BlueCross BlueShield of Texas

Small Group

Submission Checklist

The following documentation will help you prepare and submit new cases in the small group market.

- ☐ Is the business a candidate for small employer group coverage? (two to 50 total employees on payroll)
- ☐ Small Employer Benefit Program Application (BPA) – Must be completed, signed and dated by the employer (get the most current version of the form at www.bcbstx.com/producer)
- ☐ Employee Enrollment Applications – Application or declination for each eligible employee is required; employees must complete, sign and date
- ☐ Signed Small Group Proposal – Submit the signature page from the proposal with the group administrator's signature and date
- ☐ Proof of Wages – Most recent quarterly wage report from the Texas Workforce Commission (TWC) or other payroll documents. Mark/Indicate employee status as full time, part time, terminated, seasonal etc.
- ☐ Texas Supplemental Employee Verification Form – Needed for anyone (including new hires) not listed on the proof of wages documentation (i.e., payroll reports, TWC reports, etc.)
- ☐ Proof of Business – Required only if a current quarterly TWC wage report is not available
- ☐ Small Group Pediatric Dental EHB Attestation Form – Required for all new groups enrolling in a health plan
- ☐ Employer Group Information Form (included with Benefit Program Application) – Must be signed and dated by the employer
- ☐ Proxy Form (included with employer application)
- ☐ First Premium Payment
- ☐ Ensure the Group Meets the 75 Percent Participation Requirement – Indicate employees who are part-time, seasonal or terminated.

MAIL PAPERWORK TO YOUR SALES REPRESENTATIVE AT

Dallas (888-338-6293)
4851 LBJ Freeway, #100
75244

Fort Worth (800-875-0149)
6100 Western Place Dr., #801
76107

Austin (800-749-8672
4401 Westgate Blvd. #320
78745

Houston (800-756-7889)
5177 Richmond Ave, #1050
77056

San Antonio (866-635-1618)
85 NE Loop 410, #207
78216

Online Resources:
www.benefitmall.com *www.bcbstx.com/producer*

If the Blue Directions enrollment tool is used, all information above applies with exception of Employee Enrollment Applications, which do not need to be submitted.

Quote Requests Checklist

Small Group: 2-50 Employees

EFFECTIVE: 01/01/2014

QUALIFYING THE CANDIDATE

Due to Texas Senate Bill 1332, the total number of employees on payroll will determine if we can release a small group rate proposal. Group size is no longer based on number of "eligible" employees. Total employee count must include those working full time, part time, seasonal, temporary and those waiving or declining health insurance.

If there are 50 or less total employees on payroll on business days during the preceding calendar year, please note the helpful information in this small group checklist. If there are more than 50 total employees on payroll, please contact your BCBSTX Sales Representative for further guidance. Please note, groups with more than 50 total employees will not be approved for enrollment in the small regulated group market.

To obtain the most recent versions of the information needed to quote small groups (2-50), go to **bcbstx.com/producer** and click Forms, then select the Small Group Forms link to access the following:

- **Checklist for submitting quotes (2-50)** *(for eff. dates on and after 1-1-2014)*
- **Regulated Small Group (2-50) Request for Proposal & Template Census** *(for eff. dates on and after 1-1-2014)*

Producer Information

- ❑ Agents name
- ❑ Agency name, if applicable
- ❑ Email address of the requestor
- ❑ Email address that the quote should be sent to, if different from the requestor
- ❑ Phone number of the requestor
- ❑ BCBS [insert applicable state] producer number (nine digit number used for Blue Access for Producers (BAP)

Company Information

Company information should include the following:

- ❑ Business name and address: The legal name of the business and complete address of the company headquarters including ZIP code and county
- ❑ Standard industry code (SIC): The four-digit standard industry code is required because all our proposals include rates for Life and Disability
- ❑ Requested effective date of coverage

Employee Information

Employee information should include a complete census. The preferred format for census submissions is Microsoft Excel. Please obtain Excel template from our website. Each census should include all employees and dependents interested in health, dental, life or disability coverage.

The following is requested for each employee who is interested in coverage:

- ❑ Name (preferred)
- ❑ Employee date of birth & gender (required)
- ❑ Spouse/Child date of birth & gender (if applicable, required)
- ❑ State employee resides in
- ❑ Salary (if a quote for STD/LTD coverage based on salary is desired)
- ❑ Type of Coverage, including coverage code (required)
  - Employee only - EO
  - Employee and spouse - ES
  - Employee and child - EC
  - Employee and Family - EF
  - Life only - LO
  - COBRA/continuation - CO
  - COBRA/continuation with spouse - CS
  - COBRA/continuation with child - CC
  - COBRA/continuation with family - CF

BlueCross BlueShield of Texas

SMALL GROUP Important Timelines

BlueCross BlueShield of Texas

Step	Who Does It	Action	Timing*
1.	**Broker/Producer**	**Review all paperwork to check accuracy and completeness. When complete, submit new group paperwork** to Blue Cross and Blue Shield of Texas (BCBSTX) Small Business Service Center at 1001 E. Lookout Dr., Building B, 12th Floor, Richardson, TX 75082.	At least **14 calendar days** prior to the group's effective date
2.	**Blue Cross and Blue Shield of Texas (BCBSTX)**	**Verify accuracy and completeness of all paperwork**. If additional or missing information is required, send an e-mail to the broker. When all requirements are received, forward the group to Underwriting.	Within **two business days** of receiving completed required documents
3.	**BCBSTX**	During enrollment, all groups require **review by Underwriting**, to validate small group status prior to membership processing.	Within **two business days** after Step 2
4.	**BCBSTX**	**Develop final rates** based on actual enrollment documentation submitted. BCBSTX will generate a welcome letter when rates are released from Underwriting.	Within **one business day** after underwriting is complete
5.	**BCBSTX**	**Final membership processing occurs** after BCBSTX sends Broker/Producer a welcome letter. **IMPORTANT:** Members are not eligible for benefits until this step is completed.	Within **two to four business days** of mailing the welcome letter
6.	**BCBSTX**	**Generate identification cards** for members. **NOTE:** BCBSTX mails the identification cards via the U.S. Postal Service; delivery times may vary.	Upon **completion of Step 5**
7.	**BCBSTX**	**Mail Administrative Guide** to the employer.	Within **30 days** of the group's effective date

*The Timing column represents BCBSTX processing target goals and is not a guarantee.

725874.0913

BlueCross BlueShield of Texas

Dearborn National®*

SMALL EMPLOYER BENEFIT PROGRAM APPLICATION
(Employer Application)

(The following information only applies if selecting a Consumer Choice plan)

You have the option to choose a Consumer Choice of Benefits Health Maintenance Organization (HMO) health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage (Certificate of Coverage).

Application is hereby made to Blue Cross and Blue Shield of Texas (BCBSTX) and/or Dearborn National® Life Insurance Company ("Dearborn National").

