BlueCross and BlueShield of TX Enrollment Kit

General Info

Producer:		**Email:**	
Phone:		**Fax:**	
Group Name:		**Effective:**	

Submission Checklist

	document/item	accessible form	doc #	revised
☐	**Small Group Employer Application** *Completed and signed by both the Group Executive and Broker, includes Proxy* ☐ **Disclosure Notice** *Only complete if enrolling in a Group HMO plan*	download	TXBPASG-OFF-EX06.19 TX-G-H-CCD-19-B	10-2019 10-2019
☐	**EFT** *Required for first month premium. BCBS no longer accepts binder checks.*			11-2017
☐	**Employer Group Information**	download	TX-SG-EGI	03-2016
☐	**Proof of Payroll Documentation** ☐ Most recent Quarterly Wage & Tax Statement. signed/dated or copy of electronic validation *--Or, if no TWC report, submit--* ☐ Complete Articles of Incorporation ☐ Texas Supplemental Employment Verification ☐ Complete W-4s on all employees and 1099s (if covering full time 1099s)	download		12-2009
☐	**Common Ownership Form** *Completed and signed by employer if group consists of more than one tax ID, consistent with IRC Sec 414(b)(c).*	download	57035.0113	01-2013
☐	**Copy of last billing statement from current carrier**			
☐	**Original Proposal** *Plan selection marked on census page with signature and date. All pages must be submitted.*			
☐	**Affidavit of Domestic Partnership** *Required for anyone covering a Domestic Partner*	download	45331.1017	11-2017
☐	**Employee Enrollment Application** *Required for all eligible including declines/waivers*	download	730197.0120	06-2019

Communication Materials

Visit the BCBS 2020 Small Group Sales Kit to access the prescription formulary and download plan summaries and value-added program flyers.

Contact

Submit Paperwork to

Kilpatrick Companies, LLC
1050 Wilcrest Dr.
Houston, TX 77042

Call

800-833-8478

Internet

www.kilpatrickcos.com

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Kilpatrick COMPANIES

BlueCross BlueShield of Texas

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 Life Insurance Company ("Dearborn Life").

<table>
<tr><td colspan="3">Legal Name of Company:</td></tr>
<tr><td>Employer Identification Number (EIN):</td><td>Nature of Business:</td><td>Standard Industry Code (SIC):</td></tr>
<tr><td colspan="3">Physical Address (number & street), City, State, ZIP:</td></tr>
<tr><td colspan="2" rowspan="2">E-Mail Address of Authorized Company Official:

Secondary E-Mail Address, if different from Authorized Company Official:</td><td>Telephone Number:</td></tr>
<tr><td>FAX Number:</td></tr>
<tr><td colspan="3">Complete Mailing Address, if different from physical address:</td></tr>
<tr><td colspan="3">Billing and Correspondence to the attention of:</td></tr>
<tr><td colspan="3">Billing Method Selection:
Please select one of the following billing methods.
(If no selection is made, your benefit plan(s) will default with their current billing method)
☐ Composite Billing
☐ Age Billing</td></tr>
<tr><td colspan="3">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: _____</td></tr>
<tr><td colspan="3">Requested Contract(s)/Policy(ies) Effective Date (1st or 15th): _____/ _____ / _____
Month Day Year</td></tr>
</table>

Proprietary and Confidential Information of Blue Cross and Blue Shield of Texas. Not for use or disclosure outside Blue Cross and Blue Shield of Texas, Employer, their respective affiliated companies and third-party representatives, except with written permission of Blue Cross and Blue Shield of Texas.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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:

   If a person is added to the Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply to the Employee or dependent, based on the Waiting Period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the coverage date for such person.

   a. 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. Annual Open Enrollment: For Health and Dental Plans only, an Eligible Person, who did not enroll under Timely Enrollment, may apply for individual coverage, Family coverage or add dependents during the Employer's Annual Open Enrollment Period. Such person's Individual Coverage Date, Family Coverage Date and/or dependent's Coverage Date will be the Contract Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

   Specify Open Enrollment Period:

   ☐ To be held thirty-one (31) days prior to the Contract Anniversary Date of the program

   ☐ 31 days immediately following the Contract Anniversary Date

5. 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.

