



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. BlueSTAR 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.
- 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Section 3- HSA

HSA Vendor: * If an HSA plan is selected, a vendor will need to be selected. (If no HSA selection is made, HSA Vendor will default to Other / None.)	<input type="checkbox"/> Option A: BenefitWallet
	<input type="checkbox"/> Option B: HSA Bank
	<input type="checkbox"/> Option C: FlexHSA Plan
	<input type="checkbox"/> Option D: Other / None

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Section 4- New Business

Group Number:

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

A. PPO (Participating Provider Options)									
2019 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay ¹	Ped Dental (In/Out) ²	Non-Preferred Pharmacy**	Preferred Pharmacy	
Platinum									
<input type="checkbox"/> P503PPO	\$250/\$500	\$25/\$45	80%/50%	\$1250/Unlimited	\$300	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
Gold									
<input type="checkbox"/> G530PPO	\$3250/\$6500	\$15/\$35	100%/100%	\$3250/Unlimited	\$400	100%/100%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
<input type="checkbox"/> G531PPO	\$2500/\$3000	\$20/\$60	80%/50%	\$5000/Unlimited	\$400	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
<input type="checkbox"/> G532PPO	\$1500/\$2500	\$35/\$60	80%/50%	\$4500/Unlimited	\$400	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> G534PPO	\$750/\$1500	\$40/\$60	80%/50%	\$5500/Unlimited	\$400	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> G536PPO	\$1800/\$3600	\$20/\$40	90%/60%	\$4000/Unlimited	\$400	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
<input type="checkbox"/> G537PPO	\$2000/\$4000	NA/NA	100%/100%	\$2000/\$4000	NA	100%/100%	100%	100%	
Silver									
<input type="checkbox"/> S501PPO	\$4500/\$9000	NA/NA	80%/50%	\$7900/Unlimited	NA	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> S531PPO	\$4350/\$8700	\$30/\$50	80%/50%	\$7350/Unlimited	\$500	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> S532PPO	\$2800/\$5600	\$50/\$70	60%/50%	\$7500/Unlimited	\$500	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> S535PPO	\$7350/\$14700	\$20/\$40	100%/100%	\$7350/Unlimited	\$500	100%/100%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
PPO HSA Plans									
2019 Plan ID	HSA Contr.	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay ¹	Ped Dental (In/Out) ²	Non-Preferred Pharmacy**	Preferred Pharmacy
Gold									
<input type="checkbox"/> G533PPO ³	\$350-\$575	\$2800/\$5400	NA/NA	90%/60%	\$3500/Unlimited	NA	70%/50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> G535PPO ³	\$650-\$900	\$2800/\$5400	NA/NA	80%/50%	\$5000/Unlimited	NA	70%/50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
Silver									
<input type="checkbox"/> S534PPO	\$0-\$275	\$4800/\$9600	NA/NA	100%/100%	\$4800/\$9600	NA	100%/100%	100%	100%
Bronze									
<input type="checkbox"/> B535PPO	\$0	\$6550/\$12800	NA/NA	100%/100%	\$6550/\$12800	NA	100%/100%	100%	100%
<input type="checkbox"/> B536PPO	\$0	\$6150/\$12300	NA/NA	80%/50%	\$6500/Unlimited	NA	70%/50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
 **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 Ped Dental Out coinsurance is subjected to INN ded/coins.
 *3 These HSA plans require a mandatory employer contribution.

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B. Blue Choice Preferred									
2019 Plan ID	Deductible (In/Out)	Office Visit/Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay ^{*1}	Ped Dental (In/Out) ^{*2}	Non-Preferred Pharmacy**	Preferred Pharmacy	
Gold									
<input type="checkbox"/> G530BCE	\$3250/\$6500	\$15/\$35	100%/100%	\$3250/Unlimited	\$400	100%/100%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
<input type="checkbox"/> G531BCE	\$2500/\$3000	\$20/\$60	80%/50%	\$5000/Unlimited	\$400	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
<input type="checkbox"/> G532BCE	\$1500/\$2500	\$35/\$60	80%/50%	\$4500/Unlimited	\$400	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
Silver									
<input type="checkbox"/> S501BCE	\$4500/\$9000	NA/NA	80%/50%	\$7900/Unlimited	NA	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> S531BCE	\$4350/\$8700	\$30/\$50	80%/50%	\$7350/Unlimited	\$500	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> S532BCE	\$2800/\$5600	\$50/\$70	60%/50%	\$7500/Unlimited	\$500	70%/50%	\$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250	
<input type="checkbox"/> S535BCE	\$7350/\$14700	\$20/\$40	100%/100%	\$7350/Unlimited	\$500	100%/100%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
Blue Choice Preferred HSA Plans									
2019 Plan ID	HSA Contr.	Deduct (In/Out)	Office Visit/Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay	Ped Dental (In/Out) ^{*2}	Non-Preferred Pharmacy**	Preferred Pharmacy
Gold									
<input type="checkbox"/> G533BCE ^{*3}	\$350-\$575	\$2800/\$5400	NA/NA	90%/60%	\$3500/Unlimited	NA	70%/50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<input type="checkbox"/> G535BCE ^{*3}	\$650-\$900	\$2800/\$5400	NA/NA	80%/50%	\$5000/Unlimited	NA	70%/50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
Silver									
<input type="checkbox"/> S534BCE	\$0-\$275	\$4800/\$9600	NA/NA	100%/100%	\$4800/\$9600	NA	100%/100%	100%	100%
Bronze									
<input type="checkbox"/> B535BCE	\$0	\$6550/\$12800	NA/NA	100%/100%	\$6550/\$12800	NA	100%/100%	100%	100%
<input type="checkbox"/> B536BCE	\$0	\$6150/\$12300	NA/NA	80%/50%	\$6500/Unlimited	NA	70%/50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
<p>All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.</p> <p>**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy then a lower copay may apply</p> <p>*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.</p> <p>*2 Ped Dental Out coinsurance is subjected to INN ded/coins.</p> <p>*3 These HSA plans require a mandatory employer contribution.</p>									

