BlueCross BlueShield of Texas

DocuSign

Reference Guide: Importing Completed & Signed DocuSign Data to the ACA Enrollment Tool

Feb. 3, 2017

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- Assumptions
  - Only DocuSign Envelopes that are Completed and Signed can be imported.
  - DocuSign Envelope ID is used to import data into ACA Enrollment Tool. Please refer to Appendix for mapping.
  - In the ACA Enrollment Tool, existing data validation rules apply.
- Steps for DocuSign Data Import
  - Step 1: Submit DocuSign Enrollment Package for signature through Blue Access for Producers℠
  - Step 2: Download and Save Completed and Signed DocuSign Documents as separate PDFs
  - Step 3: In ACA Enrollment tool, copy and paste DocuSign Envelope ID to import DocuSign data
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Step 1: Submit DocuSign Enrollment Package for signature through Blue Access for Producers

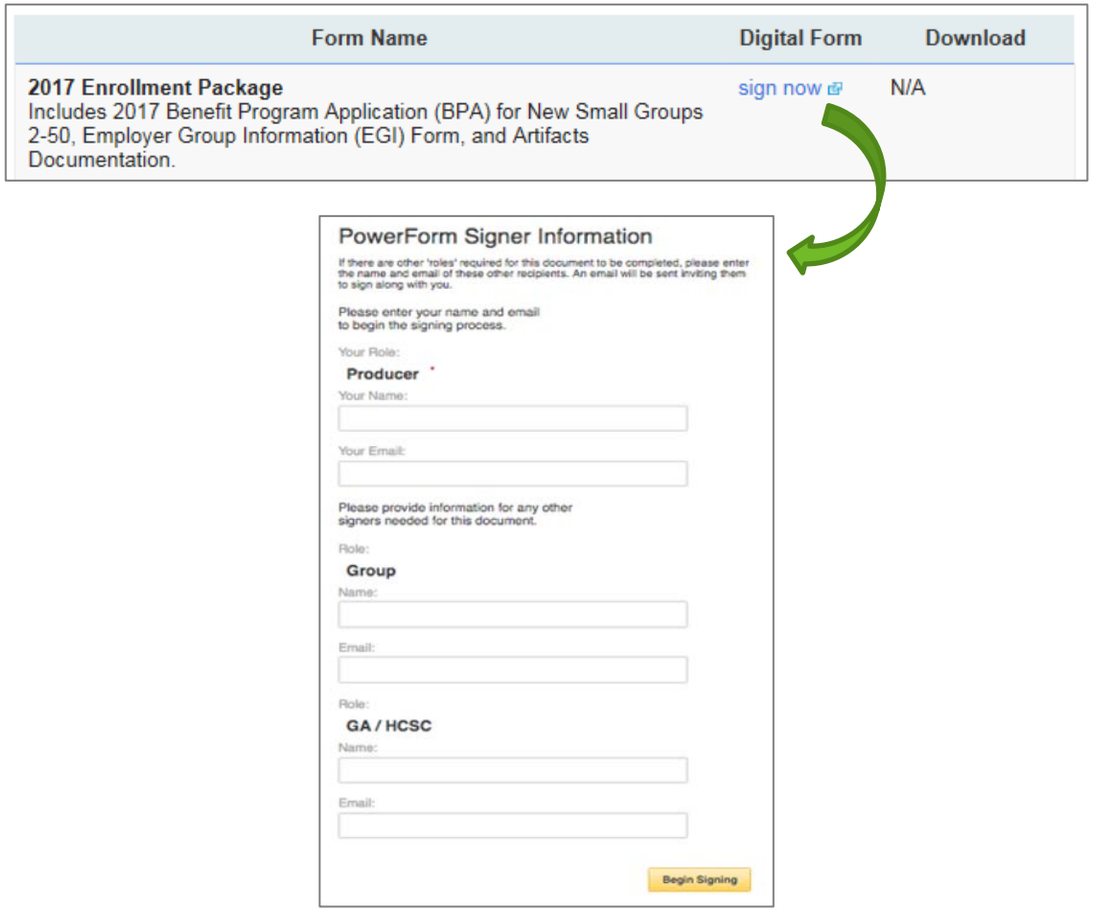
a) Through Blue Access for Producers, navigate to Small Group Enrollment Forms.

b) Click on sign now (sign now) to begin the process of submitting Enrollment Package via DocuSign.

c) PowerForm Signer Information displays.

- Please refer to Producer Training Guide for completing and signing Enrollment Package via DocuSign.

d) An email will be received once the DocuSign package is completed and signed.



