BlueCross BlueShield of Illinois

Employer *Name:* _____

EIN*#:* _____

Initial Premium Payment Information

Note: Do not cancel any current coverage you may have until your Application is approved and your new plan is effective. To use ACH for payment of initial premium payment please select ONE-TIME BANK DRAFT below, complete the balance of the form in its entirety, and submit to your Broker or Producer for processing.

Payment will be drafted upon approval and acceptance of a final rate offer. You must complete the Authorization Agreement below.
☐ ONE-TIME BANK DRAFT

AUTHORIZATION AGREEMENT

Required for Bank/Financial Institution Draft Payments Only

I request and authorize BCBSIL and/or its designee to obtain a one-time ACH payment by initiating the charge from my checking or savings account and I request and authorize the Financial Institution named below to accept and honor the same from my account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. If an ACH Transaction from my account is rejected for Non-Sufficient Funds (NSF), I understand I will have to make a payment arrangement via a different payment channel. I also understand that both the Financial Institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein.

Please complete the following – print or type information

I authorize BCBSIL to deduct the one-time ACH payment from our checking or savings account.

Please ensure adequate funds are available at the time of Application. BCBSIL is not responsible for fees incurred due to insufficient funds.

PLEASE CHECK ONE ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT	**BANK NAME**	
BANK ROUTING NUMBER	**EMPLOYER'S ACCOUNT NUMBER**	
PREMIUM AMOUNT: $		
AUTHORIZED SIGNATURE	**DATE**	**NAME AND TITLE OF AUTHORIZED PURCHASER**
NOTE: An E-mail notification will be sent to the below listed address when funds are withdrawn.		
E-MAIL ADDRESS		
☐ **I HAVE READ AND ACCEPT THE ABOVE AGREEMENT**		

NOTES: A minimum of 90 percent of the estimated initial/first month's health and/or dental premium is required in order to use ACH. An explanation should be provided by a company official authorized to represent the business on company letterhead or the electronic equivalent if the address or name on the bank account associated with this binder payment differs from the company's primary address and name. This includes if the address is that of another location in the same state, if the address is out of state, if the address is a post office box, etc. The ACH option for the initial premium through the BCBSIL is a one-time payment. All payments for future monthly bills must be arranged using the EFT option in Blue Access for Employers or paid via check. The initial premium for life coverage, if purchased, will be requested on the first bill from Dearborn National.

When you renew BCBSIL coverage or reenroll by selecting a new product, you will need to be current on your premium payments. Any past due premium payments for coverage we provided will be due at the beginning of the new plan year in addition to current premium charges. New coverage will not be effective until all such payments are made.

INTERNAL USE ONLY

BCBSIL Account Number:

Enrollment State:

Effective date:

BlueCross BlueShield of Illinois

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

BENEFIT PROGRAM APPLICATION ("BPA")

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

Employer Group No.(s): _____ Section No.(s):_____

Account No. (BlueStar): _____ Customer No. (if different, for existing business only): _____

Employer's Legal Name: _____

(Specify the employer applying for coverage and list the names of any subsidiary or affiliated companies to be covered below.)

Physical 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: _____ / _____ / _____
Month Day Year

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

ERISA Regulated Group Health Plan*: Yes ☐ No ☐

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

ERISA Plan Sponsor*: _____

ERISA Plan Administrator*: _____

ERISA Plan Administrator's Address: _____ City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: _____

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

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

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

For more information regarding ERISA, contact your Legal Advisor.

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

1. Eligible Person:

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 _____ 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 Employer may elect to offer continuation coverage to Domestic Partners similar to that available to spouses under COBRA continuation.

Domestic Partner Coverage Continuation (only available if Domestic Partners are covered) ☐ Yes ☐ No

4. Retiree Coverage: Yes ☐ No ☐ If yes, complete the following, as applicable:

A. Retiree means those persons covered as retirees under the Employer's health care plan prior to the date the Employer initially purchased coverage from Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Yes ☐ No ☐ If yes, complete item 14. below.