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C. Blue Options

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

2019 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}	Ped Dental (In/Out) ^{*2}	Non-Preferred Pharmacy**	Preferred Pharmacy	
Gold										
<input type="checkbox"/> G506OPT	\$700/ \$1500/ \$3000	\$20/ \$50	\$40/ \$100	80%/ 70%/ 50%	\$4200/ \$6000/ Unlimited	\$400	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
<input type="checkbox"/> G507OPT	\$2000/ \$3500/ \$5000	\$35/ \$60	\$50/ \$100	90%/ 70%/ 50%	\$3500/ \$6500/ Unlimited	\$400	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
<input type="checkbox"/> G508OPT	\$1500/ \$3000 \$6000	\$15/ \$40	\$30/ \$80	90%/ 70% 50%	\$3000/ \$5000/ Unlimited	\$400	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
Silver										
<input type="checkbox"/> S506OPT	\$4000/ \$5000/ \$10000	\$25/ \$50	\$50/ \$90	80%/ 60%/ 50%	\$6000/ \$6850/ Unlimited	\$500	70%/50%	\$10/\$20/\$55/\$95/\$150/\$250	\$0/\$10/\$35/\$75/\$150/\$250	
Blue Options HSA Plans										
2019 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	Ped Dental (In/Out) ^{*2}	Non-Preferred Pharmacy**	Preferred Pharmacy
Silver										
<input type="checkbox"/> S507OPT	\$0- \$200	\$4000/ \$4750/ \$9500	NA/ NA	NA/ NA	100%/ 80%/ 50%	\$4000/ \$6550/ Unlimited	NA	70%/ 50%	100%	100%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
 **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 Ped Dental Out coinsurance is subjected to INN ded/coins.

D. Blue Precision HMO

2019 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay ^{*1}	Ped Dental (In)	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum								
<input type="checkbox"/> P506PSN	\$0	\$10/\$45	100%	\$1500	\$300	100%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
Gold								
<input type="checkbox"/> G532PSN	\$2500	\$35/\$55	70%	\$6750	\$400	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
<input type="checkbox"/> G533PSN	\$4000	\$30/\$50	80%	\$5500	\$400	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
Silver								
<input type="checkbox"/> S530PSN	\$6250	\$30/\$50	70%	\$7150	\$500	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
<input type="checkbox"/> S531PSN	\$3000	\$35/\$55	80%	\$7900	\$1000	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250

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

E. BlueCare Direct HMO

2019 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay ^{*1}	Ped Dental (In)	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum								
<input type="checkbox"/> P506BCH	\$0	\$10/\$45	100%	\$1500	\$300	100%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
Gold								
<input type="checkbox"/> G532BCH	\$2500	\$35/\$55	70%	\$6750	\$400	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
<input type="checkbox"/> G533BCH	\$4000	\$30/\$50	80%	\$5500	\$400	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
Silver								
<input type="checkbox"/> S530BCH	\$6250	\$30/\$50	70%	\$7150	\$500	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250
<input type="checkbox"/> S532BCH	\$3000	\$35/\$55	80%	\$7900	\$1000	70%	\$0/\$10/\$50/\$100/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250

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

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Section 5- Ancillary Product Selection:

