Section 7 - Signature

Signatures	
Employer / Authorized Purchaser: Title:	Date
Underwriter: Title:	Date

BlueCross BlueShield of Illinois

Employer Group Information
(Small Group)

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

SECTION A

Employer Name	Employer Tax ID #
Account # (renewing groups only)	

SECTION B

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 312-233-4244; data_collection@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		
Current BCBSIL clients please check the correct box:	☐ Submitting this form as an update ☐ Submitting this form as an error correction		
Do you have any affiliates or subsidiaries? If "yes", list name of each: _____ _____		☐ Yes	☐ No
Some of the following responses are based on the current calendar year, while others are based on the preceding year. Unless making an update or error correction, please use the year of your upcoming renewal as 'current year' when answering the following questions. For example, if your upcoming renewal is effective July 1, 2016, base your current year answers on 2016. Or, if your upcoming renewal is effective January 1, 2017, base your current year answers on 2017. 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 2021	
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 EGI, checking this box and entering the date the threshold was met in the space above.	Current Year (see above)	☐ Yes	☐ No
	Preceding Year	☐ Yes	☐ No
5. If you are currently or were during the preceding year part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ➔ If you answered 'Yes' to #3, then check 'Yes' or 'No' for both the current and preceding calendar years ➔ If you answered 'No' to #3, then check 'Yes' or 'No' for the preceding calendar year only	Current Year (see above)	☐ Yes	☐ No
	Preceding Year	☐ Yes	☐ No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No

SECTION C

COBRA IS FEDERALLY MANDATED AND APPLIES TO EMPLOYERS WITH 20 OR MORE FULL-TIME OR PART-TIME EMPLOYEES. EMPLOYER PENALTIES FOR NONCOMPLIANCE MAY APPLY.

a. Did your company employ 20 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year? ☐ Yes ☐ No

b. Are you subject to the Consolidated Omnibus Reconciliation Act (COBRA)? ☐ Yes ☐ No
If "yes", list names and number of individuals (qualified beneficiaries) currently on COBRA continuation*:

Name of COBRA Continuee	Coverage Type (Individual or Family)	Projected COBRA Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental

It is your responsibility to annually inform BCBSIL of whether COBRA is applicable to you based upon your full and part-time employee count in the prior calendar year. Failure to advise BCBSIL of a change of status could subject you to governmental sanctions.

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

Workers' Compensation.

Are any employees currently receiving Workers' Compensation benefits? ☐ Yes ☐ No
If "yes", list names and date last worked:

Employee Name	Date Last Worked
	_____/_____/_____
	_____/_____/_____
	_____/_____/_____

State Continuation Privilege on Termination of Coverage.

All employees, members, or dependents are entitled to state continuation of group coverage under certain conditions. List names and number of continued persons currently on state continuation coverage:

Name of State Continuee	Coverage Type (Individual or Family)	Projected State Continuation Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental

State Continuation of Group Coverage for Certain Dependents.

A dependent of an insured is entitled to state dependent continuation under certain conditions. List names and number of continued dependents on state (3 years) dependent continuation coverage:

Name of State Dependent Continuee	Coverage Type (Individual or Family)	Projected State Continuation Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental
	☐ Individual ☐ Family	_____/_____/_____	☐ Health ☐ Dental

SECTION D

FOR MLR AND MARKET SEGMENT PURPOSES ONLY

The Affordable Care Act (ACA) established Medical Loss Ratio (MLR) standards for health insurers, which requires that Blue Cross and Blue Shield of Illinois report annually whether coverage is in the individual, small group or large group market of a state. Therefore, your assistance is needed to classify your coverage for each MLR reporting year. 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. This section and the information you provide will also assist us in determining your market segment, products and rates.

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.
- If your company is wholly owned by an individual (or an individual and his/her spouse), do not include the individual and his/her spouse in your response below.
- Partners in a partnership should not be counted as employees.

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, 2016 then you would base your answer on calendar year 2015. _____

☐ 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? _____

Is your company a partnership? ☐ Yes ☐ No

2. Church Plan.

In order to provide an ACA-MLR rebate to a policyholder the MLR regulations require that an insurer obtain a written assurance from the policyholder that any rebate will be used for the benefit of enrollees as described in MLR regulations (45 C.F.R. 158.242). If the written assurance is not provided, the MLR regulations require that an insurer distribute any rebate directly to certain subscribers of the plan (rather than to the policyholder).