B. Retiree means those persons who retire on or after the effective date of this BPA: Yes ☐ No ☐ If yes: Such retirees must be at least _____ years of age on the date of retirement with _____ years of continuous full-time employment with the Employer. Note: Minimum years of age is fifty-five (55); minimum years of continuous full-time employment is ten (10).

For existing groups, former employees who retired after the date the Employer initially purchased coverage from HCSC and prior to the initial effective date of the retiree coverage specified in item 4.B. above are not eligible. An Employer may only elect or change retiree coverage on the Policy Effective Date or Policy Anniversary Date. For Life Plans, retiree coverage is not available.

5. Eligibility Date: All current and new employees must satisfy the 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 one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage. In the case of a Special Enrollment event due to loss of coverage under Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

Annual Open Enrollment: For Health and Dental Plans only, an Eligible Person, who did not enroll under Timely Enrollment, may apply for Individual coverage, Family coverage or add dependents during the Employer's Annual Open Enrollment Period. The Open Enrollment Period is to be held thirty (30) days prior to the Policy Anniversary Date of the program. Such person's Individual Coverage Date, Family Coverage Date and/or dependent's Coverage Date

will be the Policy Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

Late Enrollment: For Non-Voluntary Life, Accidental Death and Dismemberment (AD&D) and Short Term Disability Plans only, an Eligible Person who did not apply under Timely Enrollment may apply for Individual coverage, Family coverage or add dependents. Late enrollees must furnish acceptable evidence of insurability if the employer contributes less than one hundred percent (100%). If the employer contributes one hundred percent (100%), such person's effective date will be a date mutually agreed to by the insurance company and the employer. For Voluntary Life Plans only, employees applying for or increasing coverage after their initial eligibility period can only enroll during the employer's annual enrollment period. Satisfactory evidence of insurability will be required for Voluntary Life coverages in these circumstances**.**

8. Extension of Benefits: An Extension of Benefits will be provided for a period of thirty (30) days in the event of Temporary Layoff, Disability or Leave of Absence. However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. In the event of Total Disability at the time the group policy is terminated, an Extension of Benefits will be provided for a period of no more than twelve (12) months from the date of termination, to the extent required, and in accordance, with any applicable federal or state law.

For Life Plans, an extension of benefits will be provided as follows: Due to Disability - until the end of the twelfth month following the month in which the disability began; Due to Layoff and Leave of Absence - until the end of the month following the month during which the layoff or leave of absence began. The extension will apply, provided all premiums are paid when due.

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

☐ First (1st) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO coverage.)
☐ Fifteenth (15th) day of each calendar month through the fourteenth (14th) day of the following calendar month. (This option is not available for any coverage if the Employer has BlueCare Dental HMO coverage.)
Note: Groups with Dearborn National ® Life Insurance Company ("Dearborn National") Life coverage and having less than one hundred dollars ($100.00) monthly premium will be billed on a quarterly basis.

10. Employer Contribution:

(a) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**
Health and Dental Plans

☐ _____% for Employee Coverage	☐ _____% for Employee plus Spouse Coverage
☐ _____% for Employee plus Child(ren) Coverage	☐ _____% for Family Coverage
☐ 100% of the Employee Coverage Premium will be applied toward the Family Coverage Premium.	☐ Other (specify): _____

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

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

(c) **The following applies to both Grandfathered and Non-Grandfathered Groups:**

HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

(d) **The following applies to Grandfathered Groups:**

The required minimum employer contribution is twenty five percent (25%). No policy will be issued or renewed unless at least seventy percent (70%) of eligible employees have enrolled for coverage. This applies to health and dental business separately. This does not include those eligible employees waiving coverage under HCSC due to other group coverage. In no event, however, shall the policy be issued or renewed unless at least two (2) eligible employees have enrolled for coverage.

(e) **The following applies to Non-Grandfathered Groups:**

HCSC reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of 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% of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify HCSC of any change in participation and Employer contribution.