A. Dental Products

1. Blue Care Dental								
Plan Pairings (Groups 10+ enrolled)					Participation Requirements			
Contributory Group		Voluntary			Contributory Group		Voluntary	
High Option DILHR01 DILHR02 DILHR03	Low Option DILLR06 DILLR07 DILLM21	High Option DILHR13 DILHR22	Low Option DILLM25 DILLM26	>70% Participation >50% Employer contribution		>25% Participation Employers are not required to contribute to Voluntary Dental plans		
Any one contributory group high option can be paired with any one contributory group low option; DILHM12 can be freely paired with any contributory group.		Any one voluntary high option can be paired with any one voluntary low option. DILHM16 can be freely paired with any voluntary option						
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 Group²								
<input type="checkbox"/> DILHR01	Passive	\$25/\$25	\$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High
<input type="checkbox"/> DILHR02	Passive	\$50/\$50	\$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$2000	High
<input type="checkbox"/> DILHR03	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500	High
<input type="checkbox"/> DILHR04	Active	\$50/\$75	\$1500/\$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	\$1000	High
<input type="checkbox"/> DILHM08	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	High
<input type="checkbox"/> DILHM10	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A	High
<input type="checkbox"/> DILHM12	Passive	\$25/\$75	\$750	MAC	100%/80 ³ /NA/NA	100%/80 ³ /NA/NA	N/A	High
<input type="checkbox"/> DILHR20	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	High
<input type="checkbox"/> DILLR06	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	Low
<input type="checkbox"/> DILLR07	Passive	\$75/\$75	\$1000	90th R&C	90%/70%/50%/NA	90%/70%/50%/NA	N/A	Low
<input type="checkbox"/> DILLM11	Active	\$75/\$75	\$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	N/A	Low
<input type="checkbox"/> DILLM21	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low
Voluntary²								
<input type="checkbox"/> DILHR13 ¹	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1500	High
<input type="checkbox"/> DILHM14 ¹	Active	\$50/\$50	\$1500/\$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A	High
<input type="checkbox"/> DILHM16	Passive	\$25/\$75	\$750	MAC	100%/80 ³ /NA/NA	100%/80 ³ /NA/NA	N/A	High
<input type="checkbox"/> DILHR22 ¹	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	High
<input type="checkbox"/> DILHR23 ¹	Passive	\$50/\$50	\$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	High
<input type="checkbox"/> DILLR24 ¹	Passive	\$50/\$50	\$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	Low
<input type="checkbox"/> DILLM25 ¹	Passive	\$50/\$50	\$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	\$1000	Low
<input type="checkbox"/> DILLM26 ¹	Active	\$50/\$100	\$750	MAC	100%/80%/50%/NA	100%/50%/50%/NA	N/A	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, MAC: Maximum Allowable Charge *1 Waiting Period 12 month applicable for Surgical Perio/Major Restorative/Prosthetics/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								

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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)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Complete Item 4 below if Term Life benefits vary by class
Choose a Benefit:	
<input type="checkbox"/> Flat Benefit of \$_____ per Employee	Choose a Reduction Method: (Only available to groups with 10 or more enrolled lives) <input type="checkbox"/> 35% of the original amount at age 65 / 50% of the original amount at age 70
<input type="checkbox"/> _____ 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	<input type="checkbox"/> 50% of the original amount at age 70
	(Only applicable to groups with 2 - 9 enrolled lives) <input type="checkbox"/> 35% of the original amount at age 65, 50% of the original amount at age 70, 75% of the original amount at age 75, 85% of the original amount at age 80.

Excess Amounts of Life Insurance:

Evidence of Insurability will be required for individual life insurance amounts in excess of \$_____. Such excess insurance amounts shall become effective on the date Evidence of Insurability is approved by Dearborn National® Life Insurance Company. Waiver of Premium, in the event of total disability, will terminate at age 65 or when no longer disabled, whichever is earlier. Being Actively at Work is a requirement for coverage. If an employee is not Actively at Work on the day 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

<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Option 1	\$10,000	\$100	\$100
	<input type="checkbox"/> Option 2	\$5,000	\$100	\$100
	<input type="checkbox"/> Option 3	\$5,000	\$100	\$100

3. Short Term Disability (STD)

<input type="checkbox"/> Yes <input type="checkbox"/> 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:	
<input type="checkbox"/> Flat \$_____ weekly (not to exceed \$250)	
<input type="checkbox"/> Salary Based (select one) -	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% of Basic Weekly Salary up to a maximum of \$_____
Choose a Plan: Accident/Sickness/Duration	
<input type="checkbox"/> 1 / 8 / 13 weeks <input type="checkbox"/> 8 / 8 / 13 weeks <input type="checkbox"/> 15 / 15 / 13 weeks	* <input type="checkbox"/> 31 / 31 / 13 weeks *Only available to groups with 10 or more lives enrolled
<input type="checkbox"/> 1 / 8 / 26 weeks <input type="checkbox"/> 8 / 8 / 26 weeks <input type="checkbox"/> 15 / 15 / 26 weeks	* <input type="checkbox"/> 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

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Section 6 - Additional Provisions:

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

Section 7 - Signature

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

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