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

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

8. 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

9. 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: _____ / _____ / _____ (Month Day Year) End Date: _____ / _____ / _____ (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 six 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:
(Vendor: **Select Vendor**)

Benefit Design (select up to 6)		**Blue Choice PPO**		***Blue Advantage HMO**[SM]	
		(select up to 6)			
☐	B660	☐	B660CHC	☐	B660ADT
☐	B661	☐	B661CHC	☐	B661ADT
☐	B662	☐	B662CHC		
☐	B9E1			☐	B9E1ADT
☐	S640			☐	S640ADT
☐	S641			☐	S641ADT
☐	S642			☐	S642ADT
☐	S643			☐	S643ADT
☐	S644			☐	S644ADT
☐	S660	☐	S660CHC		
☐	S661	☐	S661CHC		
☐	S662	☐	S662CHC		
☐	S663	☐	S663CHC		
☐	S665	☐	S665CHC		
☐	S666	☐	S666CHC		
☐	S667	☐	S667CHC		
☐	S9E1			☐	S9E1ADT
☐	S9E3			☐	S9E3ADT
☐	S9E5			☐	S9E5ADT

☐	G650	☐	G650CHC		
☐	G651	☐	G651CHC		
☐	G652	☐	G652CHC		
☐	G653	☐	G653CHC		
☐	G654	☐	G654CHC		
☐	G656	☐	G656CHC		
☐	G660			☐	G660ADT
☐	G661			☐	G661ADT
☐	G662			☐	G662ADT
☐	G663			☐	G663ADT
☐	G664			☐	G664ADT
☐	G665			☐	G665ADT
☐	G666			☐	G666ADT
☐	G9E1			☐	G9E1ADT
☐	G9E3			☐	G9E3ADT
☐	G9E5			☐	G9E5ADT
☐	P610			☐	P610ADT
☐	P611			☐	P611ADT
☐	P620	☐	P620CHC		
☐	P621	☐	P621CHC		
*If a Blue Advantage HMO product/benefit plan (with the **exception** of G665ADT plan) is selected, please complete, sign and submit a Disclosure Statement with this Application for Amendment.					

Additional Information: _____

DENTAL PRODUCTS/ BENEFIT PLAN SELECTION:

Plan Pairings (Groups 10+)
Contributory
Any one contributory high option can be paired with any one contributory low option; DTXHM11 can be freely paired with any contributory option.

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. DTXHM15 can be freely paired with any one voluntary option.

High Option	Low Option
DTXHR12	**DTXLR23**
DTXHR21	**DTXLM24**

Participation Requirements
Contributory
>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	Contributory
☐ DTXHR02	Contributory
☐ DTXHR03	Contributory
☐ DTXHR04	Contributory
☐ DTXHM09	Contributory
☐ DTXHM11	Contributory
☐ DTXHR20	Contributory
☐ DMTHM27	Contributory
☐ DTXHR12	Voluntary
☐ DTXHM13	Voluntary
☐ DTXHM15	Voluntary
☐ DTXHR21	Voluntary
☐ DTXHR22	Voluntary
☐ DMTHM29	Voluntary
Low Coverage Allocation	
☐ DTXLR05	Contributory
☐ DTXLR06	Contributory
☐ DTXLR07	Contributory
☐ DTXLM08	Contributory
☐ DTXLM10	Contributory
☐ DMTLR28	Contributory
☐ DTXLR23	Voluntary
☐ DTXLM24	Voluntary
☐ DMTLR30	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 **(Note: If selected an additional charge will be added to your rates.)**
☐ 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 or dental 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 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 Contract(s) issued. 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 Life no later than the first day of each billing period. If the premium payments are not received by Dearborn Life, 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 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 in accordance with the terms of the Policy. Premium rates may change 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. The Employer's participation in the Life Insurance Plan may terminate 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 of the approval of the employee's application for coverage.