(f) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**

Life, Accidental Death & Dismemberment (AD&D) and Short Term Disability Plans

☐ _____% for Group Life, AD&D	☐ _____% for Dependent Life	☐ _____% for Short Term Disability

If the employer contributes one hundred percent (100%) toward the cost of coverage, no policy will be issued or renewed unless at least one hundred percent (100%) of eligible employees have enrolled for that coverage. If both the employer and employee contribute toward the cost of coverage, no policy will be issued or renewed unless at least seventy five percent (75%) of eligible employees have enrolled for that coverage. Eligible employees are those who meet the definition of an Eligible Person, regardless of if an eligible employee waives coverage under HCSC medical due to having coverage elsewhere.

11. 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. Blue Directions for Large Business purchased: ☐ Yes ☐ No (if yes, The Blue Directions Addendum is attached and made a part of the Policy.)

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. Electronic Issuance: The Employer consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet and SBC provided by HCSC 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 HCSC, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and hold HCSC harmless from any misuse of the E-file provided by HCSC. By providing your consent, you agree to the 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 SBC's for covered Employees. Employer may withdraw this consent at any time and request receipt of hard copy versions by contacting their HCSC 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 HCSC to print and distribute hard copy versions.

Authorized Company Official's Initials: _____ Date: _____

17. Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

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

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the proposal document submitted to the Employer by the Sales Representative. It is understood and agreed that the actual terms and conditions are those contained in the Policy. It is further understood and agreed that the terms of the BPA may be subject to change. The final terms may be specified in a benefit program and premium notification letter or the applicable rate summary (ies) for the plan number(s) selected which may be attached hereto and made a part of the BPA. Payment of the first premium due under the Policy constitutes acceptance of such terms. No coverage will begin until receipt of the first premium by HCSC.

This BPA is subject to acceptance by HCSC and by Dearborn National as to coverage it underwrites. We certify that all the information and all attestations provided to HCSC and Dearborn National is correct and complete. Upon acceptance of this BPA, Dearborn National shall issue this BPA to the Employer. Upon acceptance of this BPA, HCSC shall issue a Policy to the Employer and this BPA and the benefit program and premium notification letter or the applicable rate summary (ies) for the plan number(s) selected shall be incorporated and made a part of the Policy. Upon acceptance of this BPA by HCSC and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the proposal document and the Policy, the provisions of the Policy shall prevail.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid to the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities there under. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Employer is effective with respect to or accepted by HCSC and Dearborn National except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC and Dearborn National.

With respect to coverage applied for under Dearborn National:
We agree to comply with and participate in all provisions of the Small Group Employer Benefits Program, the Group Policy providing the coverage applied for and the Trust to which the policy is issued. We understand that Dearborn National intends to rely on this information in determining whether the enrolling employees may become insured.

ADDITIONAL PROVISIONS:

A. Grandfathered Health Plans: Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. Retiree Only Plans and/or Excepted Benefits: If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions

of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, (e) the SBC, and/or (f) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. One of those fees is: the Annual Fee on Health Insurers or "Health Insurer Fee."

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

In addition, ACA Section 1341 and/or other applicable laws may provide for the establishment of a temporary reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees or Amounts") collected from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how these Reinsurance Fees or Amounts are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees or Amounts will help stabilize premiums in the individual market.

Your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees or Amounts, if any. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees or Amounts, if any.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, HCSC reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require HCSC to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Renewals Only: If this BPA is blank, it is intentional and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Policyholder's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

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

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the certificate booklet.