Legal Name of Company:		
Employer Identification Number (EIN):	Nature of Business:	Standard Industry Code (SIC):
Physical Address (number & street), City, State, ZIP:		
E-Mail Address of Authorized Company Official:		Telephone Number:
Secondary E-Mail Address, if different from Authorized Company Official:		FAX Number:
Complete Mailing Address, if different from physical address:		
Billing and Correspondence to the attention of:		
The Blue Access for Employers (BAE) contact person is the individual authorized by the Employer to access and maintain its account/employee information. Name and title of the BAE contact person: _____ E-mail address of BAE contact person: _____		
Requested Contract(s)/Policy(ies) Effective Date (1st or 15th): _____/ _____ / _____ Month Day Year (Note: Products with a Health Maintenance Organization (HMO) component must be effective on the first day of the month. Contract/Policy Anniversary Dates will be 12 months from the Effective Date.)		

A copy of your most recent Texas Workforce Commission (TWC) Report(s) or other supporting documentation must be submitted with this Employer Application (please identify part-time employees and terminations). W4s, 1099s, or a Texas Supplemental Employment Verification form must be submitted for any applicants not included on the TWC Report.

1. Select a Waiting Period:

   a. Newly eligible individuals will become effective on:

   ☐ The first day of the contract/participation month following ☐ 0 days ☐ 30 days ☐ 60 days
   Employee and dependent Health and/or Dental Benefit Plans will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period and any substantive eligibility criteria.

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

   c. Number of employees serving Waiting Period: _____

   d. 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. In no event can the substantive eligibility criteria result in a delay of coverage for eligible employees, as defined under Texas law, longer than 90 days inclusive of the Waiting Period. If any of these eligibility conditions change, you are 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).

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

   _____
   _____
   _____
   _____

2. Total number of enrollment applications submitted: _____ Total number of declinations submitted: _____

3. Do all employees reside in Texas? ☐ Yes ☐ No
   If no, is Texas the state with the greatest number of employees eligible to enroll in this group plan? ☐ Yes ☐ No

4. Domestic Partners covered: ☐ Yes ☐ No
   If yes: A Domestic Partner, as defined in the Plan, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those covered Employees with Domestic Partners.

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

5. Is the company headquarters in Texas? ☐ Yes ☐ No

6. Are you an independent school district that is a large employer electing to participate as a small employer?
   ☐ Yes ☐ No

7 Will you have been without group coverage (uninsured) for at least two months prior to the requested Contract(s)/Policy(ies) effective date of coverage? ☐ Yes ☐ No

8 If you currently have group health care coverage, complete the following:
   a. Present health carrier's name_____
   b. Paid-to-date with current carrier: _____/ _____/ _____ (mm/dd/yyyy)
   c. Calendar year medical deductible amount with current carrier: Individual: _____Family: _____

LEGISLATIVE REQUIREMENTS

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.

Please provide your ERISA Plan Year*: Beginning Date: _____ / _____ / _____ End Date: _____ / _____ / _____

Month Day Year Month Day Year

ERISA Plan Sponsor*: _____

If you maintain that ERISA is not applicable to your account, please give the legal reason for exemption*:

☐ Federal Governmental plan (e.g., the government of the United States or agency of the United States)
☐ Non-Federal Governmental plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
☐ Church plan
☐ Other; please specify: _____

Please provide Non-ERISA Plan Year: _____ / _____ / _____

Month Day Year

For more information regarding ERISA, contact your Legal Advisor.

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

BENEFIT PLAN SELECTIONS

Understanding the Plan # Sample Plan # : **B634ADT**		
Metallic Level	B	**B**ronze, Silver, Gold, Platinum
Benefit Design	634	633, **634**, etc.
Network/Product Name	ADT	**ADT** = Blue Advantage HMO CHC = Blue Choice PPO

Health Products/Benefit Plan Selection:

The left hand column lists the benefit designs. Up to three selections from this column are allowed. The corresponding rows to the right of the benefit designs indicate network/product choices for the specified benefit. A maximum of six network/product options may be selected.

If HSA/HDHP is selected, provide name of HSA administrator/trustee; _____

Benefit Design (select up to 3)		**Blue Choice PPO** (select up to 6)			***Blue Advantage HMO℠** (select up to 6)
☐	B600	☐	B600CHC		
☐	B601	☐	B601CHC		
☐	B633	☐	B633CHC		
☐	B634	☐	B634CHC	☐	B634ADT
☐	S600	☐	S600CHC		
☐	S606	☐	S606CHC	☐	S606ADT
☐	S607	☐	S607CHC	☐	S607ADT
☐	S608	☐	S608CHC	☐	S608ADT
☐	S609	☐	S609CHC		
☐	S610	☐	S610CHC	☐	S610ADT
☐	S611	☐	S611CHC	☐	S611ADT
☐	S612	☐	S612CHC		
☐	G601			☐	G601ADT
☐	G613	☐	G613CHC		
☐	G616	☐	G616CHC		
☐	G617	☐	G617CHC	☐	G617ADT
☐	G618			☐	G618ADT
☐	G619	☐	G619CHC		
☐	G620	☐	G620CHC	☐	G620ADT
☐	G621	☐	G621CHC	☐	G621ADT
☐	G622	☐	G622CHC	☐	G622ADT
☐	G623	☐	G623CHC	☐	G623ADT
☐	G632			☐	G632ADT
☐	P600	☐	P600CHC	☐	P600ADT
☐	P601	☐	P601CHC	☐	P601ADT

*****If a Blue Advantage HMO product/benefit plan (with the **exception** of G632ADT plan) is selected, please complete, sign and submit a Disclosure Statement with this Application.

Additional Information: _____

DENTAL PRODUCTS/BENEFIT PLAN SELECTION:

Plan Pairings (Groups 10+)	**Participation Requirements**
True Group **Any one true group high option can be paired with any one true group low option; DTXHM11 can be freely paired with any true group.** **High Option — Low Option** **DTXHR01 — DTXLR06** **DTXHR02 — DTXLR07** **DTXHR03 — DTXLM08** **Voluntary** **Any one voluntary high option can be paired with any one voluntary low option.** **High Option — Low Option** **DTXHR12 — DTXLM14** **DTXHM13 — DTXHM15**	**True Group** **>75% participation** **>50% employer contribution** **Voluntary** **>25% participation** **Employers are not required to contribute to Voluntary Dental plans**

DENTAL PLAN SELECTION

	Plan #	**Segment**
	High Coverage Allocation	
☐	DTXHR01	True Group
☐	DTXHR02	True Group
☐	DTXHR03	True Group
☐	DTXHR04	True Group
☐	DTXHM09	True Group
☐	DTXHM11	True Group
☐	DTXHR12	Voluntary
☐	DTXHM13	Voluntary
☐	DTXHM15	Voluntary
	Low Coverage Allocation	
☐	DTXLR05	True Group
☐	DTXLR06	True Group
☐	DTXLR07	True Group
☐	DTXLM08	True Group
☐	DTXLM10	True Group
☐	DTXLM14	Voluntary

The following mandated benefit offers are made by BCBSTX in compliance with Texas regulations.
Please mark your acceptance or declination. Acceptance may result in a rate adjustment.