Step 2: Download completed and signed DocuSign Documents as separate PDFs

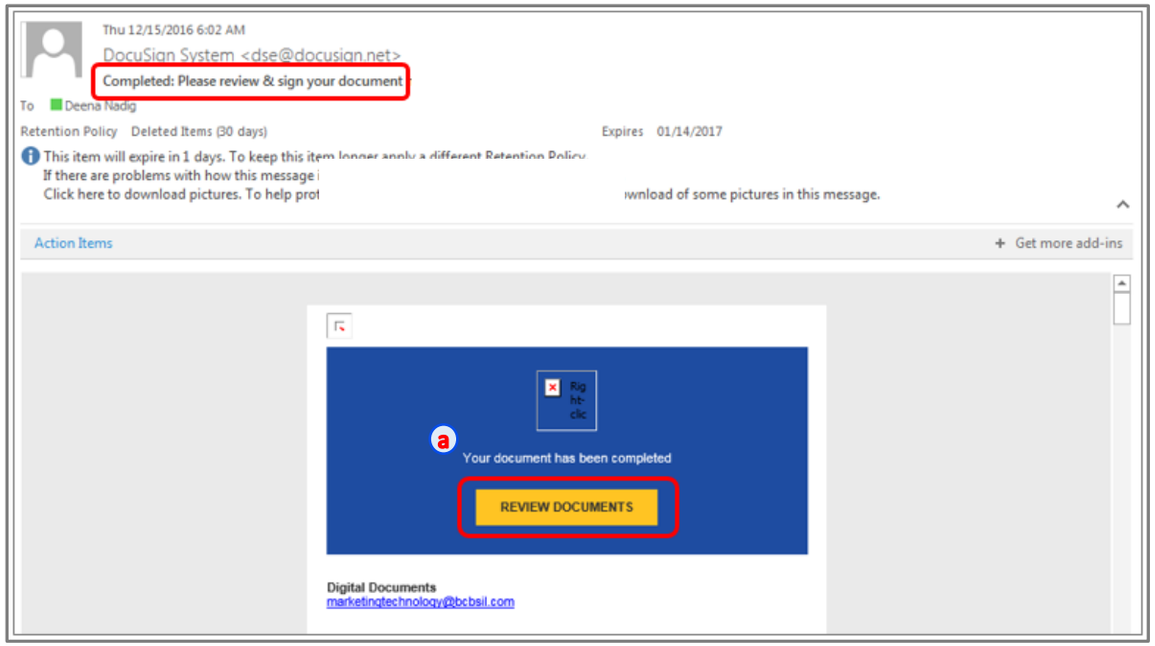
a) When Completed email is received from DocuSign, click on Review Documents to display DocuSign Documents.

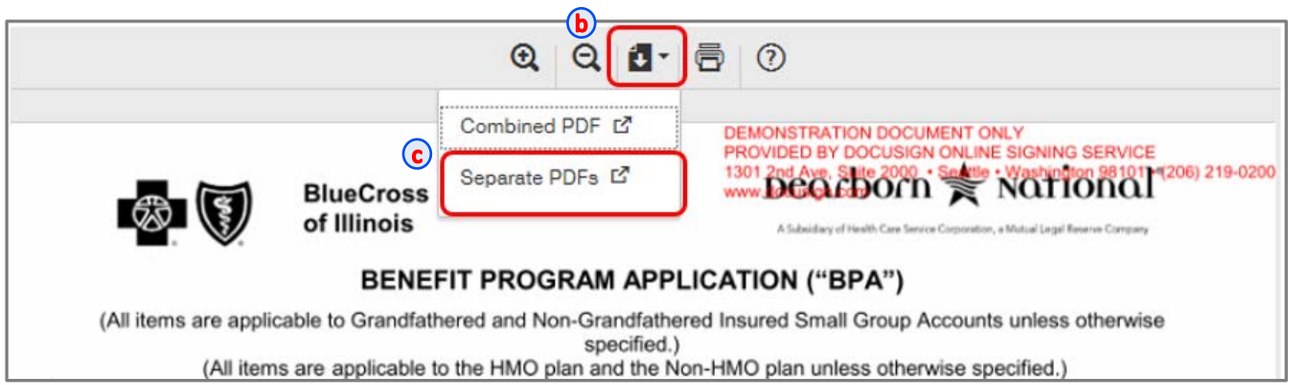
b) From the DocuSign Document, click the Down Arrow icon ( ) to download PDFs.

c) Select Separate PDFs.

Please note:

- Completed and Signed DocuSign Documents need to be downloaded as separate PDFs so that each individual PDF can be attached in ACA Enrollment Tool.