EMPLOYER: DO NOT CANCEL CURRENT COVERAGE UNTIL NOTIFIED BY BCBSTX AND/OR DEARBORN LIFE 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 and SBC 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, SBC, amendment, or other revised form provided by BCBSTX, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and will hold BCBSTX harmless from any misuse of the E-file provided by BCBSTX. By providing your consent, you agree to the electronic delivery of your insurance documents. You can go back to paper delivery at any time with no penalty. Your consent will be valid until it is withdrawn up to and including through policy renewals. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports most versions of Internet Explorer, Chrome and Firefox. ☐**Accept –** Employer consents to receive electronic versions of certificate-booklets and SBCs 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. Employer may withdraw this consent at any time and request receipt of hard copy versions by contacting their BCBSTX Account Executive. ☐**Decline –** Employer does not consent to receive electronic versions of certificate-booklets and SBCs for covered Employees or the Contract and desires BCBSTX to print and distribute hard copy versions. Authorized Company Official's Initials: ______Date _____

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 Life accept this Employer Application and issues a Group Contract/Policy/Agreement to the Employer, BCBSTX/Dearborn Life 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 Life 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 Life are complete and true to the best of my knowledge and belief. I understand that BCBSTX/Dearborn Life 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 Life. The requested Contract(s)/Policy(ies) effective date (as listed on page 1) is subject to change by BCBSTX/Dearborn Life 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 additional cost to the employee. Employer 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).

D. 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.

E. Reimbursement: It is understood and agreed that in the event BCBSTX makes a recovery on a third-party liability claim, BCBSTX will retain twenty five percent (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers’ Compensation Law.

F. Third Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 25% of any recovered amount made by the BCBSTX’s Third Party Recovery Vendor or up to 25% of any recovered amount will be deducted from the amount distributed according to established allocation processes. Employer will pay no more than 35% of any recovered amount made by BCBSTX’s third party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

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

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

Section 9010(a) of ACA requires that “covered entities” providing health insurance (“health insurers”) pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and may use 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 may be used to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

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

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

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

PRODUCERS

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 Life 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)

   Producer #: _____ Percentage of Split**: _____
   Complete Address: _____ FAX #: _____

   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): _____

   Producer #: _____ Percentage of Split**: _____
   Street, City, ZIP: _____ FAX #: _____

   Contact's E-mail address (please print clearly): _____

3. General Agent Name (if applicable): Kilpatrick Companies LLC

   Producer #: 096763000 FAX #: 713-977-9333
   Street, City, ZIP: 1050 Wilcrest Dr, Houston, TX 77042

   Contact name and telephone # for this case: _______________________ 713-977-9300
   Contact's E-mail address (please print clearly): ____________________ @kilpatrickcos.com

   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 Life and total commissions paid must equal 100%.

PROXY (OPTIONAL)

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

HCSC pays indemnification or advances expenses to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: ______________ 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
CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

Under Texas law, HMOs are permitted to market "Consumer Choice" plans, which do not have to comply with one or more state coverage requirements. They must also offer a plan that does comply with all state requirements. HMOs are required by law to obtain signatures of consumers showing they have given this notice.

I have been informed that the consumer choice plan that I am offered does not include all of the health benefits usually required by Texas law. I understand that the following benefits are either excluded from the plan or provided at a reduced level:

Description of State Requirements Reduced or Excluded	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 health care 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 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. The limitation only applies if the enrollee demonstrates that copayments in that amount have been paid that year.	For some services and supplies, this plan may include cost-sharing that exceeds the limits imposed by the mandate.	
Deductibles Section 11.506(2)(B), Subchapter F, Title 28 Texas Insurance Code: A deductible must be for specific dollar amount of the cost of the basic, limited or single health care service. Except for a consumer choice benefit plan, an HMO may not charge a deductible for services received in the HMO's delivery network, except in cases involving emergency care and services that are not available 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 and Habilitation 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.	

