BlueCross BlueShield of Texas

Dearborn National™ *

Health No._____
Life No._____

SMALL GROUP EMPLOYER APPLICATION

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).

(See page 3, Consumer Choice Plans, for available plan options and page 9 for the Disclosure Statement that applies to these plans.)

Legal Name of Company:	Nature of Business:	SIC/ Code:
Physical Address (number & street), City, State, ZIP:		Telephone Number:
E-Mail Address of Authorized Company Official: 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 is the employee of the account authorized by the Employer to access and maintain its account via BAE.

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

Will you have been uninsured for at least 2 months prior to the requested Effective Date of this coverage? ☐ Yes ☐ No

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 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. Waiting Period: Newly eligible individuals will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period selected: ☐ 0 days ☐ 30 days ☐60 days ☐ 90 days
   Waive the Waiting Period on initial group enrollment? ☐Yes ☐ No
   Number of employees serving Waiting Period: _____
   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, if any.
2. Total number of 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

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

5. Are you a public entity group? ☐ Yes ☐ No
   A public entity is a State, any of its counties, departments, agencies, independent school districts, or other political subdivisions.

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

7. If you currently have group health care coverage with another carrier, complete the following:
   a. Present health carrier's name: _____
   b. Paid-to-date with current carrier: _____/ _____/_____
      Month Day Year
   c. Calendar year medical deductible amount with current carrier: Individual: _____ Family: _____

BCBSTX GROUP PLANS COMPLY WITH THE FEDERAL REQUIREMENTS FOR COVERAGE OF MATERNITY CARE. EMPLOYER PENALTIES FOR NONCOMPLIANCE MAY APPLY.

Please check the one option below that applies to your company in regards to maternity care.

a. ☐ We are selecting a MOP, HMO (only), Triple Option Plan, or Consumer Choice HMO (only) plan. We understand maternity care is automatically included in the coverage for these small group employer plans.

b. ☐ We are selecting a PPO or Consumer Choice PPO plan and have 15 or more full or part-time employees. We understand maternity care is automatically included in the coverage as required by federal law.

c. ☐ We are selecting a PPO or Consumer Choice PPO plan and have less than 15 full or part-time employees. We have indicated below whether we would like to accept or decline maternity coverage.
   (Do not complete the checkboxes below if you selected option (a) or (b) above.)
   ☐ Accept Maternity Coverage ☐ Decline Maternity Coverage

MENTAL HEALTH PARITY AND ADDICTION EQUITY (MHPAE) ACT OF 2008

Under federal law, it is the employer's responsibility to provide its insurer with proper employee counts for the purpose of determining whether the employer meets the federal definition of small employer and, therefore, qualifies for the small employer exemption allowed under this law.

Small Employer Defined: The MHPAE Act defines a small employer as an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year.

Employers Not in Existence in Preceding Year: The determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

Predecessors: Any reference to an employer shall include a reference to any predecessor of such employer.

If you answer "yes" to the following question, you do not qualify for the small employer exemption allowed under the law and benefits for mental health care, serious mental illness, and treatment of chemical dependency will be paid same as any other medical-surgical benefits under the HMO and/or PPO benefit plan selected.

****

Did you have an average of more than 50 (full-time, part-time, seasonal, or partners) total employees for each working day in the calendar year preceding the effective date of this coverage? ☐ Yes ☐ No

****

Financial penalties for non-compliance may apply.

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Application is hereby made to Blue Cross and Blue Shield of Texas (herein called BCBSTX):

BESTCHOICE® PREFERRED PROVIDER (PPO):	**HMO:** (100% of eligible employees must reside or work in the service area. The HMO Blue Texas service area does not include all counties in Texas.)
PPO plan selected: _____ **Dual PPO plans selected:** Plan #1 _____ Plan #2 _____ BlueEdge® HSA/HDHP* selected: _____ If BlueEdge HSA/HDHP is selected, provide name of HSA administrator/trustee: _____ BlueEdge Wellness Rewards HCA plan selected: _____	HMO Blue plan selected: _____ (HMO plans R9 and R11-R19 are available)

MULTIPLE OPTION PLAN (MOP)

BestChoice PPO plan selected: _____ HMO Blue plan selected: _____
(HMO plans R9 and R11-R19 are available)

BlueEdge® HSA/HDHP plan selected: _____
If BlueEdge HSA/HDHP is selected, provide name of HSA administrator/trustee: _____
BlueEdge HCA plan selected: _____

Serious Mental Illness, Speech and Hearing Services, and In Vitro elections must be the same for PPO or BlueEdge Plans and HMO Plans.