THE FOLLOWING MANDATED BENEFIT OFFERS ARE ALREADY INCLUDED IN THE PPO AND HMO PLANS

- Treatment of mental or emotional illness
- Treatment of loss or impairment of speech or hearing
- Treatment of serious mental illness

MANDATED BENEFIT OFFERS

In Vitro Fertilization Services - (must choose one)
☐ Accept – Outpatient benefits are paid same as any other pregnancy-related expense
☐ Decline – If declined, no benefits are available

The Employer understands and agrees to comply with the following requirements regarding the Health Benefit Plan(s) elected:

- Applications/Declinations are attached for all full-time employees as well as any COBRA or state participant continuations.
- **Minimum Participation and Employer Contribution** :

  BCBSTX reserves the right to: 1) restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the 50% minimum employer contribution is met and at least 75% of eligible employees (less valid waivers) have enrolled for coverage; and 2) review participation and contribution on existing business and non-renew or discontinue health coverage if the 50% minimum employer contribution is not met and/or less than 75% of Eligible Persons (less valid waivers) are enrolled for coverage for six consecutive months.

  If applicable, BCBSTX 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 Employees/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.

  Employer will promptly notify BCBSTX of any change in participation and Employer contribution.

- The Employer must provide eligibility and enrollment information, effective dates of employment, and all other data necessary for the efficient administration of the Health Benefit Plan(s) elected, according to the terms and requests of BCBSTX.
- After approval by BCBSTX the Health and/or Dental Benefit Plan(s) applied for, individuals will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period (if any, but not to exceed 90 days). Employees whose applications are received more than 31 days after date-of-hire or received after expiration of the Waiting Period will be considered late enrollees and will be eligible to enroll during the next open enrollment period.
- The Employer, while not an agent of BCBSTX, will be responsible for collection of premiums from employees, will notify employees of the termination of their coverages and will forward to employees notices and/or amendments sent by BCBSTX to the Employer. The Employer will be bound by the terms of the Contract(s)/Policy(ies) issued pursuant to this Employer Application and such shall serve as the basis to resolve any conflict. When issued, the Contract(s)/Policy(ies) will include this Employer Application and any Addenda issued pursuant to this Employer Application.
- Premium rates for the coverages applied for are determined by BCBSTX and will become a part of the Contract(s)/Policy(ies) issued by BCBSTX and any amendments thereto.
- This Benefit Program Employer Application must pre-date the requested effective date and be received by BCBSTX at its Home Office no less than thirty (30) days prior to the requested effective date.
- Retirees are not eligible for coverage hereunder.
- Under Texas state law, ***eligible employee*** means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. The term does not include an

Employee who: (1) works on a part-time, temporary, seasonal, or substitute basis, or (2) is covered under (a) another Health Benefit Plan, or (b) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974, or (3) elects not to be covered under the small employer's health benefit plan and is covered under (a) the Medicaid program; (b) another federal program, including the TRICARE program or Medicare program; or (c) a benefit plan established in another country.

- Dependent children under age 26 are eligible for coverage until their 26th birthday. Dependent child, used hereafter, means a natural child, a stepchild, an eligible foster child, a medical support order child, an adopted child or child placed for adoption (including a child for whom the employee or his/her spouse, or Domestic Partner, if Domestic Partner coverage is elected, is a party in a legal action in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon the employee or spouse (or Domestic Partner, if Domestic Partner coverage is elected) is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application. To be eligible for coverage, a child of an employee's child must also be dependent upon employee for federal income tax purposes at the time application for coverage is made.

  A Dependent child who is medically certified as disabled and dependent upon the employee or his/her spouse (or Domestic Partner, if Domestic Partner coverage is elected) is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

- The producer(s) or agency(ies), specified in the Producer's Statement section below, is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC) , a Mutual legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for Employer. The POR is authorized to perform membership transactions on behalf of Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.
- For the current year's premium and rate information, refer to the accepted finalized new group rates letter ("Letter") or the renewal exhibit ("Exhibit") for complete details. The Letter, or Exhibit, shall be incorporated by reference and made part of the BPA and Group Administration Document.

Application is hereby made to Dearborn National® Life Insurance Company (herein called"Dearborn National") for a Life Insurance Plan (including Term Life Insurance, Accidental Death and Dismemberment (AD&D), Dependents' Life, and/or Short Term Disability (STD).

I. Group Life Administration Information

Eligibility: ☐ All active employees ☐ All active employees enrolled for health insurance who work a minimum of 30 hours per week excluding seasonal, temporary, or retired employees

Benefit: All employees according to the following schedule:

Class	Job Title, as shown on the enrollment form	Life & AD&D Benefit Amount	STD Amount (if elected)
1			
2			
3			

	Term Life/AD&D	Dependents' Life	STD
Total eligible employees: ____			
Total enrolling: ____			

Contract Anniversary Date: ☐ 12 months from Contract Effective Date ☐ Other ____

II. Term Life Insurance and AD&D: ☐ Applied For ☐ Not Applied For

Complete Life and AD&D Benefit Amount in Section I	Guarantee Issue Maximum: $
Rates: ☐ Step-Rated ☐ Composite Rated (Include a copy of the rating exhibit if rated in the field)	
Employer Contribution: ☐ 100% ☐ Other % (Minimum 25% Employer contribution required)	
Life/AD&D Reductions due to Attained Age (All benefits terminate at retirement):	
☐ Reduces by 35% at age 65, to 50% of the original benefit at age 70, to 25% of the original benefit at age 75, and to 15% of the original benefit at age 80. (Standard under 10 eligible lives)	
☐ Reduces by 35% at age 65 and to 50% of the original benefit at age 70. (Unavailable under 10 eligible lives)	
☐ Reduces to 50% at age 70. (Unavailable under 10 eligible lives)	
Term Life is ☐ in addition to, or ☐ replacement of current term life coverage ☐ no current carrier	
If replacement, give current carrier:	Termination date of prior plan:

III. Dependents' Term Life Insurance: ☐ Applied For *(offered only with Term Life/AD&D)* ☐ Not Applied For

Benefits:	Spouse	$
Rate: $	Child(ren) age 15 days up to 6 months:	$
Employer Contribution: %	Child(ren) age 6 months. up to age 25 & Students:	$

IV. Short Term Disability (STD) Insurance: ☐ Applied For *(offered only with Term Life/AD&D)* ☐ Not Applied For

Wage-Based Benefit: ☐ 50% ☐ 60% ☐ 66 2/3% of Basic Weekly Wages to a Benefit Maximum of $		
Flat Benefit: ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 not to exceed 66 2/3% of Basic Weekly Wages		
Class Defined Plan: Complete STD amount in Section I		
Benefits Begin:	Due to an Accident: (select one)	Due to Sickness: (select one)
	☐ 1st day ☐ 8th day ☐ 15th day ☐ 31st day	☐ 8th day ☐ 15th day ☐ 31st day
Maximum Weekly Benefit Duration: ☐ 13 weeks ☐ 26 weeks		
Rates: ☐ Step-Rated ☐ Composite Rated (Include a copy of the rating exhibit if rated in the field)		
Employer Contribution: ☐ 100% ☐ Other % (Minimum 25% Employer contribution required)		
STD is ☐ in addition to, or ☐ replacement of current STD coverage ☐ no current STD carrier		
If replacement, give current carrier:	Termination date of prior plan:	
STD benefits are payable for non-occupational disabilities only.	STD benefits terminate at retirement.	