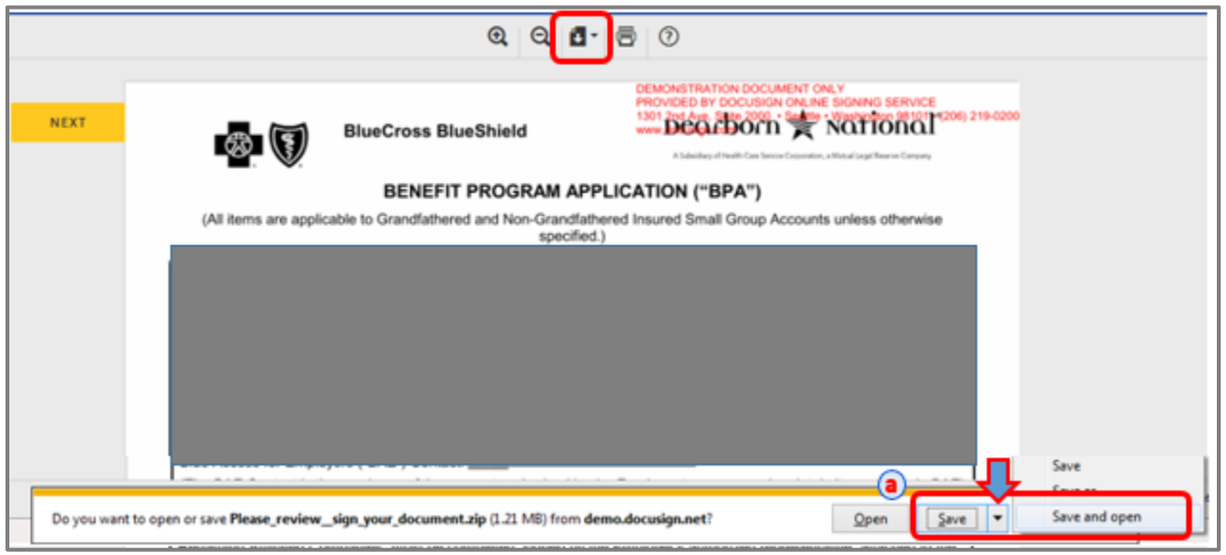
Step 2: (Continued) Save completed and signed DocuSign Documents as separate PDFs

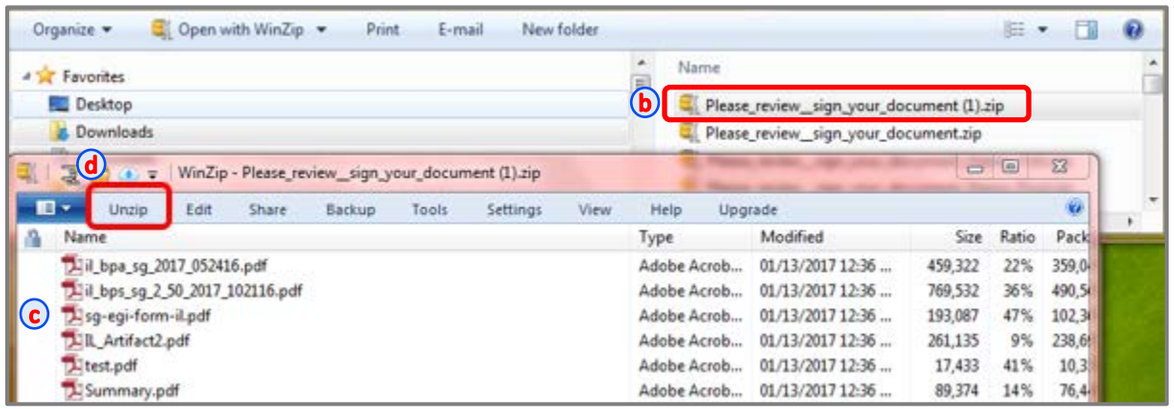
a) Click on down arrow by the Save button and select Save and Open from the drop down list.

b) DocuSign Documents download as a zip file.

c) File Manager displays the PDFs within the downloaded zip file.

d) Unzip the downloaded zip file and save in an existing folder or create a new folder and then Save.





Step 3: In ACA Enrollment tool, copy and paste DocuSign Envelope ID to import DocuSign data

Once a DocuSign Envelope is completed and signed, DocuSign data can be imported in ACA Enrollment Tool.

a) Hover over Help Tip ( ) displays information on where to locate DocuSign Envelope ID on the DocuSign BPA and a sample Envelope ID.
   - DocuSign Envelope ID is available on the bottom right hand corner of the BPA.