TRIPLE OPTION PLAN

Plan #1 _____ Plan #2 _____ Plan #3 _____

Three HSA plans and/or HCA plans are allowed.

One of the following is required: an HSA plan, an HCA plan, RS32, RS33, or RS34. Only one HMO plan is allowed.
. Serious Mental Illness, Speech and Hearing Services, and In Vitro elections must be the same for PPO or BlueEdge Plans and HMO Plans.

Was a 100% contribution plan selected?
☐ Yes – If yes, Employer confirms that 100% contribution is being paid toward the Employee Only premium
☐ No – If no, Employer confirms that a minimum of 50% contribution is being paid toward the Employee only premium

PPO or BlueEdge Plans	**HMO**
The following mandated benefit offers are made by BCBSTX in compliance with Texas and federal regulations. Please mark your acceptance or declination. Acceptance may result in a rate adjustment.	
Serious Mental Illness (SMI) – (must choose only one) ☐ Accept – Inpatient days limited to 45 ☐ Decline – If declined, benefits for SMI are included in the benefits for Mental Health Care ☐ Public entities must cover SMI same as any other illness ☐ MHPAE Act applies (refer to MHPAE Act text box)	**Serious Mental Illness (SMI) –** (must choose one) ☐ Accept – Inpatient days limited to 45 (unlimited if MHPAE Act Applies) ☐ Decline – If declined, benefits for SMI are included in the benefits for Outpatient Mental Health Care ☐ Public entities must cover SMI same as any other illness
In Vitro Fertilization Services – (must choose one) ☐ Accept – Outpatient benefits are paid same as any other medical-surgical expense ☐ Decline – If declined, no benefits are available	**In Vitro Fertilization Services –** (must choose one) ☐ Accept – Limited Benefits available ☐ Decline – If declined, no benefits are available
Speech and Hearing Services – (must choose one) ☐ Accept – Benefits are paid same as any other illness ☐ Decline – If declined, speech and hearing services covered same as any other illness; hearing aid benefit is limited to $1,000 max every 36 months	**Speech and Hearing Services –** (must choose one) ☐ Accept – Benefits are paid same as any other illness ☐ Decline – If declined, medically necessary speech therapy is covered on an outpatient basis only; limited hearing. Hearing aids are covered under a DME additional benefit option only
Home Health Care – 60 visits each Calendar Year are included in all benefit plans with no rate impact	**Additional Benefit Options** Inpatient Mental Health (IPMH): ☐ IM1 ☐ IM2 Inpatient Mental Health (IPMH) if MHPAE Act applies: ☐ IM4 Vision: ☐ IC ☐ O2 Durable Medical Equipment (DME): ☐ DM1 ☐ DM2

CONSUMER CHOICE PLANS

(These options are offered in place of PPO-only, HMO-only, MOP, or Triple Option Plan)

☐ Consumer Choice PPO coverage
☐ Consumer Choice HMO coverage
☐ Pharmacy Benefits Option 99 (20/35/50)

*If a Consumer Choice Plan is accepted, please sign **Disclosure Statement** on page 9.*

DENTAL BENEFIT PLANS

Dental Benefit Plan selected: _____ Dual Option Dental Benefit Plans selected: Plan #1 _____ Plan #2 _____

* Health Savings Account (HSA) - High Deductible Health Plan (HDHP) – Health Care Account (HCA)

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SMALL GROUP EMPLOYER MEDICAL QUESTIONNAIRE

Complete the following questions to the best of your knowledge for eligible employees, their dependents, and any COBRA participants, state continuation participants, or state dependent continuation participants. If your current carrier is BCBSTX, your response to the medical questions should be based on eligible employees and/or dependents not currently on your employee group health plan. If BCBSTX is your current carrier, provide your Group/Account Health Number: _____

1. How many employees or dependents have had a claim of $5000 or more in the past 12 months? _____

2. How many employees or dependents have been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years? _____

3. How many employees or dependents have been advised, diagnosed, or treated by a physician in the past 5 years for:
(Enter the number of employees or dependents with the condition and provide details on the next page.)