BlueCross BlueShield
of Texas

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 and Habilitation Services except for treatment of Acquired Brain Injury and Autism Spectrum Disorder.	

I understand that I can get more information about consumer choice plans from the Texas Department of Insurance (TDI) by visiting the TDI website at http://tdi.texas.gov/consumer/consumerchoice.html or by calling the TDI Consumer Help Line at 1-800-252-3439.

____

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

____

Name of Business (if applicable)

____

Address

______________________________ ______________________________

City **State** **Zip**

____

Date

Note: The HMO issuing the policy must keep this disclosure statement and provide it to the Commissioner of Insurance on request. **You have the right to a copy of this written disclosure free of charge.** You must sign a new disclosure statement when you buy a consumer choice plan and each time your policy renews.

ELECTRONIC PAYMENT/ONE TIME BINDER CHECK EFT

PLEASE RETURN THIS FORM TO YOUR CLIENT CONTACT

① **Select Payment Type:**

☐ ACH Debit – Client Initiated

Client/Group Contact Representative (Name): ______________________________

Signature: ______________________________ Date: ______________

BCBS Account Name (IL; NM; OK; or TX) ______________________________

Funds Transfer From:

Organization Name:______________________________

Address:______________________________

Contact Name:______________________________

Telephone Number:______________________________

Bank Name:______________________________

Bank Address:______________________________

Bank Account Name:______________________________

ABA (Bank Routing #:______________________________

Bank Account Number:______________________________

Type of Account:______________________________

$______________________________

******Informational Purposes ONLY. Do not submit with enrollment documents. This form is for your records only and collection of initial premium payment information.**

Employer Group Information

(Small Group)

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

SECTION A

Employer Name	Employer Tax ID #
Account # (renewing groups only)	

SECTION B

MEDICARE SECONDARY PAYER (MSP) EMPLOYER ACKNOWLEDGEMENT

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Fax or email completed form to 312-233-4244; data_collection@bcbsil.com. A response is required for every question. For help in completing this form, refer to the *Instructions – Completing the Annual MSP Employer Acknowledgement* located at the end of this document.**

New 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 correct box:	☐ Submitting this form as an update ☐ Submitting this form as an error correction

Question			
Do you have any affiliates or subsidiaries? If "yes", list name of each: ______________________ ______________________		☐ Yes	☐ No
Some of the following responses are based on the current calendar year, while others are based on the preceding year. Unless making an update or error correction, please use the year of your upcoming renewal as 'current year' when answering the following questions. For example, if your upcoming renewal is effective July 1, 2016, base your current year answers on 2016. Or, if your upcoming renewal is effective January 1, 2017, base your current year answers on 2017. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee current year count. Understand that you are obligated to notify 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 ☐ 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 EGI, checking this box and entering the date the threshold was met in the space above.	Current Year (see above)	☐ Yes	☐ No
	Preceding Year	☐ Yes	☐ No
5. If you are currently or were during the preceding year part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ➔ If you answered 'Yes' to #3, then check 'Yes' or 'No' for both the current and preceding calendar years ➔ If you answered 'No' to #3, then check 'Yes' or 'No' for the preceding calendar year only	Current Year (see above)	☐ Yes	☐ No
	Preceding Year	☐ Yes	☐ No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No

SECTION C

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

a. Did your company employ 20 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year? ☐ Yes ☐ No

b. Are you subject to the Consolidated Omnibus Reconciliation Act (COBRA)? ☐ Yes ☐ No
If "yes", list names and number of individuals (qualified beneficiaries) currently on COBRA continuation*:

Name of COBRA Continuee	Coverage Type (Individual or Family)	Projected COBRA Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental

It is your responsibility to annually inform 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
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental

State Continuation of Group Coverage for Certain Dependents.