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

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

Producer Agency Representative

Signature of 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

BlueCross BlueShield of Illinois

Dearborn National®
Underwritten by Dearborn National® Life Insurance Company

BENEFIT PLAN SELECTION (BPS)

(To Be Used for Mid-Market Group Accounts)

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

Section 1 - Account Information:

Employer Name:					
BlueSTAR Account #:		Effective Date:		Anniversary Date:	

Health Products / Mid-Market Benefit Plan Selection:

- The Out of Pocket Max for Non-HSA plans listed will not exceed $7,350 for Individual and $14,700 for Family medical.
- The Out of Pocket Max for HSA Aggregate plans listed will not exceed $6,650 for Individual and $7,350 for Family medical, for HSA Embedded plans listed will not exceed $6,650 for Individual and $13,300 for Family medical.
- The Out of Pocket Max is inclusive of all deductibles, copays and coinsurance costs incurred on in-network benefits.
- A group may select up to six health plan options.
- The Prescription Drug Card may vary between products.

Section 2a - Renewing Groups Only: (*If New Business, skip to Section 3)

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	

Section 2b - Renewing Groups Only: (*If New Business, skip to Section 3)

Adding Plan (Medical and/or Dental): Please list new plan(s) below
1.
2.
3.
4.
5.
6.

Section 3 – HSA / FSA Plans:

HSA Vendor: *** If HSA is selected, a vendor will need to be selected.** (If no selection is made, HSA Vendor will default to Other / None.)	**FSA Vendor:** *** If FSA is selected, a vendor will need to be selected.** (If no selection is made, FSA Vendor will default to Other / None.)
☐ **Option A:** BenefitWallet® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**	☐ **Option 1:** FSA: BenefitWallet®
☐ **Option B:** HSA Bank® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**	☐ **Option 2:** FSA: HSA Bank®
☐ **Option C:** FlexHSA® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**	☐ **Option 3:** FSA: FlexHSA®
☐ **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.)	☐ **Option 4:** Other FSA Vendor / None (Select this option if using an FSA vendor other than above or are not offering an employer sponsored FSA vendor.)

Section 4 – New Business: **GROUP NUMBER:**

1. **Blue Directions (Private Exchange) Purchased?** Yes ☐ No ☐ (If yes, the Blue Directions Addendum is attached and made a part of the policy.)
2. Please select plan designs (Up to a maximum of 6 plans)

A. Blue Choice Options SM *1
Tiered Network (Blue Choice OPT PPO – BC / PPO – PPO / Out of Network - OON)

2018 NRMM Plan ID	Deductible (BC/ PPO/ OON)	Coins (BC/ PPO/ OON)	OPX (BC/ PPO/ OON)	PCP Copay (BC/ PPO)	ER Copay (BC / PPO)	Non-Preferred Pharmacy	Preferred Pharmacy
☐ **MIBCO100*2*3**	$500/ $1500/ $3000	90%/ 70%/ 50%	$4000/ $5600/ $12000	$20/$50	400/400	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCO101*2*3**	$500/ $1500/ $3000	100%/ 70%/ 50%	$500/ $3000/ $6000	$20/$50	400/400	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCO102*2*3**	$500/ $1500/ $3000	90%/ 70%/ 50%	$2500/ $5500/ $11000	$20/$50	400/400	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCO103*2*3**	$1000/ $2500/ $5000	90%/ 70%/ 50%	$2500/ $5500/ $11000	$25/$50	400/400	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCO104*2*3**	$1500/ $3500/ $7000	90%/ 70%/ 50%	$3000/ $5500/ $11000	$30/$50	400/400	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCO105*2*3**	$4000/ $5000/ $10000	80%/ 60%/ 50%	$5600/ $5600/ $13200	$35/$60	500/500	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCO106*4**	$2700/ $4500/ $9000	100%/ 80%/ 60%	$2700/ $6450/ $12900	DC	N/A	100%	100%

*1 For HMO and PPO plans the Performance Drug List will be utilized. Members pays the difference applies.
*2 ER Copays are pre-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.
*3 The ER Copay is applicable across all tiers.
*4 DC indicates Deductible and Coinsurance applies.