The undersigned represents he/she is an Employer engaged in *(groups with 2 to 9 employees must check ✓one):*

☐ Wholesale, Retail, or Distribution Business; or ☐ Service Business; or ☐ Manufacturing Business

The Employer agrees to comply with all terms and provisions of the Group Life and/or Disability Contracts(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Dearborn National trust policy(ies), if applicable. The Employer further agrees to comply with the following requirements:

1. For Life and STD, if coverage is contributory, a minimum of 75% of the eligible employees must enroll. If coverage is non-contributory, 100% of the eligible employees must enroll.
2. Group term life, for groups with less than ten (10) eligible employees, may be sold on a contributory basis, however, in no event may the contribution by the insured employee exceed forty cents ($0.40) per thousand dollars of coverage per month.
3. STD may be sold on a contributory basis; however, the Employer must contribute a minimum of 25%. STD is available only if group term life and AD&D is selected.
4. Coverage for employees who are not actively at work, as defined in the policy, on the date their coverage would otherwise become effective will be deferred until the date they return to active work.
5. If life and AD&D benefits are selected by occupational class, there must be at least one eligible employee in each class, and no class may have a benefit greater than 2½ times the amount for the next lower class.
6. The Employer shall remit all required premium payments to Dearborn National no later than the first day of each billing period. If the premium payments are not received by Dearborn National, insurance for the Employer and all covered employees shall cease in accordance with the terms of the Policy.
7. The Employer shall provide eligibility and enrollment information, dates of employment, and all other data necessary for the efficient administration of the Dearborn National Life and/or Disability Insurance Plan.
8. Coverage for the Employer may be amended from time to time, and the Employer's participation may be terminated with 31 days written notice by Dearborn National in accordance with the terms of the Policy. Dearborn National reserves the right to change premium rates for reasons including, but not limited to, change in benefit design or Policy terms, change of industry, utilization within the industry, or other factors bearing on the assumed risk.
9. Dearborn National reserves the right to terminate the Employer's participation in the Life Insurance Plan if the Employer fails to maintain compliance with the requirements set forth herein.
10. Benefit amounts in excess of the guarantee issue and all late applications for contributory coverage are subject to satisfactory evidence of insurability. The Employer agrees not to collect any premium from employees on amounts for which satisfactory evidence of insurability is required until notified by Dearborn National of the approval of the employee's application for coverage.

EMPLOYER: DO NOT CANCEL CURRENT COVERAGE UNTIL NOTIFIED BY BCBSTX AND/OR DEARBORN NATIONAL THAT THIS EMPLOYER APPLICATION HAS BEEN APPROVED.

ELECTRONIC RECEIPT OF CERTIFICATE-BOOKLETS AND CONTRACTS

Electronic Issuance: The Employer consents to receive, via an electronic file or access to an electronic file, any Certificate Booklet provided by BCBSTX 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, amendment, or other revised form provided by BCBSTX, or to provide a paper copy of the same to an Employee upon request or to an HMO subscriber who has not agreed to accept the certificate of coverage electronically. The Employer is solely responsible and holds BCBSTX harmless from any misuse of the E-file provided by BCBSTX.

☐**Accept –** Employer consents to receive electronic versions of certificate-booklets for covered Employees. If accepted, please ensure that a valid email address is entered in the Email Address of Authorized Company Official field on page 1.

☐**Decline –** Employer does not consent to receive electronic versions of certificate-booklets for covered Employees or the Contract and desires BCBSTX to print and distribute hard copy versions.

I have read and understand this Employer's Application, and the producer, if any, named below is authorized to represent the Employer in the purchase of the Benefit Plan(s). This Employer Application is incorporated into and made a part of the Contract entered into and agreed upon by BCBSTX and the Employer. For HMO, the title of the contract is HMO Group Agreement. For non-HMO, the title of the contract is Group Administration Document. For dental, the title of the contract is Dental Group Administration Document.

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

I acknowledge that the producer(s) or agency(ies) named on the producer's Statement page is/are is acting on behalf of the Employer for purposes of purchasing Employer insurance, and that if BCBSTX/Dearborn National accept this Employer Application and issues a Group Contract/Policy/Agreement to the Employer, BCBSTX/Dearborn National may pay the producer(s)/agency(ies) a commission and/or other compensation in connection with the issuance of such Group Contract/Policy. The undersigned further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the producer(s)/agency(ies) by BCBSTX/Dearborn National in connection with the issuance of a Group Contract/Policy, they should contact the producer(s)/agency(ies).

I certify that all statements contained in this Employer Application and all information required to be furnished to BCBSTX/ Dearborn National are complete and true to the best of my knowledge and belief. I understand that BCBSTX/Dearborn National will rely on the statements made and information furnished, as the basis in determining the appropriate rate level and/or approval of this Employer Application. I understand that no insurance or changes will become effective without approval of BCBSTX/Dearborn National. The requested Contract(s)/Policy(ies) effective date (as listed on page 1) is subject to change by BCBSTX/Dearborn National if all required documents are not completed and received by the date requested. If documents are not received by the date requested, the Employer will be required to complete a new Employer Application.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans: Employer shall provide BCBSTX with written notice prior to renewal (and during the plan year, at least 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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX 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 Employer represents and warrants that such Form is true, complete and accurate. If Employer fails to timely provide BCBSTX with any requested grandfathered health plan information, BCBSTX 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 Employer 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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Religious Employer Exemption or Eligible Organization Accommodation: Although federal regulations describe a limited exemption for certain group health plans from the Affordable Care Act requirement to cover contraceptive services under guidelines supported by the Health Resources and Services Administration (HRSA), your insurance Policy must comply with applicable state requirements regarding contraceptive coverage. Accordingly, your Policy currently includes coverage for contraceptives consistent with the state and federal coverage requirements and applicable exemptions. Some contraceptives may be covered without cost to the employee."