A.	_____Stroke	_____Heart Disease or Disorder
	_____Circulatory Disease or Disorder	_____Vascular Disease or Disorder
	_____High Blood Pressure	
B.	_____Cancer	_____Tumors
	_____Leukemia	_____Lupus
	_____Chronic Skin Condition	_____Any other Systemic Disease
C.	_____Multiple Sclerosis	_____Paralysis
	_____Osteoarthritis	_____Other Severe Arthritis
	_____Joint Disorders	_____Back Disorders
	_____Muscle Disorders	_____Bone Disorders
D.	_____Asthma	_____Emphysema
	_____Respiratory and Lung Disorders	
E.	_____Diabetes	_____Pancreas
	_____Growth Disorder	_____Endocrine Disorder
F.	_____AIDS	_____Tested Positive for HIV
	_____Immune System Disorders	_____Blood Disorders
G.	_____Hepatitis	_____Liver Disorder
	_____Digestive System Disease or Disorder	_____Colon Disorder
	_____Kidney Disorder	_____Prostate Disorder
	_____Reproductive Organs Disorder	_____Infertility
	_____Urinary Tract Disorder	
H.	_____Nervous System/Brain/Seizure Disorders	_____Mental/Emotional Disorders
	_____Alcohol/Drug/Substance Abuse or Dependency	
I.	_____Organ Transplant	_____Bone Marrow Transplant
J.	_____Other	

4. How many employees or dependents are currently pregnant? _____

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If you have indicated medical conditions on the previous page, please provide details for each person with the condition. If more than one person has the condition, add a separate entry for each person. See the example in the first line.

Name of Person with Condition (Optional)	Age	Gender	Relation to Insured*	Condition/ Diagnosis Details	Treatment/ Medication Details	Date(s) Treated	Current Status
John Doe *"Example"*	42	M	Spouse	Appendicitis	Surgery to remove appendix	01/01/99 to 01/05/99	Full recovery

* Employee, Spouse, Child

I understand the information on this form and any other medical information provided to BCBSTX in prior preliminary medical requests or otherwise provided to BCBSTX, is the basis for premium determination by BCBSTX for the health plan. I acknowledge that any intentional misinterpretation of a material fact may result in legal consequences. I certify the information is complete and true to the best of my knowledge.

For Employer:

_____
Name of Authorized Company Official (print name)

_____
Signature of Authorized Company Official

For Agent:

_____
Name of Agent, if applicable (print name)

_____
Signature of Agent

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The Employer understands and agrees to comply with the following requirements regarding the Health Benefit Plan (Plan), inclusive of the Dental Benefit Plan, when Dental coverage is elected :

- Applications/Declinations are attached for all full-time employees as well as any COBRA or state participant continuations.
- Minimum Participation Requirement: A small employer must maintain enrollment of at least 75% participation of eligible employees under this Health Benefit Plan and 75% participation under the Dental Benefit Plan, when Dental coverage is elected.
- Employer Contribution: A small employer must contribute a minimum of 50% of the employee only premium for the Health Benefit Plan selected for all enrolled employees. Certain small employer Health Benefit Plans available require the employer to contribute 100% of the premium for each eligible participating employee. A small employer must contribute 50% of the employee only premium for the Dental Benefit Plan for all enrolled employees, when Dental coverage is elected.
- 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 and Dental Benefit Plan, when Dental coverage is elected, according to the terms and requests of BCBSTX.
- After approval by BCBSTX for the Health and/or Dental Benefit Plan 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.
- Appropriate credit for time served under a previous Health Benefit Plan will be applied toward the pre-existing condition waiting period for BestChoice preferred provider Health Benefit Plan(s). A pre-existing condition waiting period is not applicable for dependent children under age 19 and all other eligible individuals under age 19.
- 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 the Application and such shall serve as the basis to resolve any conflict. When issued, the Contract(s)/Policy(ies) will include this Application and any Addenda issued pursuant to this 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 Application and all enrollment materials must pre-date the requested effective date and be received by BCBSTX at its Home Office no later than the Contract/Policy effective date. (Applications may not pre-date the requested effective date by more than 45 days.)
- Retirees are not eligible for coverage under this Health Benefit Plan or under the Dental Benefit Plan, when Dental coverage is elected.
- 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.
- 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, public school districts, and "church plans" as defined by the Internal Revenue Code. Please provide your ERISA Plan Month/Year _____/_____

  If you contend ERISA is inapplicable to your health plan, please state the basis _____

  Please provide your Non-ERISA Plan Month/Year _____/_____

  For more information regarding ERISA, contact your Legal Advisor

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Application is hereby made to Fort Dearborn Life Insurance Company® (herein called FDL) 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:			

First 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 mos:	$
Employer Contribution: %	Child(ren) age 6 mos. 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.	