A dependent of an insured is entitled to state dependent continuation under certain conditions. List names and number of continued dependents on state (3 years) dependent continuation coverage:

Name of State Dependent Continuee	Coverage Type (Individual or Family)	Projected State Continuation Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental
	☐ Individual ☐ Family	________/________/__________	☐ Health ☐ Dental

SECTION D

FOR MLR AND MARKET SEGMENT PURPOSES ONLY

The Affordable Care Act (ACA) established Medical Loss Ratio (MLR) standards for health insurers, which requires that Blue Cross and Blue Shield of Texas report annually whether coverage is in the individual, small group or large group market of a state. Therefore, your assistance is needed to classify your coverage for each MLR reporting year. Generally, the MLR is the percentage of earned premiums that the insurer spends on health care services and quality improvement activities. If the insurer's MLR is less than ACA's MLR standard for a group market of a state, the insurer may provide ACA-MLR rebates in that market.

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

1. Employer Size. (Required for new groups only)

For the purpose of determining employer size:

- An "employee" is defined as any individual employed by an employer. An employee includes full-time, part-time and seasonal employees.
- Persons treated as a single employer under Internal Revenue Code Section 414(b), (c), (m) or (o) should be treated as a single employer.
- If your company is wholly owned by an individual (or an individual and his/her spouse), do not include the individual and his/her spouse in your response below.
- Partners in a partnership should not be counted as employees.

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

☐ My company (employer) **existed** during the preceding calendar year. What is the average number of employees that your company (employer) employed on business days during the calendar year (January 1 – December 31) preceding the effective date of coverage? For example, if your effective date is July 1, 2016 then you would base your answer on calendar year 2015. ______

☐ My company (employer) **did not exist** at any time during the preceding calendar year. What is the average number of employees that your company (employer) is reasonably expected to employ on business days during the current calendar year? ______

Is your company a partnership? ☐ Yes ☐ No

2. Church Plan.

In order to provide an ACA-MLR rebate to a policyholder the MLR regulations require that an insurer obtain a written assurance from the policyholder that any rebate will be used for the benefit of enrollees as described in MLR regulations (45 C.F.R. 158.242). If the written assurance is not provided, the MLR regulations require that an insurer distribute any rebate directly to certain subscribers of the plan (rather than to the policyholder).

Does the policyholder listed sponsor a church plan* in connection with the policyholder's BCBSTX coverage?

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

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

- ☐ The policyholder **WILL** use any rebate for the benefit of enrollees as described above.
- ☐ The policyholder **WILL NOT** use any rebate for the benefit of enrollees as described above. I understand that, if this box is checked, BCBSTX may distribute any rebate directly to certain subscribers of the plan.

** "Church plan" has the meaning given the term in Internal Revenue Code Section 414(e).*

If you have any general questions about this request, please contact our Medical Loss Ratio Hotline at 855-804-3635, 8 a.m. to 6 p.m. CT, Monday through Friday. Should the employer's or plan's status change, please contact your account representative.

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

______________________________ ______________

Employer or Authorized Purchaser Signature and Title Date

INSTRUCTIONS – COMPLETING THE ANNUAL MSP EMPLOYER ACKNOWLEDGEMENT

IMPORTANT NOTE

Under federal law, it is the employer's responsibility to annually inform its insurer or third-party administrator, such as Blue Cross and Blue Shield of 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.

The information in these instructions should not be construed as legal advice or as a legal opinion on any specific facts or circumstances, and is not intended to replace advice of independent legal counsel.

- *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

Experience. Wellness. Everywhere.℠

Texas Supplemental Employment Verification

To be used with the TWC report or other proof of wages documentation

Employer's Name	SIC Code		
Employer's Address	City	State	ZIP Code

- Proof-of-wages documentation is required when enrolling new small groups. We encourage employers to submit the most recent quarterly Wage and Tax Report (commonly referred to as the TWC report). If a current TWC report is not available, we will accept other types of documentation as described in our Broker Tips guide.
- You must submit this form (Texas Supplemental Employment Verification-TSEV) when you have hired or are compensating employees other than those found on your proof-of-wages documentation.
- On your proof-of-wages documentation, please mark each employee listed with the appropriate status code from the list below.
- Additionally, the status codes below should be used on page 2 of this form.