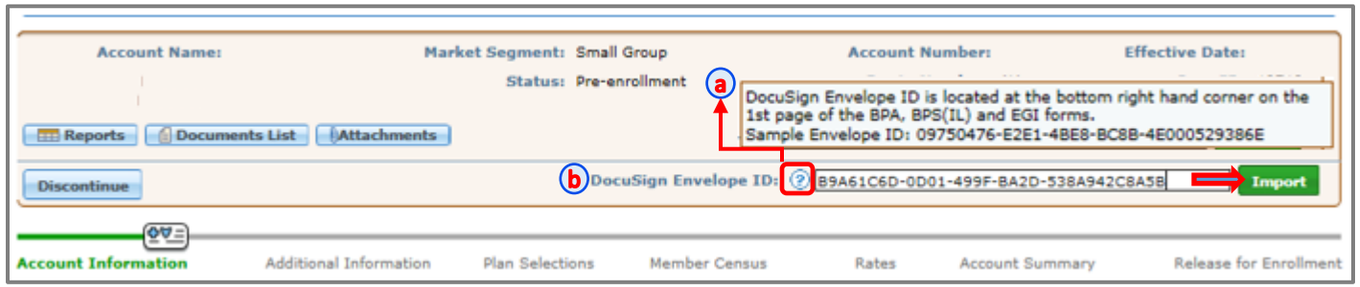
b) Copy DocuSign Envelope ID from the DocuSign BPA and paste it on the Account Information page in ACA Enrollment Tool and Click on Import button.

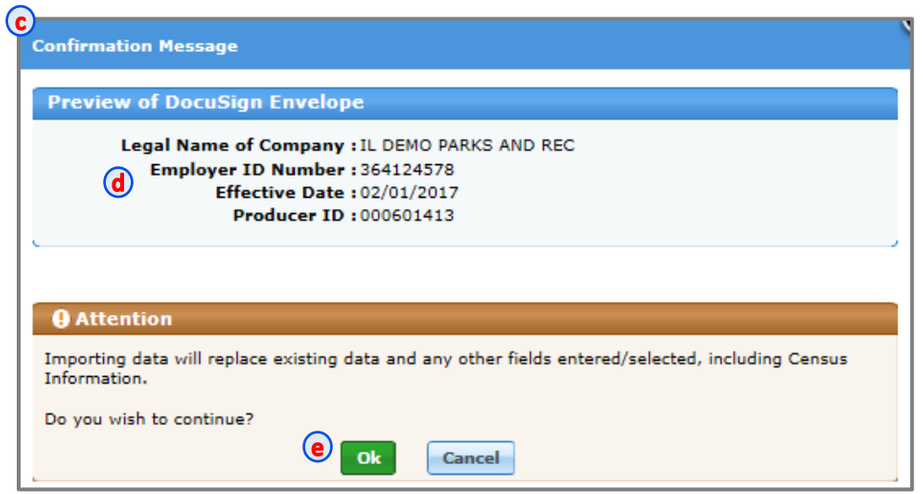
c) Confirmation message displays with Preview of DocuSign Envelope.

d) Verify Preview Information - Legal Name of Company, Employer ID Number, Effective Date and Producer ID.

e) Click on Ok button to proceed with the DocuSign data import. DocuSign data prepopulates.

f) Verify the imported DocuSign data. Select/enter values for fields that are not populated/filled out as needed.





Step 4: Attach completed and signed DocuSign PDFs in ACA Enrollment Tool

a) In ACA Enrollment Tool, click Attachments button to attach completed and signed DocuSign PDFs.

