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 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. (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: _____

(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. HCSC reserve 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 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 Benefit Program Application: Yes ☐ No ☐ If yes: Such retirees must be at least _____ years of age on the date of retirement with _____ years of continuous full-time employment with the Employer. Note: Minimum years of age is fifty-five (55); minimum years of continuous full-time employment is ten (10).

For existing groups, former employees who retired after the date the Employer initially purchased coverage from HCSC and prior to the initial effective date of the retiree coverage specified in item 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, based on the Waiting Period and eligibility conditions the Policyholder provided to the Plan, the Plan 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 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
☐ 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 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.

(c) **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 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 HCSC of any change in participation and Employer contribution.

(d) **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.

(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 HCSC medical due to having coverage elsewhere.

11. **Reimbursement:** It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC 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. **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.

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

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 (not applicable to BlueLincs):** The Employer consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet or SBC provided by BCBSIL to the Employer for delivery to each employee. The Employer further agrees that it is solely responsible for providing each Employee access, to the most current version of any E-file Certificate Booklet, SBC, amendment, or other revised form provided by BCBSIL, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and holds BCBSIL harmless from any misuse of the E-file provided by BCBSIL. By providing your consent, you agree to electronic delivery of your insurance documents. You can go back to paper delivery at any time with no penalty. Your consent will be valid until it is withdrawn up to and including through policy renewals. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports most versions of Internet Explorer, Chrome and Firefox.

☐ Accept – Employer consents to receive electronic versions of Certificate Booklets and SBC's for covered Employees. Employer may withdraw this consent at any time and request receipt of hard copy versions by contacting their BCBSIL Account Executive.

☐ Decline – Employer does not consent to receive electronic versions of Certificate Booklets and SBC's for covered Employees or the Contract and desires BCBSIL to print and distribute hard copy versions.

Authorized Company Official's Initials: _____ Date: _____

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:

_____

Producer Agency Representative

Signature of Producer Agency Representative

Producer Agency Name

Producer Address

Producer Phone No.

Producer Number

Contracted Producer Tax ID No.

HCSC Sales Representative District / Cluster

Signature of Employer/Authorized Purchaser

Title

Date

Witness

$ _____ Amount Submitted (for initial enrollment only)

Other Information: _____

	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 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 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 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