D. Policyholder will provide BCBSTX with immediate written notice in the event Employer and/or any of the entities referenced above no longer qualify for the religious employer exemption and/or eligible organization accommodation (as they may be amended, replaced or superseded from time to time). Employer shall indemnify and hold harmless BCBSTX 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 BCBSTX in connection with (a) any plan's exempt status, (b) religious employer exemption and/or eligible organization accommodation, (c) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder, and/or (d) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

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

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

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

In addition, ACA Section 1341 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish a flat per member per month fee. The temporary reinsurance programs funded by these Reinsurance Fees 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. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSTX 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 BCBSTX 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).

For Employer:

Name of Authorized Company Official (please print) **Title**

Signature of Authorized Company Official **City and State of signing official**

Date

PRODUCER'S STATEMENT
TO BE COMPLETED BY PRODUCER(S) - PLEASE PRINT

PRODUCER'S

I certify that I have reviewed all enrollment materials and I have advised the Employer not to terminate any existing coverage(s) until receiving notice that BCBSTX/Dearborn National have accepted and approved this Employer Application. I have advised the Employer of its rights as a small group employer to purchase the **HMO** Blue Advantage Benefits Plans. I have also advised the Employer that I have no authority to bind these coverages, to alter the terms of the Contract(s)/Policy(ies), this Employer Application, or enrollment material in any manner or to adjust any claims for benefits under the Contract(s)/Policy(ies).

Writing **Producer's** name (please print) _____ E-Mail Address _____

_____ _____ _____ _____

Writing **Producer's** signature **Producer** # Date Telephone #

_____ _____

BCBSTX Sales Representative Date

1. Primary **Producer's** or Agency Name* (to whom commissions are to be paid): _____

   (Please also use 2. below, for split commissions)
   Percentage of Split**:_____
   Complete Address: _____

   Tax ID/SSN: _____ **Producer** #:_____ FAX number: _____

   Name and phone # of agent to contact for this case: _____
   Contact's E-mail address (please print clearly): _____

2. **Producer's** or Agency Name* (if commissions are to be split): _____
   Percentage of Split**:_____
   Street, City, ZIP: _____
   Tax ID/SSN: _____ **Producer** #:_____ FAX number: _____
   Contact's E-Mail address (please print clearly): _____

3. General Agent Name (if applicable): Centerstone Financial dba BenefitMall
   Street, City, ZIP: 4851 LBJ Freeway, Suite 100, Dallas, TX 75244
   Tax ID/SSN: 95-4018229 **Producer** #: 008009274 FAX number: _____
   Contact name and telephone number for this case: _____
   Contact's E-Mail address (please print clearly): _____

   General Agent's Signature: _____

* The **Producer** or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

If commissions are to be split, please provide the information requested above on both **Producers or agencies. **Both Producers** or agencies must be appointed to do business with BCBSTX and/or Dearborn National and total commissions paid must equal 100%.

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No.: _____ 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 Texas

TEXAS DEPARTMENT OF INSURANCE
REQUIRED DISCLOSURE NOTICE FOR ALL GROUP HMO CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Health Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or excluded completely from the plan.

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
Copayments Section 11.506(2)(A), Subchapter F, Title 28 Texas Insurance Code: A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrolled in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee.	For some services and supplies, this plan may include cost-sharing that exceeds the limits imposed by the mandated.	
Deductibles Section 11.506(2)(B), Subchapter F, Title 28 Texas Insurance Code: A deductible shall be for specific dollar amount of the cost of the basic, limited or single health care service. An HMO shall charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.	Deductibles may apply to some services provided by HMO Participating Providers in the HMO service area. Deductibles may apply to Professional Services, Inpatient Hospital Services, Outpatient Facility Services, Outpatient Lab and X-Ray Services, Rehabilitation Services, Maternity Care and Family Planning, Behavioral Health Services, Emergency and Ambulance Services, Extended Care Services, some Preventive Care Services, Dental Surgical Procedures, Cosmetic, Reconstructive or Plastic Surgery, Allergy Care, Diabetes Care, Prosthetic Appliances, Orthotic Devices, Durable Medical Equipment, Hearing Aids and Prescription Drugs.	
Coverage for Telehealth and Telemedicine Services: Chapter 1455 (b), Texas Insurance Code		Not Covered
Coverage for therapies for children with developmental delays: Subchapter E, Texas Insurance Code Chapter 1367		Not Covered

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
Limitations Section 11.508 (d) Subchapter F, Title 28 Texas Insurance Code: A state-mandated health benefit plan defined in §11.2(b) of this title (relating to Definitions) shall provide coverage for the basic health care services as described in subsection (a) of this section, as well as all state-mandated benefits as described in §§21.3516 - 21.3518 of this title (relating to State-mandated Health Benefits in Individual HMO Plans, State-mandated Health Benefits in Small Employer HMO Plans, and State-mandated Health Benefits in Large Employer HMO Plans), and must provide the services without limitation as to time and cost, other than those limitations specifically prescribed in this subchapter.	Benefit limits will apply to coverage for Home Health Services. Benefit limits will also apply to Rehabilitation Services except for treatment of Acquired Brain Injury and Autism Spectrum Disorder.	

This HMO Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments or annual or lifetime benefit amounts that differ from other HMO plans. I understand that I may obtain addition information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html, or by calling 1-800-252-3439.

_____ _____

Signature of Applicant **Name of Applicant (print name)**

_____

Name of Business (if applicable)

_____

Address

_____ _____ _____

City **State** **Zip**

_____

Date

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure free of charge.** A new form must be completed upon each subsequent renewal of this policy.

BlueCross BlueShield of Texas

An Independent Licensee of the Blue Cross and Blue Shield Association

TEXAS SUPPLEMENTAL EMPLOYMENT VERIFICATION

To be used with the TWC Report

Employer's Name	SIC Code	Group Policy Number

Address	City	State	Zip

EMPLOYEE CENSUS INFORMATION

Under our Small Group Employer products, BCBSTX verifies employment information. **We require the submission of a current TWC Report.** The TWC Report is used to verify the SIC Code applicable to your company and to assist us in verifying employment. Please utilize the status codes listed below to denote the employment status of all employees listed on your TWC Report. Employees who are not indicated on the TWC Report should be reported using this Supplemental Employment Verification Form. All full-time employees must complete a BestChoice Application indicating (1) they are requesting coverage or (2) they are declining coverage. Applications for individuals requesting coverage cannot be processed without verification of employment. If this information is missing, the effective date of coverage may be delayed.