Does the policyholder listed sponsor a church plan* in connection with the policyholder's BCBSIL coverage?

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

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

- ☐ The policyholder **WILL** use any rebate for the benefit of enrollees as described above.
- ☐ The policyholder **WILL NOT** use any rebate for the benefit of enrollees as described above. I understand that, if this box is checked, BCBSIL may distribute any rebate directly to certain subscribers of the plan.

** "Church plan" has the meaning given the term in Internal Revenue Code Section 414(e).*

If you have any general questions about this request, please contact our Medical Loss Ratio Hotline at 855-804-3635, 8 a.m. to 6 p.m. CT, 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

GROUP #	SECTION #	SOC. SEC. #	ACCOUNT #	CATEGORY

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ **NEW ENROLLEE** ☐ **ADD DEPENDENT** ☐ **OPEN ENROLLMENT** ☐ **OTHER CHANGES**

ARE YOU APPLYING AS A RESULT OF A SPECIAL ENROLLMENT EVENT? ☐ NO ☐ YES, EVENT DATE:

EVENT: ☐ **NEW HIRE** ☐ **MARRIAGE*** ☐ **BIRTH**

☐ ADOPTION, PLACEMENT FOR ADOPTION OR SUIT FOR ADOPTION (PROVIDE LEGAL DOCUMENTS)

☐ COURT ORDER (PROVIDE COURT ORDER OR DECREE)

☐ LOSS OF OTHER COVERAGE

☐ OTHER (EXPLAIN):

EFFECTIVE DATE OF BENEFITS: ☐ **COMPLETION OF OTHER ELIGIBILITY REQUIREMENTS**

☐ **CANCEL ENROLLEE** ☐ **CANCEL DEPENDENT**

CANCEL COVERAGE: ☐ HEALTH ☐ DENTAL

☐ TERM LIFE ☐ DEPENDENT LIFE

☐ SHORT-TERM DISABILITY ☐ LONG-TERM DISABILITY

LIST NAMES OF THOSE CANCELING IN SECTION 4 BELOW

EVENT: ☐ DIVORCE** ☐ DEATH

☐ TERMINATED EMPLOYMENT ☐ OTHER

INDICATE EVENT DATE:

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

LAST NAME	FIRST NAME	MI (OPT)	SUFFIX	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #

MAILING ADDRESS - STREET - APT #	CITY	STATE	ZIP CODE

EMAIL ADDRESS	☐ MALE ☐ FEMALE	HOME/CELL PHONE #

NAME OF EMPLOYER	JOB TITLE	BUSINESS PHONE #	EMPLOYMENT DATE (MM/DD/YYYY)	ON AVERAGE, HOW MANY HOURS A WEEK DO YOU WORK? (REQUIRED)

ELIGIBILITY STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED EMPLOYEE - DATE OF RETIREMENT: ☐ COBRA COVERAGE START DATE PROJECTED END DATE

☐ ILLINOIS CONTINUATION (INSURED PLANS ONLY) START DATE PROJECTED END DATE

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

SMALL GROUP PLANS (1-50 EMPLOYEES)

AFFORDABLE CARE ACT PLANS

☐ PPO ☐ OTHER

☐ BLUE CHOICE PREFERRED PPO℠

☐ BLUE OPTIONS℠

☐ BLUE PRECISION HMO℠

☐ BLUECARE DIRECT℠

PLAN # (REQUIRED)

GRANDFATHERED AND GRANDMOTHERED/TRANSITIONAL PLANS

☐ BLUE ADVANTAGE ENTREPRENEUR PPO℠ ☐ BLUE ADVANTAGE HMO℠

☐ BLUE CHOICE SELECT PPO℠ ☐ BLUE ADVANTAGE HMO VALUE CHOICE℠

☐ BLUE EDGE SELECT HSA℠ ☐ COMMUNITY PARTICIPATION ORGANIZATION (CPO)

☐ BLUE EDGE HSA℠ ☐ CPO VALUE CHOICE

☐ BLUE EDGE HCA DIRECT℠ ☐ OTHER

☐ PPO VALUE CHOICE PLAN # (REQUIRED)

MID-MARKET AND LARGE GROUP STANDARD PLANS (51+ EMPLOYEES)