Each full-time employee must complete an enrollment application indicating whether they are requesting or declining coverage.

STATUS CODES

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
O	Owners, partners and officers
S	Seasonal employee or temporary employee
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 OR OTHER PROOF OF WAGES DOCUMENTATION

On page 2 of this form, please list the following persons employed by you:

- New employees who work a minimum of 30 hours per week
- Owners, partners and officers
- Independent contractors
  (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 that I have read this document and that the information provided is accurate and complete. I also certify that 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 that providing incomplete, inaccurate or untimely information may void, reduce or terminate the group’s coverage.

______________________________ ______________________ ________________

Signature of Authorized Company Official Title Date

____

Print Name of Authorized Company Official

____

Signature of Agent

BCBSTX reserves the right to request documents verifying the above information. In addition, it reserves the right to reverify employment information at any time during the course of your contract with BCBSTX.

BlueCross BlueShield of Texas

Common Ownership – Small Group

In order to ensure that Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, issues the appropriate insurance coverage, please complete the following for all companies applying for one policy of group coverage due to common ownership. This form should be signed by the group's accountant, officer of the company, legal counsel, or authorized representative.

The undersigned authorized representative acknowledges that the employer and affiliated companies listed below are required or permitted to be aggregated pursuant to Internal Revenue Code Section 414(b) and Section 414(c). NOTE: Small group coverage is not available to Section 414(m) affiliated service groups.

List all companies that qualify as one employer according to the above-referenced sections of the Internal Revenue Code:

BUSINESS NAME	**EMPLOYER ID NUMBER**

Name of Group to appear on policy ______________________________

Employer Identification Number (EIN) ______________________________

I certify that the entities named above are a single employer according to the above-referenced Internal Revenue Code. I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I understand that Blue Cross and Blue Shield of Texas will rely on this information, and that any misrepresentation or fraudulent statements may result in rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, and any other consequences as permitted by law.

______________________________ ____________________

Name of Authorized Company Official (Print Name) Title of Authorized Official

______________________________ ____________________

Signature of Authorized Company Official Date

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Texas

AFFIDAVIT OF DOMESTIC PARTNERSHIP

DECLARATION

We certify that ________________________________ is a Domestic Partner of ________________________________
Domestic Partner's name (please print) Employee's name (please print)

in accordance with the following eligibility criteria.

1. We have lived together for at least six months prior to enrollment in the plan.
2. We are not married to anyone else and do not have another domestic partner.
3 We are at least 18 years of age and mentally competent to consent to contract.
4. We reside together in the same residence and intend to do so indefinitely.
5. We have an exclusive mutual commitment similar to that of marriage.
6. We are jointly responsible for each other's common welfare and share financial obligations.
7. We can provide all or some of the following types of documentation if requested:
   - Domestic Partner Affidavit
   - Designation of Domestic Partner as beneficiary for life insurance and retirement contract
   - Designation of Domestic Partner as primary beneficiary in employee's or insured's will
   - Durable property and health care powers of attorney
   - Joint ownership of motor vehicle, joint checking account or joint credit account
   - Joint mortgage or lease

CHANGE IN DOMESTIC PARTNERSHIP

We agree to notify the group within thirty (30) days of any change in Domestic Partnership status which would make the Domestic Partner no longer eligible for benefits (e.g., a change in joint residency) by filing a Statement of Termination of Domestic Partnership. The Statement of Termination shall affirm that the domestic partnership status is terminated as of the date of execution specified therein and that a copy has been mailed to the other party by the party authorizing the action.

Upon termination of this Affidavit of Domestic Partnership (evidenced by a Statement of Termination of Domestic Partnership signed by the Insured), I ____________________ agree that another Affidavit of Domestic Partnership cannot be filed for a minimum of six months.

ACKNOWLEDGMENTS

1. We have provided this information in this Affidavit for the sole purpose of determining our eligibility for Domestic Partnership benefits.
2. We further understand that any false or misleading statements made in order to receive benefits for which we do not qualify may subject the employee/insured to disciplinary action.