B. Blue Choice Select SM *1

2018 NRMM Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	PCP Copay	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ **MIBCS101**	$250/$500	80%/50%	$1250/$2500	$20	$200	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCS102**	$500/$1000	90%/60%	$1500/$3000	$20	$200	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBCS103**	$500/$1000	80%/50%	$2500/$5000	$20	$200	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBCS104**	$1000/$2000	90%/60%	$2000/$4000	$20	$200	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBCS105**	$1000/$2000	80%/50%	$3000/$6000	$30	$200	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCS107**	$1500/$3000	80%/50%	$3500/$7000	$30	$200	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCS109**	$2000/$4000	80%/50%	$4000/$8000	$30	$200	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCS110**	$2000/$4000	80%/50%	$5500/$11000	$30	$200	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCS112**	$2500/$5000	80%/50%	$4500/$9000	$30	$200	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBCS115**	$4000/$8000	100%/100%	$4000/$8000	$30	$200	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBCS116**	$4000/$8000	80%/50%	$5500/$11000	$30	$200	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250

*1 For HMO and PPO plans the Performance Drug List will be utilized. Member pays the difference applies.

C. Blue Advantage ®HMO*1

2018 NRMM Plan ID	Deductible In-Network	Coins In-Network	OPX In-Network	PCP Copay	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ **MIBAH100**	$0	N/A	$1500	$40	$350	$0/$10/$35/$75/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBAH101**	$0	N/A	$1500	$30	$250	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBAH102**	$0	N/A	$1500	$20	$250	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250

*1 For HMO and PPO plans the Performance Drug List will be utilized. Member pays the difference applies.

D. Blue Advantage HMO® Value Choice*1							
2018 NRMM Plan ID	Deductible In Network	Coins In Network	OPX In-Network	PCP Copay	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ **MIBAV001**	$0	N/A	$3,000	$40	$350	$0/$10/$35/$75/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBAV002**	$0	N/A	$3,000	$50	$400	$0/$10/$35/$75/$150/$250	$0/$10/$35/$75/$150/$250
*1 For HMO and PPO plans the Performance Drug List will be utilized. Member pays the difference applies.							

E. Blue Edge SM Select HSA							
2018 NRMM Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	PCP Copay	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ **MIBES001***4*5	$2500 / $5000	80%/50%	$5000/$10000	DC	N/A	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%50%
☐ **MIBES002***4*5	$2500 / $5000	100%/100%	$2500/$5000	DC	N/A	100%	100%
*4 DC indicates Deductible and Coinsurance applies. *5 Indicates HSA plan is an aggregate plan.							

F. Blue Edge SM HSA							
2018 NRMM Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	PCP Copay	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ **MIBEE100***4*5	$1500/$1500	100%/80%	$3000/$3000	DC	N/A	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ **MIBEE101***4*5	$1500/$3000	80%/60%	$3000/$6000	DC	N/A	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ **MIBEE102***4*5	$2500/$2500	100%/80%	$5000/$5000	DC	N/A	100%	100%
☐ **MIBEE103***4*5	$2500/$5000	80%/60%	$5000/$10000	DC	N/A	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ **MIBEE104***4	$2700/$5400	100%/100%	$2700/$5400	DC	N/A	100%	100%
☐ **MIBEE105***4	$2700/$5400	90%/70%	$3500/$7000	DC	N/A	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ **MIBEE106***4	$2700/$5400	80%/60%	$5400/$10800	DC	N/A	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ **MIBEE107***4*5	$3500/$7000	80%/60%	$5800/$11600	DC	N/A	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐ **MIBEE108***4	$6000/$12000	100%100%	$6000/$12000	DC	N/A	100%	100%
*4 DC indicates Deductible and Coinsurance applies. *5 Indicates HSA plan is an aggregate plan.							