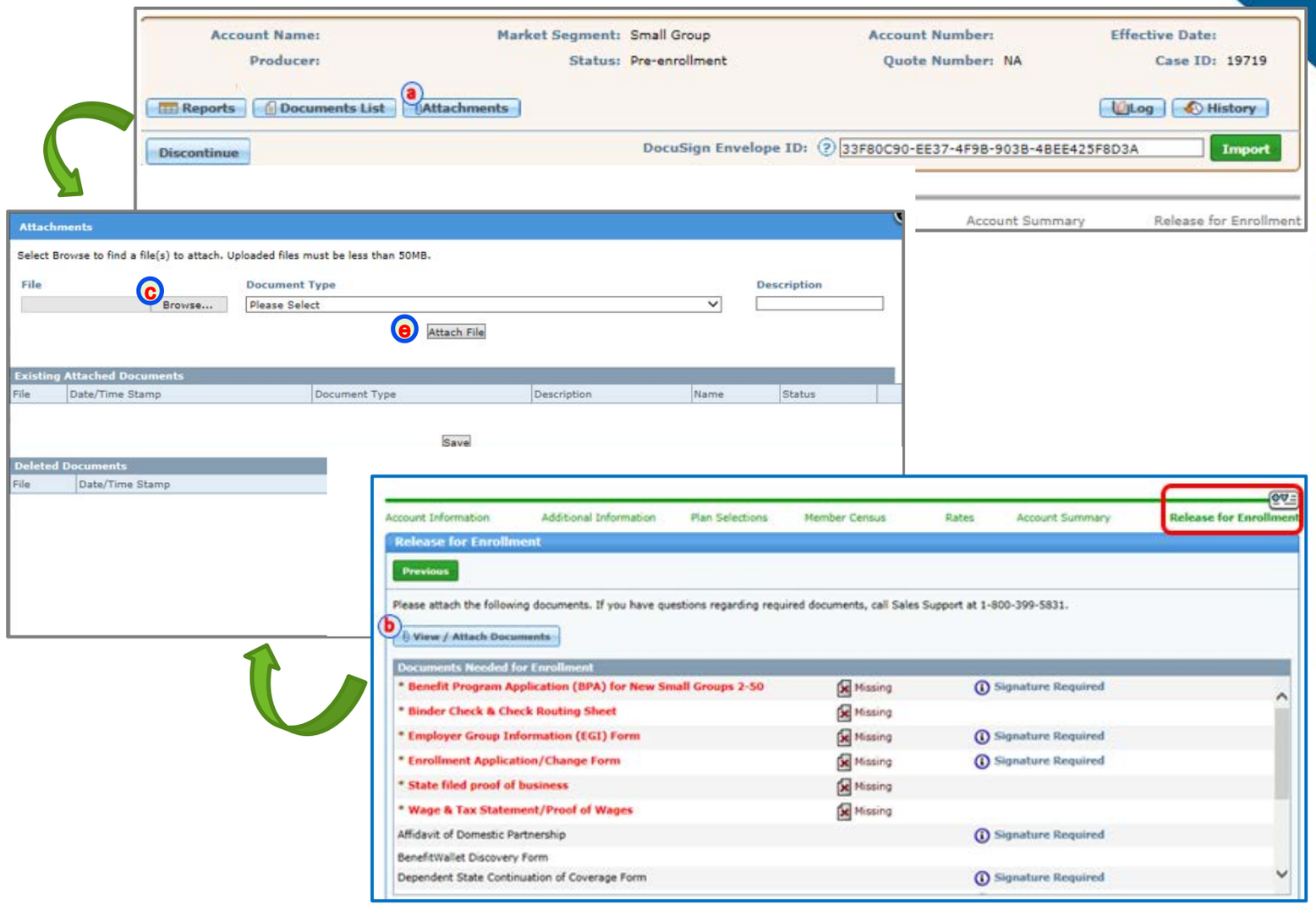
OR

b) DocuSign Documents can be attached in Release for Enrollment.

c) In the Attachments pop up, click on Browse and select the DocuSign PDF to be attached.

d) Select a Document Type from the drop down list.

e) Click on Attach File button.



Step 5: Submitting Changes after DocuSign Data is Imported in ACA Enrollment Tool

Important:

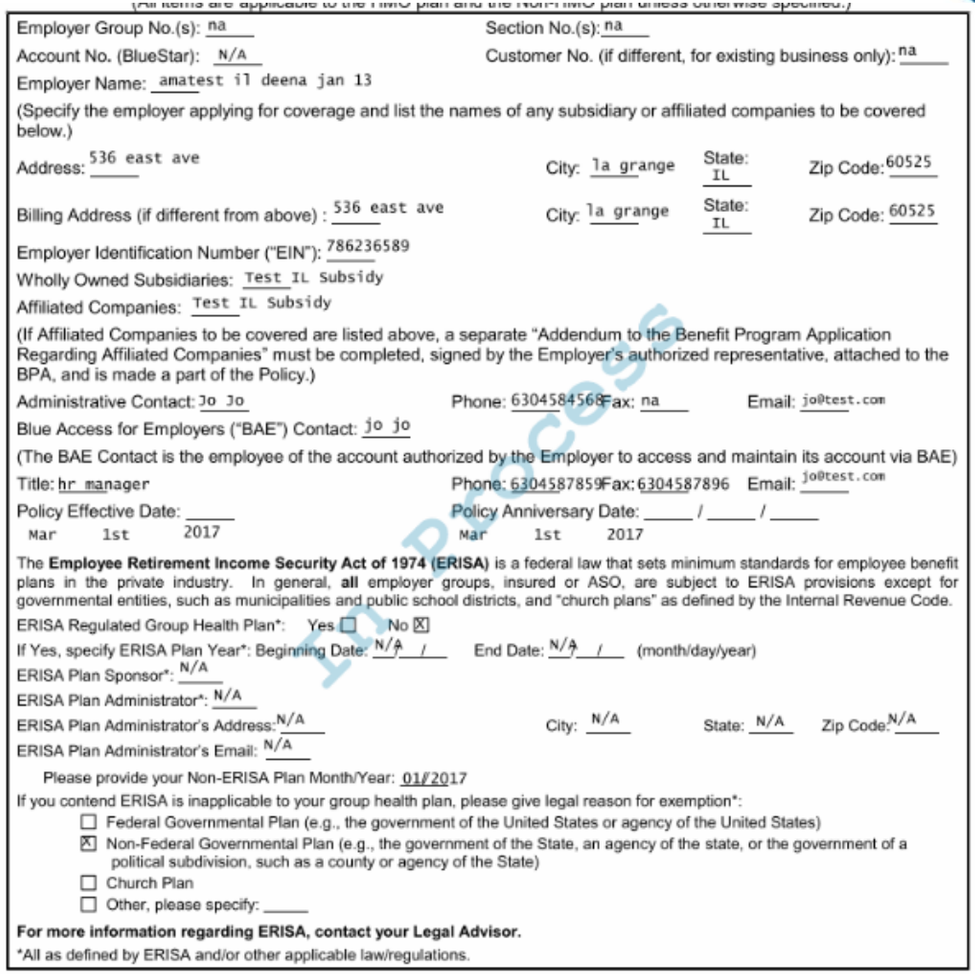
- Import feature should not be used for importing data a second time as doing so will wipe out all the existing data including
  - DocuSign data that was imported the first time
  - other information that was manually entered/selected
  - Census information

- For changes or corrections, another DocuSign form can be submitted to complete and sign.

- In ACA Enrollment tool, make changes to data manually as needed and attach the revised completed and signed DocuSign PDF(s).

Watermark Feature for "In Process" DocuSign Documents

- In the event that a DocuSign PDF is downloaded prior to being completed and signed, "In Process" watermark will be displayed diagonally on the center of the page.
- "In Process" DocuSign PDFs should not be attached in ACA Enrollment Tool
- "In Process" watermark does not display on signed and completed DocuSign PDFs.



(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Group No.(s): na — Section No.(s): na

Account No. (BlueStar): N/A — Customer No. (if different, for existing business only): na

Employer Name: amatest il deena jan 13

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

Address: 536 east ave — City: la grange — State: IL — Zip Code: 60525

Billing Address (if different from above) : 536 east ave — City: la grange — State: IL — Zip Code: 60525

Employer Identification Number ("EIN"): 786236589

Wholly Owned Subsidiaries: Test IL Subsidy

Affiliated Companies: Test IL Subsidy

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, attached to the BPA, and is made a part of the Policy.)

Administrative Contact: Jo Jo — Phone: 6304584568 — Fax: na — Email: jo@test.com

Blue Access for Employers ("BAE") Contact: jo jo

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE)

Title: hr manager — Phone: 6304587859 — Fax: 6304587896 — Email: jo@test.com

Policy Effective Date: Mar 1st 2017 — Policy Anniversary Date: ____ / ____ / ____ Mar 1st 2017

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

ERISA Regulated Group Health Plan*: Yes ☐ No ☒

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

ERISA Plan Sponsor*: N/A

ERISA Plan Administrator*: N/A

ERISA Plan Administrator's Address: N/A — City: N/A — State: N/A — Zip Code: N/A

ERISA Plan Administrator's Email: N/A

Please provide your Non-ERISA Plan Month/Year: 01/2017

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

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

For more information regarding ERISA, contact your Legal Advisor.

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

Decline to Sign DocuSign Documents

In the event that the DocuSign document no longer needs to be completed and signed, please "Decline to Sign" the document.