MID-MARKET & LARGE GROUP STANDARD PLANS 51+

☐ PPO ☐ BLUE CHOICE OPTIONS℠ ☐ BLUE EDGE SELECT HSA℠

☐ BLUE ADVANTAGE HMO℠ ☐ BLUE CHOICE SELECT PPO℠ ☐ PLAN # (REQUIRED)

☐ BLUE ADVANTAGE HMO VALUE CHOICE℠ ☐ BLUE EDGE HSA℠ ☐ OTHER

PREVIOUS BCBSIL OR HMO MEMBERSHIP

GROUP #:

SECTION #:

IDENTIFICATION #:

LARGE GROUP CUSTOM PLANS (151+ EMPLOYEES)

☐ TRADITIONAL ☐ BLUE ADVANTAGE HMO℠ W/HCA ☐ BLUE EDGE SELECT HSA℠

☐ PPO ☐ BLUE CHOICE OPTIONS℠ ☐ BLUE EDGE SELECT HCA DIRECT℠

☐ CPO ☐ BLUE CHOICE SELECT PPO℠ ☐ VISION

☐ CPO VALUE CHOICE ☐ BLUE EDGE HCA℠ ☐ HEARING

☐ HMO ILLINOIS® ☐ BLUE EDGE HSA℠ ☐ MEDICARE SUPPLEMENT

☐ HMO ILLINOIS® W/HCA ☐ BLUE EDGE HCA DIRECT℠ ☐ OTHER

☐ BLUE ADVANTAGE HMO℠ ☐ BLUE EDGE SELECT HCA℠

DENTAL

☐ BLUECARE DENTAL PPO℠ ☐ BLUECARE DENTAL HMO℠

☐ DENTAL GROUP #
(IF DIFFERENT THAN MEDICAL GROUP POLICY #)

☐ EMPLOYEE AND PARTY TO A CIVIL UNION OR DOMESTIC PARTNER ☐ MALE ☐ FEMALE

☐ INDIVIDUAL/EMPLOYEE ☐ EMPLOYEE/SPOUSE

☐ EMPLOYEE/CHILDREN ☐ FAMILY

PRIMARY LANGUAGE

GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) AND DISABILITY INSURANCE

☐ I AM NOT APPLYING FOR GROUP TERM LIFE, AD&D OR DISABILITY INSURANCE COVERAGE

EMPLOYEE OCCUPATION/JOB TITLE: WAGE RATE $ PER ☐ HOUR ☐ WEEK ☐ MONTH ☐ YEAR

GROUP BASIC TERM LIFE AND AD&D	☐ I DO NOT APPLY	☐ I DO APPLY	AMOUNT $
GROUP DEPENDENTS' LIFE	☐ I DO NOT APPLY	☐ I DO APPLY	
GROUP SUPPLEMENTAL LIFE	☐ I DO NOT APPLY	☐ I DO APPLY	EMPLOYEE ELECTION: $ SPOUSE ELECTION: $ CHILD ELECTION: $
SHORT-TERM DISABILITY	☐ I DO NOT APPLY	☐ I DO APPLY	LONG-TERM DISABILITY ☐ I DO NOT APPLY ☐ I DO APPLY

	FIRST NAME	INITIAL	LAST NAME	RELATIONSHIP	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #
PRIMARY BENEFICIARY						
CONTINGENT BENEFICIARY						

LAST NAME	SOC. SEC. #	GROUP #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY
(IF YOU ARE ADDING AN ELIGIBLE MILITARY PERSONNEL DEPENDENT WHO IS OVER THE AGE LIMIT OF YOUR EMPLOYER'S PLAN, COMPLETION OF A DEFENSE DEPARTMENT FORM 214 (DD 214) IS REQUIRED IN ADDITION TO THIS APPLICATION.)