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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 FDL 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 FDL no later than the first day of each billing period. If the premium payments are not received by FDL, 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 FDL 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 FDL in accordance with the terms of the Policy. FDL 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. FDL 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 FDL of the approval of the employee's application for coverage.

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

***Additional Information:** Include list of COBRA and/or state continuation participants or state dependent continuation participants, anyone currently receiving Workers' Compensation benefits, and the names of any full-time employees NOT submitting an application/declination (give reason).

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ELECTRONIC RECEIPT OF CERTIFICATE-BOOKLETS AND CONTRACTS

The Employer consents to receive an electronic file (E-file) version of the certificate-booklets provided by BCBSTX for covered employees. The Employer also agrees to receive E-files of all documents that together constitute the contract between the Employer and BCBSTX (the "Contract"). In providing this consent, the Employer agrees to and/or understands that:

(1) the E-file certificate-booklet provided by BCBSTX is a certificate-booklet and is not intended to satisfy all ERISA compliance regulations as a summary plan description (SPD);

(2) the Employer is aware of the basic requirements established by Department of Labor regulations governing electronic distribution of coverage documents to employees;

(3) the Employer is solely responsible for providing each insured employee access to the most current version of any E-file certificate-booklet, amendment, or other revised employee 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;

(4) upon receipt, the Employer may receive paper copies of the Contract provided as an E-file;

(5) as modifications are made to existing forms or when new, revised forms are necessary, they will be received via an E-file and all provisions above will apply. The Employer will rely on BCBSTX instructions to determine if the file is a replacement or addition to existing documents and will provide the information to employees accordingly; and

(6) the Employer is solely responsible and holds BCBSTX harmless from any misuse of the E-file provided by BCBSTX; and

(7) the electronic transmission shall be in the format specified by BCBSTX, and if transmission errors occur, the Employer will contact BCBSTX immediately to request redirection of the information.

☐ **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.

DISCLOSURE STATEMENT

(Only sign and complete this section if a Consumer Choice Plan was selected)

I acknowledge this Consumer Choice of Benefit Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization Health Care Plan (Plan), 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 (Certificate of Coverage) in Texas.

I am aware this Plan may provide more affordable health benefits, although, it may provide fewer health benefits than those normally included in policies or evidences of coverage (Certificate of Coverage) with state mandated health benefits in Texas.

Excluded PPO State Mandates
1. Chemical Dependency
2. Prescription Contraceptive Drugs and Devices and Related Drugs (Oral Contraceptives not excluded)
3. In-Vitro Fertilization
4. Serious Mental Illness (non-public entities only)
5. Speech and Hearing (limited benefit)
6. Home Health (limited benefit)

Excluded HMO State Mandates
1. Chemical Dependency
2. Prescription Contraceptive Drugs and Devices and Related Drugs (Oral Contraceptives not excluded)
3. In-Vitro Fertilization
4. Serious Mental Illness (non-public entities only)
5. Speech and Hearing

For Employer:

_____ _____
Name of Authorized Company Official (print name) **Date**

_____
Signature of Authorized Company Official

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

TEFRA. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) is a Medicare secondary payer requirement that mandates employers that employ 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 to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. Are you subject to the Tax Equity and Fiscal Responsibility Act (TEFRA)? ☐ Yes ☐ No

COBRA.

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*: _____

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.

Are any employees currently receiving Workers' Compensation benefits? ☐ Yes ☐ No
If "yes", list names and conditions*: _____

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*: _____

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*: _____

I have read and understand this Employer's Application, and the agent, if any, named below is authorized to represent the Employer in the purchase of the Health Benefit Plan and/or the Dental Benefit Plan and/or Group Life Insurance Plan.

I acknowledge that the agent(s) or agency(ies) named on the Agent's Statement page (page 11) is/are is acting on behalf of the Employer for purposes of purchasing Employer insurance, and that if BCBSTX/FDL accept this Small Group Employer Application and issues a Group Contract/Policy to the Employer, BCBSTX/FDL may pay the agent(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 agent(s)/agency(ies) by BCBSTX/FDL in connection with the issuance of a Group Contract/Policy, they should contact the agent(s)/agency(ies).