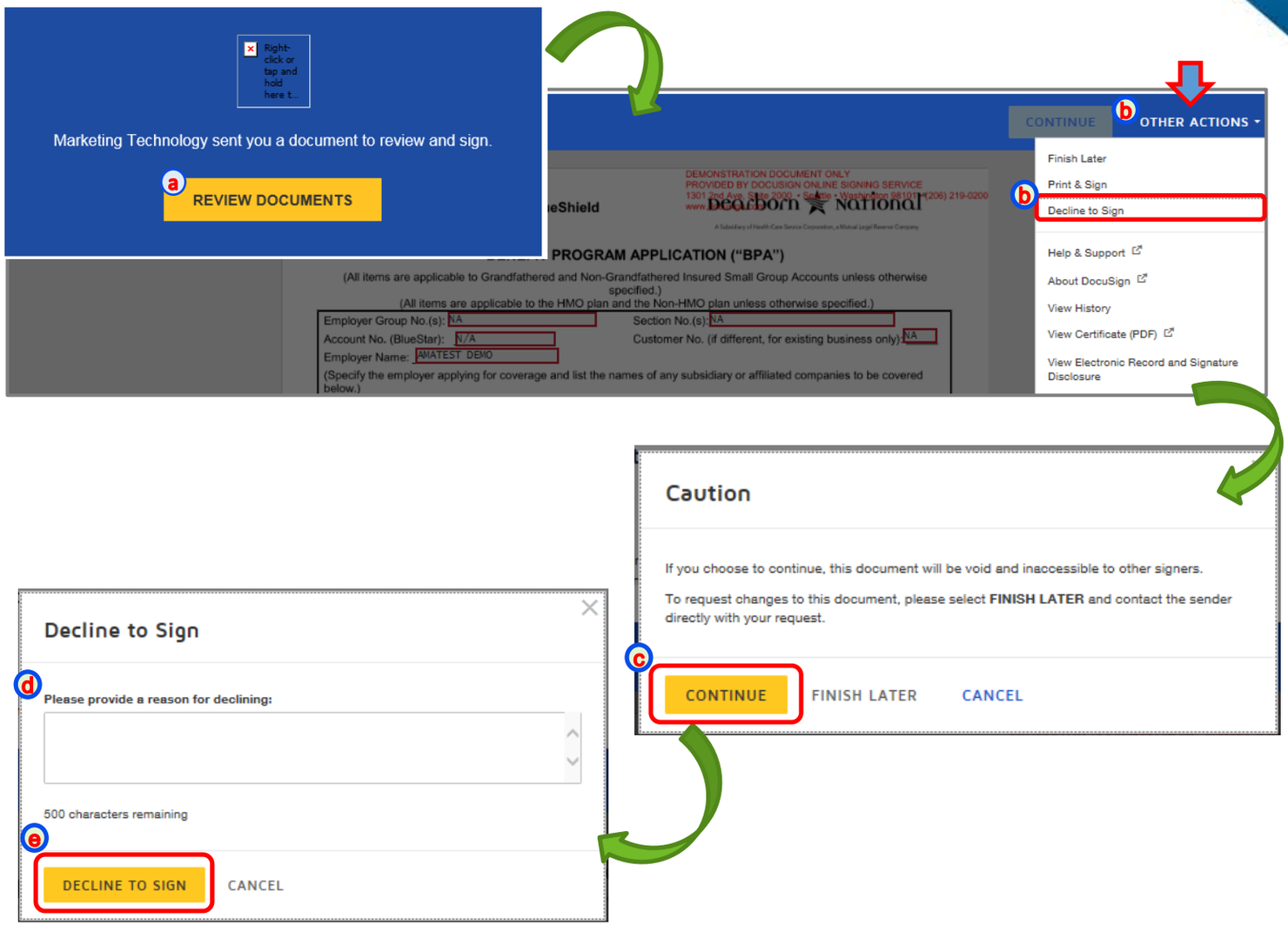
a) On the DocuSign email, click on Review Documents. DocuSign document displays.

b) Click on Other Actions option and select Decline to Sign.

c) Caution message displays. Click on Continue.

d) Decline to Sign message displays. Type in a reason for declining to sign.

e) Click on DECLINE TO SIGN.



Reporting Issues

- For technical issues with the eSales Enrollment tool
  - Please contact our ITG Service Center at 1-888-706-0583

- If there are any questions regarding any of the information within the user manual or the DocuSign Data Import process
  - Please feel free to email us at ACASmallGroupEnrollmentSupport@bcbsil.com
    - On the email, please include:
      1. DocuSign Data Import on the Subject line
      2. DocuSign Envelope ID in the email body
      3. Screen shot (if possible)

APPENDIX

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BlueCross BlueShield of Texas

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SMALL EMPLOYER BENEFIT PROGRAM APPLICATION
(Employer Application)