G. Blue Print® PPO*1							
2018 NRMM Plan ID	Deductible In/Out	Coins In/Out	OPX In/Out	PCP Copay	ER Copay	Non-Preferred Pharmacy	Preferred Pharmacy
☐ **MIBPP100**	$0/$0	90%/70%	$250/$1000	$20	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP101**	$250/$500	80%/60%	$1250/$2500	$20	$150	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBPP102**	$500/$1000	90%/70%	$1500/$3000	$20	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP103**	$500/$1000	80%/60%	$2500/$5000	$20	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP104**	$1000/$2000	90%/70%	$2000/$4000	$20	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP105**	$1000/$2000	80%/60%	$3000/$6000	$30	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP106**	$1000/$2000	80%/60%	$4000/$8000	$30	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP107**	$1500/$3000	80%/60%	$3500/$7000	$30	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP108**	$1500/$3000	80%/60%	$4500/$9000	$30	$150	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBPP109**	$2000/$4000	80%/60%	$4000/$8000	$30	$150	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBPP110**	$2000/$4000	80%/60%	$5500/$11000	$30	$150	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBPP111**	$2500/$5000	90%/70%	$3500/$7000	$20	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP112**	$2500/$5000	80%/60%	$4500/$9000	$30	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP113**	$2500/$5000	80%/60%	$5500/$11000	$30	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP114**	$3500/$7000	80%/60%	$5500/$11000	$20	$150	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐ **MIBPP115**	$4000/$8000	100%/100%	$4000/$8000	$30	$150	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBPP116**	$4000/$8000	80%/60%	$5500/$11000	$30	$150	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐ **MIBPP117**	$5000/$10000	80%/60%	$5600/$11200	$40	$250	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
*1 For HMO and PPO plans the Performance Drug List will be utilized. Member pays the difference applies.							

Section 5 - Ancillary Product Selection:

A. Dental Products

DENTAL PPO GROUP NUMBER:
DENTAL HMO GROUP NUMBER:

1. Blue Care Dental*

Plan Pairings (Groups 10+)		Participation Requirements	
Contributory Group	**Voluntary**	**Contributory Group**	**Voluntary**
High Option **Low Option** DINHR01 DINLR06 DINHR02 DINLR07 DINHR03 DINLM21 Any one of the above three contributory group high option plans (DINHR01, DINHR02, DINHR03) can only be paired with any one of the above three contributory group low option plans (DINLR06, DINLR07, DINLM21); DINHM12 can be paired freely with any contributory plan option.	**High Option** **Low Option** DINHR13 DINLM25 DINHR22 DINLM26 Any one of the above two voluntary high option plans (DINHR13, DINHR22) can be paired with any one of the above two voluntary low option plans (DINLM25, DINLM26). DINHM16 can be paired freely with any voluntary plan option.	>70% Participation >50% Employer contribution	>25% Participation Employers are not required to contribute to Voluntary Dental plans

IL Plan Code	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								
☐ DINHR01	Passive	$25/$25	$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DINHR02	Passive	$50/$50	$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DINHR03	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DINHR04	Active	$50/$75	$1500/$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	$1000	High
☐ DINLR06	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	Low
☐ DINLR07	Passive	$75/$75	$1000	90th R&C	90%/70%/50%/NA	90%/70%50%/NA	N/A	Low
☐ DINHM08	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	High
☐ DINHM10	Active	$50/$50	$1500/$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A	High
☐ DINLM11	Active	$75/$75	$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	N/A	Low
☐ DINHM12	Passive	$25/$75	$750	MAC	100%/80%*3/NA/NA	100%/80%*3/NA/NA	N/A	High
☐ DINHR20	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	High
☐ DINLM21	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
Voluntary Group								
☐ DINHR13*1	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DINHM14*1	Active	$50/$50	$1500/$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	N/A	High
☐ DINHM16	Passive	$25/$75	$750	MAC	100%/80%*3/NA/NA	100%/80%*3/NA/NA	N/A	High
☐ DINHR22*1	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	High
☐ DINHR23*1	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	High
☐ DINLR24*1	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	N/A	Low
☐ DINLM25*1	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
☐ DINLM26 *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 Periodontal/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/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