STATUS CODES

Please use the appropriate code indicating applicable status of the person listed on the TWC Report or this form:

F	Full-time employee who works 30 or more hours per week
P	Part-time employee who works less than 30 hours per week
I	Independent contractor working 30 or more hours per week
O	Owners, Partners and Officers who work 30 or more hours per week
D	Totally disabled employee
C	Continued employee under State or Federal law
T	Terminated employee no longer employed by the company
W	Full-time employees in Waiting Period

EMPLOYEES NOT LISTED ON THE TWC REPORT

Please list the following persons employed by you:

- New employees who do not appear on your TWC Report and work a minimum of 30 hours per week
- Owners, Partners and Officers who work a minimum of 30 hours per week
- Independent contractors who work a minimum of 30 hours per week
  (List only if offering coverage. It is not necessary for you to offer coverage to Independent Contractors; however, you must offer coverage to all Independent Contractors who work for you if you wish to cover any Independent Contractors.)
- Other
  (Please define employees who fall into this category so BCBSTX may determine if they are eligible for coverage.)

These Persons Must Be Listed Even If They Decline Coverage

	NAME	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK	STATUS CODE	APPLYING FOR COVERAGE (YES) DECLINING COVERAGE (NO) ATTACH APPLICATION
1					☐ Yes ☐ No
2					☐ Yes ☐ No
3					☐ Yes ☐ No
4					☐ Yes ☐ No
5					☐ Yes ☐ No
6					☐ Yes ☐ No
7					☐ Yes ☐ No
8					☐ Yes ☐ No
9					☐ Yes ☐ No
10					☐ Yes ☐ No
11					☐ Yes ☐ No
12					☐ Yes ☐ No
13					☐ Yes ☐ No
14					☐ Yes ☐ No
15					☐ Yes ☐ No
16					☐ Yes ☐ No
17					☐ Yes ☐ No
18					☐ Yes ☐ No
19					☐ Yes ☐ No
20					☐ Yes ☐ No
21					☐ Yes ☐ No
22					☐ Yes ☐ No
23					☐ Yes ☐ No
24					☐ Yes ☐ No
25					☐ Yes ☐ No

I HEREBY CERTIFY I HAVE READ THIS DOCUMENT AND THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE. I ALSO CERTIFY THE INFORMATION PROVIDED HERE CAN BE SUBSTANTIATED BY BUSINESS RECORDS MAINTAINED BY ME. UPON REQUEST, I AGREE TO PROVIDE THE DOCUMENTATION REQUESTED BY BCBSTX VERIFYING PARTICIPATION AND ELIGIBILITY REQUIREMENTS. I UNDERSTAND PROVIDING INCOMPLETE, INACCURATE, OR UNTIMELY INFORMATION MAY VOID, REDUCE OR TERMINATE THE GROUPS COVERAGE.

Signature of Authorized Company Official _____ Title _____ Date _____

Print Name of Authorized Company Official _____

Signature of Agent _____

BCBSTX does reserve the right to randomly request documents verifying the above information. In addition, we reserve the right to reverify employment information at any time during the course of your contract with us.

EMPLOYER GROUP INFORMATION

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

BlueCross BlueShield of Texas

SECTION A

Employer Name _____ Employer Tax ID # _____

Account # (renewal 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 972-664-0907; sbsc_changes@bcbstx.com. A response is required for every question. For help in completing this section, refer to the *Instructions – Completing the MSP Employer Acknowledgement* located at the end of this document.**

New BCBSTX 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 BCBSTX clients please check the applicable box:	☐ Submitting this form at renewal ☐ 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. Please use the year of your upcoming renewal as 'current year' when answering the following questions. For example, if your upcoming renewal is effective July 1, 2013, base your current year answers on 2013. Or, if your upcoming renewal is effective January 1, 2014, base your current year answers on 2014. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee **current year** count. Understand that you are obligated to notify BCBSTX if and when your status changes. **Please indicate the current calendar year for which the form is being completed:**		Current year	
1. In the year immediately prior to the current calendar year, did you file a separate federal tax return that is not consolidated with another individual or entity? If you are not required to file a federal tax return, please check N/A	☐ N/A	☐ Yes	☐ No
2. How many employees did all the entities on the preceding calendar year's tax return have on the payroll (whether full-time, part-time, seasonal, or partners) during the preceding calendar year? Enter number of employees.		_____ (# of employees)	
3. Are you part of a multi-employer group health plan? The term "multi-employer group health plan" means any trust, plan, association or any other arrangement made by one or more employers or by employers and unions to offer, contribute to, sponsor, or directly provide health benefits. Questions 5 and 7 must also be completed.		☐ Yes	☐ No
4. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ Check 'Yes' or 'No' for both the current and preceding calendar years	Current Year (see above)	☐ Yes	☐ No
☐ 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 BCBSTX by completing a new MSP Employer Acknowledgement, checking this box and entering the date the threshold was met in the space above.	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?	Current Year (see above)	☐ Yes	☐ No
⇨ 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	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**
			☐ Health ☐ Dental
			☐ Health ☐ Dental
			☐ Health ☐ Dental

It is your responsibility to annually inform BCBSTX of whether COBRA is applicable to you based upon your full and part-time employee count in the prior calendar year. Failure to advise BCBSTX 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**
			☐ Health ☐ Dental
			☐ Health ☐ Dental
			☐ 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**
			☐ Health ☐ Dental
			☐ Health ☐ Dental
			☐ Health ☐ Dental

SECTION D – For ACA-MLR Purposes Only

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____ _____ _____

Employer or Authorized Purchaser Signature and Title Date

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 Texas (BCBSTX), 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 BCBSTX 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 BCBSTX 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 BCBSTX 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 Texas

Reference Guide to Composite Billing (Two to 50 Employees)

For December 2015 Accounts

Background

Effective Dec. 1, 2015, premium rates for all Blue Cross and Blue Shield of Texas (BCBSTX) small group (2-50) metallic plans (medical and dental) will include two billing options:

- Individual age billing
- NEW! Composite billing

Premium rates for composite billed metallic plans are tiered by subscriber participation:

- EO – Employee Only
- ES – Employee +Spouse
- EC – Employee +Child(ren)
- EF – Employee +Family (Spouse with children)

Availability

Composite billing is only available for accounts that select metallic benefit plan options.

To select composite billing, accounts MUST complete and submit the *Composite Rate Billing Method Declaration Form* to BCBSTX. If the form is not submitted, age billing will apply.

PLEASE NOTE: Upon acceptance of composite rates, an account's billing method cannot be changed until the account's next renewal. No exceptions.

IMPORTANT: Billing Rules

1. Composite billing will be effective for 12 months.
2. Only one billing selection is allowed per account.
3. Accounts may not select a combination of plans with age billing AND composite billing (excluding pediatric dental plans that will continue to be age-rated for December renewals).
4. For existing accounts, composite billing is only available at the time of the account's renewal.
5. If an account selects composite billing for their medical plan, composite billing would also be applied to the account's dental plan (if applicable).