EMPLOYEE/ ENROLLEE'S NAME		PCP NAME PCP #	IPA NAME IPA #
WPHCP NAME WPHCP #	NEW PATIENT? ☐ YES ☐ NO	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #

DEPENDENT'S NAME ☐ HUSBAND ☐ WIFE ☐ DOMESTIC PARTNER ☐ PARTY TO A CIVIL UNION	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO
IPA NAME IPA #	WPHCP NAME WPHCP #	HMO OB/GYN NAME (OPTIONAL) HMO OB/GYN #	
DEPENDENT'S SOCIAL SECURITY #	BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE	

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO
BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE	IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO
DEPENDENT'S SOCIAL SECURITY #	IPA NAME IPA #	HMO OB/GYN NAME (OPTIONAL) HMO OB/GYN #	

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO
BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE	IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO
DEPENDENT'S SOCIAL SECURITY #	IPA NAME IPA #	HMO OB/GYN NAME (OPTIONAL) HMO OB/GYN #	

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO
BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE	IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO
DEPENDENT'S SOCIAL SECURITY #	IPA NAME IPA #	HMO OB/GYN NAME (OPTIONAL) HMO OB/GYN #	

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

NAME OF DISABLED DEPENDENT	NATURE OF DISABILITY
NAME OF DISABLED DEPENDENT	NATURE OF DISABILITY

IF DISABLED CHILD IS OVER THE DEPENDENT AGE LIMIT OF YOUR EMPLOYER'S PLAN, PLEASE ATTACH A COMPLETED DISABLED DEPENDENT CERTIFICATION AND THE DISABLED DEPENDENT PHYSICIAN CERTIFICATION DOCUMENT.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

COMPLETE THIS SECTION ONLY IF YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER HEALTH AND/OR DENTAL COVERAGE THAT WILL NOT BE CANCELED WHEN THE COVERAGE UNDER THIS APPLICATION BECOMES EFFECTIVE. **LIST NAMES OF EACH INDIVIDUAL COVERED:**

GROUP COVERAGE ☐ YES ☐ NO	INDIVIDUAL COVERAGE ☐ YES ☐ NO	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	EFFECTIVE DATE (MM/DD/YYYY)	TYPE OF POLICY ☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY

NAME OF POLICYHOLDER	BIRTH DATE (MM/DD/YYYY)	☐ MALE ☐ FEMALE	RELATIONSHIP TO APPLICANT ☐ SELF ☐ SPOUSE ☐ DEPENDENT

EMPLOYER'S NAME	EMPLOYMENT DATE (MM/DD/YYYY)	HEALTH GROUP #	HEALTH ID #	DENTAL GROUP #	DENTAL ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

NAME OF PERSON COVERED:	MEDICARE A (HOSPITAL) EFFECTIVE DATE: MEDICARE B (MEDICAL) EFFECTIVE DATE: MEDICARE D (DRUG) EFFECTIVE DATE: MEDICARE D (DRUG) CARRIER:	END DATE: END DATE: END DATE:	MEDICARE HIC # (FROM MEDICARE CARD)
PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE			
NAME OF PERSON COVERED:	MEDICARE A (HOSPITAL) EFFECTIVE DATE: MEDICARE B (MEDICAL) EFFECTIVE DATE: MEDICARE D (DRUG) EFFECTIVE DATE: MEDICARE D (DRUG) CARRIER:	END DATE: END DATE: END DATE:	MEDICARE HIC # (FROM MEDICARE CARD)
PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE			

LAST NAME	SOC. SEC. #	GROUP #

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

THIS IS TO CERTIFY THE AVAILABLE COVERAGE HAS BEEN EXPLAINED TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE COVERAGE OFFERED TO ME AND MY ELIGIBLE DEPENDENTS AND HAVE VOLUNTARILY ELECTED TO DECLINE THE COVERAGE AS INDICATED BELOW. IF I DESIRE TO APPLY FOR COVERAGE AT A LATER DATE, I UNDERSTAND THERE MAY BE A DELAY IN THE EFFECTIVE DATE OF THE COVERAGE.

NAME ☐ EMPLOYEE	REASON FOR DECLINING HEALTH: ☐ OTHER GROUP HEALTH COVERAGE – CARRIER: ☐ MEDICARE ☐ MEDICAID ☐ OTHER INDIVIDUAL HEALTH COVERAGE – CARRIER: ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME ☐ EMPLOYEE	REASON FOR DECLINING DENTAL: ☐ OTHER GROUP DENTAL COVERAGE ☐ MEDICAID ☐ INDIVIDUAL DENTAL COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY DENTAL INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME ☐ SPOUSE	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME ☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME ☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Illinois or Dearborn Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

APPLICANT'S SIGNATURE DATE

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Fax: 855-661-6960
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html