2. BlueCare Dental HMO

Plan Pairings (Groups 10+)		Participation Requirements	
Contributory Group Any one Contributory DHMO can be paired with any one Contributory PPO option.	**Voluntary** Any one Voluntary DHMO option can be paired with one voluntary PPO option.	**Contributory Group** >70% Participation >50% Employer contribution	**Voluntary** >25% Participation

IL Plan Code	Plan Type	Deductible In/Out	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								
☐ DNCAP710	DHMO	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A	N/A
☐ DNCAP730	DHMO	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A	N/A
Voluntary Group								
☐ DNCAP810	DHMO	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A	N/A
☐ DNCAP830	DHMO	N/A	N/A	N/A	Copay Schedule	Copay Schedule	N/A	N/A

B. Life Products

GROUP NUMBER:

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

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 ☐ 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	(Only applicable to groups with 2 - 9 enrolled lives) ☐ 35% of the original amount at age 65, 50% of the original amount at age 70 75% of the original amount at age 75, 85% of the original amount at age 80

Excess Amounts of Life Insurance:

Evidence of Insurability will be required for individual life insurance amounts in excess of **$**_____. Such excess insurance amounts shall become effective on the date Evidence of Insurability is approved by 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

☐ **Yes** ☐ **No**		**Spouse**	**Children** – age birth to 14 days	**Children** – age 14 days to 6 months	**Children** – age 6 months to 26 years / student 26
Choose a Plan:	☐ Option 1	$10,000	$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
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 enroll
☐ 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 (3 Max 2 – 9 lives) (6 Max 10+ lives)

Class Description	Term Life / AD&D	Short Term Disability

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 6 – Signatures:

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 2018
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

INSTRUCTIONS – COMPLETING THE ANNUAL MSP EMPLOYER ACKNOWLEDGEMENT

IMPORTANT NOTE

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

Background

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

Employer information — Who is the Employer?

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

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

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

Question 1 — Did you file a separate Federal Tax Return?

If you filed a federal tax return that did not include information about any other individual or entity, check "Yes." If you filed a federal tax return consolidated with another individual or entity, check "No." If you are not required to file a federal tax return, check "N/A."

Question 2 — Employer Size from Your Federal Tax Return Information

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

Question 3 — Are you part of a multi-employer group health plan?

Authoritative guidance for determining multiple employer group health plan participation can be found in the Code of Federal Regulations at 29 CFR § 2510.3-37.

Questions 4 and 5 — Working Aged Rule & Employer Size

Under the MSP "working aged" rule, Medicare is secondary to the employer's GHP coverage if the employer's size equals 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. *(Question 4 refers to this standard as "the threshold.")* Note: The year of your upcoming renewal is the 'current' year. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSIL if and when your status changes. This also applies to multi-employer and multiple employer group health plans in which at least one employer employs 20 or more employees.

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

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

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

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

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

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

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

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

- *Individuals affected by the working aged rule*

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

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

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

Questions 6 and 7 — Disability Rule & Employer Size

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

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

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

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

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

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

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

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

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

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

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

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

- *Individuals affected by the disability rule.*

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

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

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

BlueCross BlueShield of Illinois

Illinois Extension Form

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

This is a document to be included for multiple purposes. Please indicate the purpose for which this document has been submitted:

☐ This is a document to be included as part of a full-case submission for an offer of coverage from Blue Cross and Blue Shield of Illinois (BCBSIL). This statement applies to new business.

☐ This document is submitted for the purpose of obtaining a Stage 2 quote. If this is the case, the client should attach the full renewal (text, rates, benefits, reports, negotiations, etc.) for the purposes of obtaining a risk-adjusted proposal. The client must have 10 or more enrolled medical lives.