BlueCross BlueShield of Texas

Paperwork and Submission Requirements

- New Business
  - If new enrolling accounts want to elect the composite billing option, the *Composite Rate Billing Method Declaration Form* will be required. The form should be submitted along with other documents for new enrolling accounts such as the *Small Employer Benefit Program Application*. For new accounts, the account number field may remain blank on the *Composite Rate Billing Method Declaration Form*.
  - Please submit New Business paperwork to: Small Business Service Center, 12th Floor, Bldg B, 1001 E. Lookout Dr., Richardson, TX 75082
  - New business paperwork should be submitted at least two weeks prior to the requested effective date. We cannot accept the *Composite Rate Billing Method Declaration Form* unless it is submitted at the same time as the Small Employer Benefit Program Application.

- Existing Business
  - If an existing account selects composite billing and has NO plan changes, the *Composite Rate Billing Method Declaration Form* is the only required document to complete and submit to sbscamend@bcbstx.com or fax to (972) 231-6931.
  - If the account selects composite billing with plan changes, the *Composite Rate Billing Method Declaration Form* AND the *Benefit Program Application for Amendment* are required to be submitted to sbscamend@bcbstx.com or faxed to (972) 231-6931.
  - If a *Composite Rate Billing Method Declaration Form* is submitted, all fields on the form must be completed. Incomplete forms will be returned and processing delays may occur.
  - Renewing business paperwork must be submitted at least 45 days in advance of the groups December renewal date.

Questions

Questions related to the NEW Composite Rate Billing Method for Affordable Care Act/metallic plans, should be directed to your BCBSTX Small Group Account Management Unit.

BlueCross BlueShield of Texas

Composite Rate Billing Method Declaration Form

For New and Existing Fully Insured Accounts with Two to 50 Employees

Effective Dec. 1, 2015, premium rates for all Affordable Care Act/metallic plans (including medical and dental plans) will include the option for accounts to view and be billed with a four-tier composite rate structure (Employee, Employee + Spouse, Employee + Child(ren) and Family).

For more information regarding composite rating please contact your broker or the Blue Cross and Blue Shield of Texas Small Group Account Management Unit at 877-239-5582.

To ensure timely processing, all fields must be completed by an authorized representative of the account.

If this form is not returned within the timeframes identified within the *Reference Guide to Composite Rating*, the account will be billed as age rated.

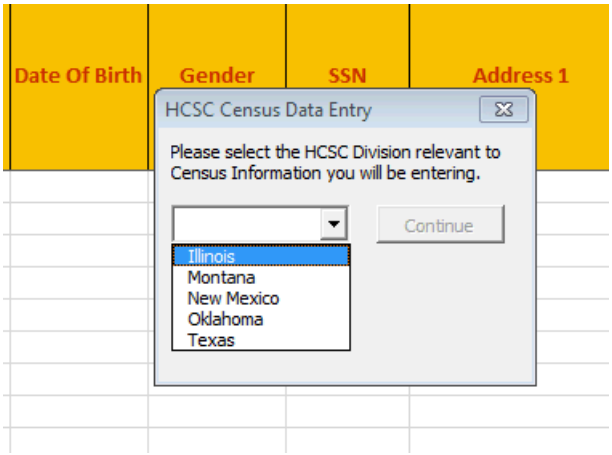
By completing and signing this form, the employer elects to utilize composite rate methodology for billing purposes for all group benefit plans, effective on the group's anniversary date.

The employer understands that the selection of composite rates will be effective until the time of the account's next renewal. <u>The billing method can only be changed at the time of the account's anniversary/renewal date.</u>

Company Name	
Account Number **(Not applicable for new business.)**	
Authorized Employer Representative **(Please print.)**	
Signature	
Date	
Title	

Census Import File Instructions

Steps:
1. Save file on your local drive
2. When you open file it asks your region



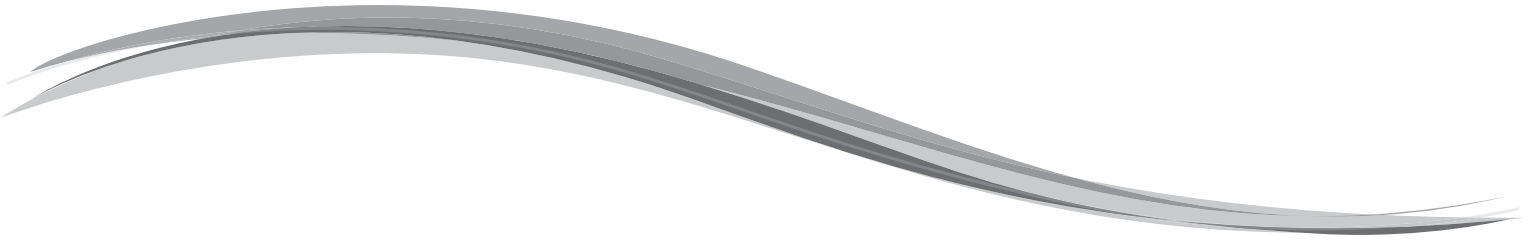
3. Select the region, and click on continue , it will ask where to save it, please DO NOT give a file name only select a folder location and click "ok."

VERY IMPORTANT NOTE: The import file will not load into eSales if the file extension name is changed. The extension must be .xlsm
e.g. : "Census Import Illinois 2015-07-14.xlsm"

4. Now you can use this file for data entry and importing.

- ◊ Each time you open the template, a new template will open. "Save" will not override the information. You must "Save As" and give the template a new name to make a copy of the template which can be edited and saved separately for each group. Be sure to keep the file extension .xlsm.
- ◊ If macros are not enabled when the template is opened, a yellow message box will appear notifying users that macros must be enabled. Click the **"enable content"** button at the top.
- ◊ Once the document is opened, select the "Division" and hit continue. It is suggested that you "Save As" at this time and name your spreadsheet to identify the group and state.
- ◊ Validation rules have been put in place to make the template user friendly, and are State specific. It is important to use the correct template for your state to avoid data entry issues.
- ◊ When the document is saved without the appropriate fields populated, the fields will highlight yellow indicating cells where information is required. There are also validation rules in those cells to assist users with entering correct information in the acceptable format.
- ◊ The Employee section of the template which is shaded in orange is mandatory. All other fields are grouped together by shaded colors. Red fonts are used to indicate conditional mandatory information is required based on previous entries.

Enrollment Application/Change Form



BlueCross BlueShield of Texas

Dearborn National®*

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

728117.0814

ENROLLMENT APPLICATION /CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION / CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

Please Note: If your group offers a Consumer Choice health plan you have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage (Certificate of Coverage).

SECTION 1

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all Sections where applicable.

Add Dependent: Complete all Sections where applicable.

- If you are enrolling a court-ordered dependent for coverage beyond the automatic 31 day period for coverage, you must submit a copy of the court order or decree.
- If student dependent coverage is part of your employer's plan and you are adding or enrolling a dependent child age 26 or over who is a student, you may be required to submit a completed Student Certification form.
- If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 6. Additional documentation may be required as addressed in that section.