Employee Signature ________________________________ Date ____________________

Employee Social Security Number ________________________________ Employee ID number ____________________

Employee/Domestic Partner Home Address ________________________________

Domestic Partner Signature ________________________________ Date ____________________

On this ________, day of ______________, 20_____, before me personally came ________________________________ and ________________________________, to me known to be the individual described as "Employee/Insured" and the individual described as Domestic Partner in the above document entitled "AFFIDAVIT OF DOMESTIC PARTNERSHIP" and who executed same as a free and voluntary act for the uses and purposes stated herein.

____
Notary Public

My Commission Expires ____________________

ENROLLMENT APPLICATION/CHANGE FORM

Group # | Section # | Social Security #
Account # | Category

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.

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Changes**

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

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

Event: ☐ New Hire ☐ 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: ____ / ____ / ____ ☐ **Completion of Other Eligibility Requirements**

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

Cancel Coverage: ☐ Health ☐ Dental
☐ Term Life ☐ Dependent Life
☐ Short-Term Disability ☐ Long-Term Disability

List names of those canceling 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 # – –

Mailing Address - Street - Apt #	City	State	ZIP code

Email Address	☐ Male ☐ Female	Home/Cell Phone #

Name of Employer	Job Title	Business Phone #	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 for health? (select one)**	**BlueCare Dental℠ Coverage**	**Who is covered for dental? (select one)**
☐ Blue Premier Access℠ ☐ Blue Choice PPO℠ ☐ Blue Essentials℠ ☐ Blue Advantage HMO℠ ☐ Blue Essentials Access℠ ☐ Other ____ 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 for health? (select one)**	**Dental Coverage**	**Who is covered for dental? (select one)**
☐ Blue Choice PPO℠ ☐ Blue Essentials℠ ☐ Blue Premier℠ ☐ Blue Essentials Access℠ ☐ Blue Premier Access℠ ☐ 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: ____

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance^

☐ I am not applying for Group Term Life, AD&D or Disability Insurance coverage

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

Group Basic Term Life and AD&D	☐ I do not apply	☐ I do apply	Amount $____
Group Dependents' Life	☐ I do not apply	☐ I do apply	
Group Supplemental Life	☐ I do not apply	☐ I do apply	
Employee Election: $____	Spouse Election: $____		Child Election: $____
Short-Term Disability	☐ I do not apply	☐ I do apply	
Long-Term Disability	☐ I do not apply	☐ I do apply	

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security #
Primary Beneficiary						– –
Contingent Beneficiary						– –

* The term "marriage" includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer's plan).
** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan).
*** The use of the term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).
^ Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Last Name: Social Security #: — — Group #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY. PCP SELECTION IS REQUIRED FOR BLUE ADVANTAGE, BLUE PREMIER AND BLUE ESSENTIALS PLANS. PCP SELECTION IS NOT REQUIRED FOR BLUE PREMIER ACCESS AND BLUE ESSENTIALS ACCESS PLANS.

Employee/Enrollee's Name	PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Social Security # – –	Birth Date (MM/DD/YYYY)	Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code		Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code		Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code		Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

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 Disabled Dependent Authorization and Disabled Dependent Physician Certification.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE ALL AREAS THAT APPLY

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

Group Coverage ☐ Yes ☐ No	Individual 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 #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

Name of person covered:	Medicare A (Hospital) Effective Date: ______ Medicare B (Medical) Effective Date: ______ Medicare D (Drug) Effective Date: ______ Medicare D (Drug) Carrier: ______	End Date: ______ End Date: ______ End Date: ______	Medicare HIC # (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: ______ Medicare B (Medical) Effective Date: ______ Medicare D (Drug) Effective Date: ______ Medicare D (Drug) Carrier: ______	End Date: ______ End Date: ______ End Date: ______	Medicare HIC # (From Medicare Card)

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

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING 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	Reason
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 ☐ Dependent	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 ☐ Dependent	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 9 — 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 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 Contract(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 receive my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Applicant's Signature ______ Date ______

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.