I certify that all statements contained in this Small Group Employer Application and all information required to be furnished to BCBSTX/FDL are complete and true to the best of my knowledge and belief. I understand that BCBSTX/FDL will rely on the statements made and information furnished, as well as other medical information provided to BCBSTX/FDL from prior Preliminary Medical requests or otherwise provided to BCBSTX/FDL, as the basis in determining the appropriate rate level and/or approval of the Employer's Application. I understand that no insurance or changes will become effective without approval of BCBSTX/FDL. The requested Contract(s) /Policy(ies) effective date (as listed on page 1) is subject to change by BCBSTX/FDL 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 Small Group Employer's Application.

For Employer:

Authorized Company Official (please print) | **Title**

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

Date

*If needed, additional space is available on page 8

Health No._____
Life No._____

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

Agent's Statement

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/FDL have accepted and approved this Employer Application. I have advised the Employer of its rights as a small group employer to purchase one of the Consumer Choice of 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 Agent's name (please print) _____ E-Mail Address _____

_____ _____ _____ _____
Writing Agent's signature Agent # Date Telephone #

1. Primary Agent or Agency Name* (to whom commissions are to be paid): _____
   (Please also use 2. below, for split commissions)
   Percentage of Split**:_____
   Street, City, ZIP: _____
   Tax ID/SSN: _____ Agent #:_____ FAX number: _____
   Name and phone # of agent to contact for this case: _____
   Contact's E-mail address (please print clearly): _____

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

3. General Agent Name (if applicable): _____
   Street, City, ZIP: _____
   Tax ID/SSN: _____ Agent #:_____ FAX number: _____
   Contact name and telephone number for this case: _____
   Contact's E-Mail address (please print clearly): _____
   General Agent's Signature: _____

* The agent 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 agents or agencies. BOTH must be appointed to do business with BCBSTX and/or FDL.

BLUE CROSS AND BLUE SHIELD OF TEXAS (BCBSTX)
MEDICARE SECONDARY PAYER (MSP) EMPLOYER ACKNOWLEDGEMENT FORM (EAF)

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, the Center for Medicare and Medicaid Services (CMS) requires that the Employer's group health plan coverage be considered primary to Medicare. Please complete this form, sign, date, and return to BCBSTX as soon as possible. **A response is required for every question.**

Employer Name – Legal Name of Company:		Employer Identification Number (EIN):
Physical Address (number & street), City, State, ZIP:		
Account Number(s): (*To be completed by BCBSTX*)	Group Number(s): (*To be completed by BCBSTX*)	
⇨ New BCBSTX clients please check the correct box	☐ The client was not in business during the preceding calendar year	☐ The client was in business during the preceding calendar year

Do you have any affiliates or subsidiaries? If "yes", list name of each:		☐ Yes	☐ No
Some of the following responses are based on the current calendar year, while others are based on the preceding year. Unless making an update or error correction, please use the year of your requested Contract Effective Date as 'current year' when answering the following questions. For example, if your requested Contract Effective Date is December 1, 2009 base your current year answers on 2009. Or, if your requested Contract Effective Date is January 1, 2010 base your current year answers on 2010. 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. **Indicate the current calendar year for which the form is being completed:**		_____ (Renewal 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 ☐		☐ 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. Question 5 must also be completed.		☐ Yes	☐ No
4. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ Check 'Yes' or 'No' for both the current and preceding calendar years ☐ If you checked "Yes" for the current calendar year, and the threshold was met during the current year, please check this box and enter the date the threshold was met in the following space. _____/_____/_____. ☐ If you check "No" for the current year and your answer changes to "Yes" at any time, you must promptly notify BCBSTX by completing a new EAF, checking this box and entering the date the threshold was met in the space above.	Current year	☐ Yes	☐ No
	Preceding year	☐ Yes	☐ No
5. If you are currently or were during the preceding year, part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ If you answered 'Yes' to #3, then Check 'Yes' or 'No' for both the current and preceding calendar year. ⇨ If you answered 'No' to #3, then check 'Yes' or 'No' for the preceding calendar year only	Current year	☐ Yes	☐ No
	Preceding year	☐ Yes	☐ No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No

I understand that BCBSTX is relying on my answer to the above questions to determine whether Medicare will be the primary payer of claims for my Medicare eligible insured(s). I certify that the answers are true to the best of my knowledge and belief. I also understand that I am responsible to promptly notify BCBSTX, as indicated above, if my answers to the above questions change because we have increased the number of employees.

For Employer: _____ _____

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

_____ _____

Signature of Authorized Company Representative **Date**

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