Cancel Enrollee: Complete Sections 1, 2, 4, and 10. In Section 4 include name, social security number, and date of birth of individual(s) cancelling.

Cancel Dependent: Complete Sections 1, 2, 4, and 10. In Section 4 include name and date of birth of individual(s) cancelling.

Declining Coverage: Complete Sections 2, 9, and 10.

SECTIONS 2 & 3

Complete all portions related to the coverages for which you are applying.

If you work for an employer with 2-50 employees: Please list the seven-character plan ID for your selected benefit design (example: B634ADT) in the Plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.

SECTION 4

Complete all areas that apply to you and each dependent.

For HMO and POS only: Those applying for HMO or POS coverage should select a PCP for each individual to be covered. List the name of the physician and the provider number from the provider directory or Provider Finder at **www.bcbstx.com**. Be sure to check the appropriate box for a new patient.

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of an OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, for HMO members, the OB/GYN from whom you receive services must belong to the same physician practice group or independent practice association (IPA) as your PCP. This is another reason to make certain that your PCP's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Change Primary Care Physician (PCP): In Section 1, check the "Other Change(s)" box, then complete sections 2, 3, 4, and 10. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.

Change Address / Name: In Section 1, check the "Other Change(s)" box, then complete sections 1, 2, and 10.

SECTION 5

Complete this section if your employer is offering life insurance coverage.

SECTION 6

Complete this section if you are applying for coverage for a disabled dependent child over the dependent child age limit of your employer's plan. A disabled dependent must be certified by medical underwriting and a completed Dependent Child's Statement of Disability form must be submitted with this enrollment application.

SECTION 7

Complete this section if you or any dependent have other health care coverage through an employer (group coverage) that will not be cancelled when the coverage under this application becomes effective.

SECTION 8

Complete this section if you or any of your dependents are covered by Medicare.

SECTION 9

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 9, not just those declining because of other coverage.

IMPORTANT NOTICE – DECLINATION OF HEALTH COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, becoming a party in a suit for adoption, or placement in your home as a foster child, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption, or placement of an eligible foster child in your home.

SECTION 10

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form to: **Group Accounts Dept. • P. O. Box 655730 • Dallas, TX 75265-5730**

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

Forms referenced above may be obtained by accessing the BCBSTX website at www.bcbstx.com, from your Marketing Service Representative, or from your employer. If you have any questions, please contact your Marketing Service Representative.

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas   Dearborn National

Group No. | Section No. | Dept No. | Social Security No.
Group No. | Section No. | Dept No. | Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 9, & 10 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Change(s)**

Are you applying as a result of a Special Enrollment Event?

☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ Marriage ☐ Birth
☐ Adoption or Suit for Adoption (Provide Legal Documents)
☐ Court Order (Provide Court Order or decree)
☐ Loss of Other Coverage
☐ Other (Explain): ____________________

Effective Date of Benefits: ____ / ____ / ____

NOTE: Declination of Coverage (Complete Sections 2, 9, & 10)

Add Coverage:
☐ Health
☐ Dental
☐ Term Life
☐ Dependent Life
☐ Short Term Disability (STD)
☐ Long Term Disability (LTD)

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

Cancel Coverage: ☐ Health ☐ Dental ☐ Term Life ☐ Dependent Life ☐ STD ☐ LTD

List names of those cancelling in Section 4 below

Event: ☐ Divorce ☐ Death ☐ Terminated Employment ☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security No.
					– –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? ☐ Yes ☐ No

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ____________ ☐ COBRA Continuation
☐ State Continuation of Group Coverage (insured plans only) ☐ Dependent State Continuation of Group Coverage (insured plans only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 employees)

Health Coverage (select one)	**Who is covered? (select one)**	**BlueCare Dental Coverage**	**Who is covered? (select one)**
☐ BlueChoice PPO℠ ☐ BlueAdvantage HMO℠ 7-character Plan # (required) ____________	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Dental coverage

Large Group Plans (more than 50 Employees)

Health Coverage (select one)	**Who is covered? (select one)**	**Dental Coverage**	**Who is covered? (select one)**
☐ BlueChoice PPO℠ ☐ EPO ☐ BlueEdge HCA℠ ☐ HMOBlue® Texas ☐ BlueEdge HSA℠ ☐ [BlueAdvantage HMO] ☐ [BlueOptions℠] ☐ [Community HMO] ☐ Other ____________ Plan # ____________	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No Plan # (required) ____________	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Dental coverage

Primary Language: ____________ ☐ Check here to request a Spanish HMO Member Handbook
Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No
If "Yes", describe special communication materials needed: ____________

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO OR POS ONLY

Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No.	Birth Date (MM/DD/YYYY)	Address (if different) - No. and Street Address	City	State	Zip
– –					

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No.	Dependent's PCP Name	PCP No.	New Patient?
	– –			☐ Y ☐ N

Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption?	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent?
		☐ Y ☐ N	☐ Y ☐ N

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No.	Dependent's PCP Name	PCP No.	New Patient?
	– –			☐ Y ☐ N

Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption?	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent?
		☐ Y ☐ N	☐ Y ☐ N

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No.	Dependent's PCP Name	PCP No.	New Patient?
	– –			☐ Y ☐ N

Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption?	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent?
		☐ Y ☐ N	☐ Y ☐ N

Last Name: Social Security No.: ___ — ___ — ____ Group # ☐☐☐☐☐☐☐

SECTION 5 — GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES

Employee Occupation/Job Title: _____ Wage Rate $_____ per ☐ hour ☐ week ☐ month ☐ year

Group Basic Term Life & AD&D	☐ I do not apply	☐ I do apply	Amount $_____
Group Dependents' Life	☐ I do not apply	☐ I do apply	
Group Supplemental Life Employee Election: $_____	☐ I do not apply Spouse Election: $_____	☐ I do apply	Child Election: $_____
Short Term Disability (STD)	☐ I do not apply	☐ I do apply	
Long Term Disability (LTD)	☐ I do not apply	☐ I do apply	

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security No.
Primary Beneficiary						– –
Contingent Beneficiary						– –

SECTION 6 — DISABLED DEPENDENT

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form.

SECTION 7 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered:**

Group Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 9 — DECLINATION OF COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for Declining Health: ☐ Other Group Health Coverage; Carrier: _____ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage; Carrier: _____ ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Employee	Reason for Declining Dental: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Dental insurance plan, but do not want this coverage.
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.

SECTION 10 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Dearborn National® Life Insurance Company. On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). As applies to HMO coverage, I will accept an electronic copy of my coverage documents (whether certificate of coverage or benefit booklet) if my Employer requests that BCBSTX deliver the information electronically. I understand that a hard copy is available to me upon request.
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.
- I understand that written communications that are required by law may be delivered to me electronically, with my consent. I understand that if I consent to receiving my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

Applicant's Signature _____ Date _____