SECTION A

Employer Name		**Employer Tax ID #**
Type of Business	**SIC Code**	**Original Business Start-Up Date** _____/_____/_____
Parent Company Name		
Prior Group Coverage with Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company? ☐ Yes ☐ No		
If Yes, provide Cancellation Date: _____/_____/_____ Group Number: _____		
Is the Group's current funding arrangement fully insured? ☐ Yes ☐ No	What is the Group's current health coverage renewal date? _____/_____/_____	

Number of Part-Time Employees: _____	Total Number Enrolled: _____	Number of Out-of-State Resident Enrollees: _____
Number of Full-Time Employees: _____	Number with Signed Waivers: _____	**List:** State / Number of Employees
Number of Union Employees: _____		_____ / _____
Number of Total Employees: _____	Number of Continuees: (State of Illinois or COBRA) _____	_____ / _____
		_____ / _____

SECTION B

INSURANCE COMPANY HISTORY (All insurance companies, including HMO, in the previous five years)

	Insurance Company Name	Period Insured
Current		_____/_____/_____ through _____/_____/_____
Previous		_____/_____/_____ through _____/_____/_____
		_____/_____/_____ through _____/_____/_____

Current Carrier Premium Rates For:	Plan Type (HMO, PPO, Other)	Current Policy	Renewal	Benefit levels (Deductible and Coinsurance)
Employee	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Employee plus Spouse	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Employee plus Child(ren)	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Family	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Total Monthly Health Premium		$ _____	$ _____	

SECTION C — This section is to be completed by groups with 51 or more average total employees.

MEDICAL QUESTIONNAIRE

Directions: Please check **Yes** or **No**. If any box is checked Yes, circle the condition, e.g., *STROKE*, and give details below.

Yes	No	Number of Members	
☐	☐		1. Has anyone had a claim of $5,000 or more in the past 12 months?
☐	☐		2. Has anyone been advised to have surgery or medical treatment in the past six months that has not yet been performed, or been hospitalized or had surgery in the past three years?
			3. Has anyone been advised, diagnosed or treated by a physician in the past five years for:
☐	☐		A. Stroke, heart, circulatory, vascular disease or disorder, or high blood pressure?
☐	☐		B. Cancer, tumors, leukemia, lupus or any other systemic disease?
☐	☐		C. Multiple sclerosis, paralysis, arthritis or bone/joint/back/muscle disorders?
☐	☐		D. Asthma, emphysema, respiratory or lung disorders?
☐	☐		E. Diabetes, pancreas, growth disorder or endocrine disorder?
☐	☐		F. AIDS, tested positive for HIV, immune system disorders or blood disorders?
☐	☐		G. Hepatitis/liver disorder, digestive system disease or disorder, colon disorder, kidney/prostate/reproductive organs disorder or infertility?
☐	☐		H. Nervous system or brain/seizure disorder, mental/emotional disorders, alcohol/drug/substance abuse or dependency?
☐	☐		I. Organ transplant or bone marrow transplant?
☐	☐		J. Other?_______________________________
☐	☐		4. Are any employees or dependents currently pregnant?

If you have answered **Yes** to any of the questions above, please provide details below.
Use an additional page if needed.

DETAILS OF MEDICAL HISTORY

Question #	Name *(optional)*	Employee, Spouse, Child	Age	Sex	Condition/ Diagnosis	Treatment Medications	Treatment Date	Date of Recovery
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____

The following information is needed to comply with Public Act 86-537, as amended, which regulates the Discontinuation and Replacement of Group Insurance policies. Each covered person will be given credit toward our participating provider program deductible for prior deductible and waiting periods satisfied under the prior carrier's coverage based on information provided to Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") by the group. HCSC reserves the right to accept or, where not prohibited by law, reject the entire group based on the information provided. HCSC further reserves the right to change the quoted rates or withdraw the proposal if any of the above information changes, was omitted, or has been reported inaccurately.

What is the provision in the current insurance carrier's contract for coverage during layoff, leave of absence and disability?

____

What is the current carrier's extension of benefits provision for medical services in the event of employer group cancellation?

____

Has the Group's medical coverage ever been cancelled, or applications for coverage been declined or withdrawn? ☐ Yes ☐ No

If yes, explain. ____

If additional space is needed for any of the above, please attach a separate sheet with the required information.