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

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

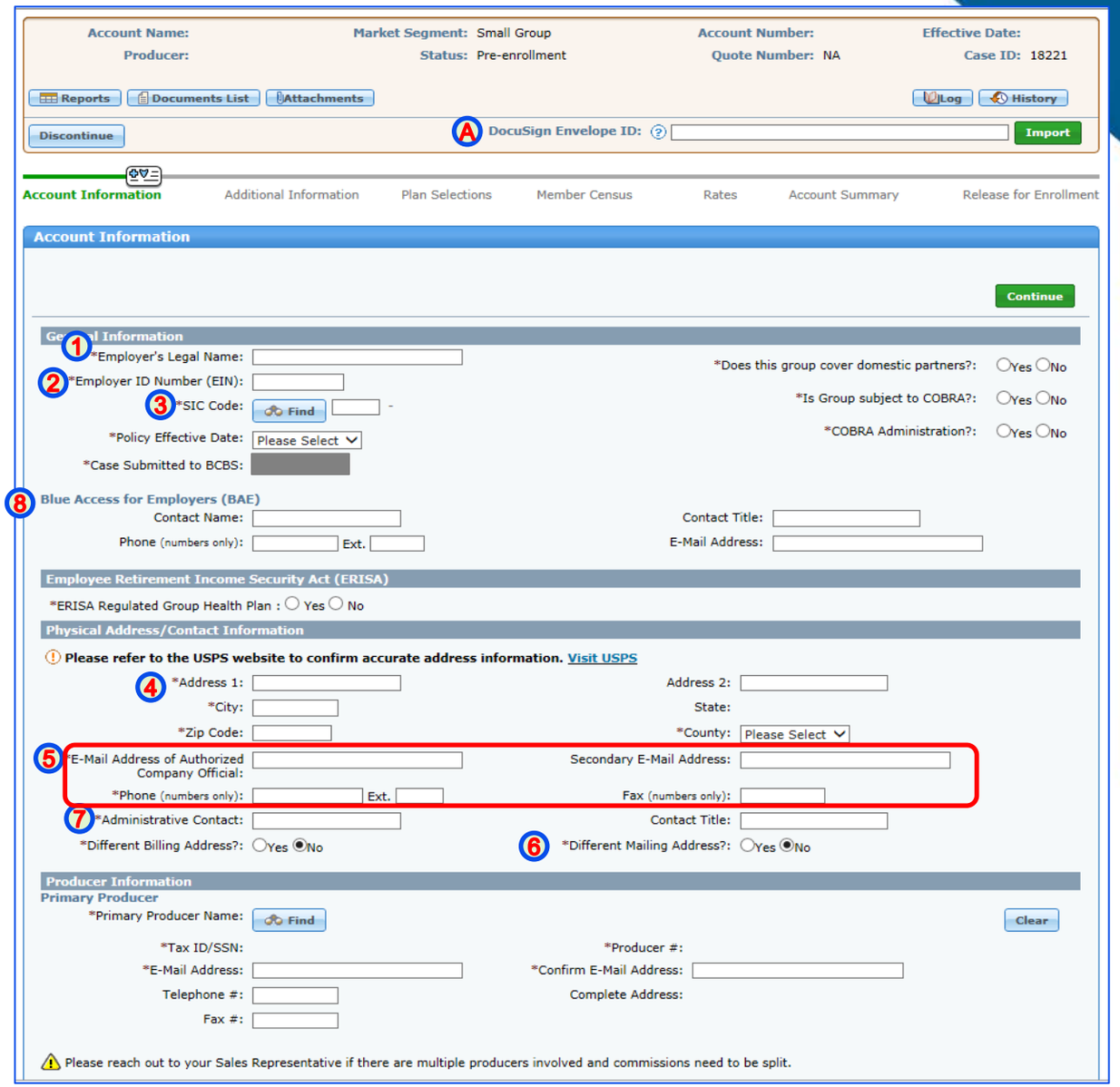
1. Legal Name of Company:
2. Employer Identification Number (EIN): | Nature of Business: | 3. Standard Industry Code (SIC):
4. Physical Address (number & street), City, State, ZIP:
5. E-Mail Address of Authorized Company Official: | Telephone Number:
   Secondary E-Mail Address, if different from Authorized Company Official: | FAX Number:
6. Complete Mailing Address, if different from physical address:
7. Billing and Correspondence to the attention of:

Billing Method Selection:
Please select one of the following billing methods.
☐ Composite Billing
☐ Age Billing

The Blue Access for Employers (BAE) contact person is the individual authorized by the Employer to access and maintain its account/employee information.
8. Name and title of the BAE contact person: ____
   E-mail address of BAE contact person: ____

A DocuSign Envelope ID: 89617335-443D-478B-B99E-877C7FBC8FF8

Small Group ACA Enrollment Tool



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9 Requested Contract(s)/Policy(ies) Effective Date (1st or 15th): ____/____/____ Month Day Year

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, 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.

10 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.

11 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).

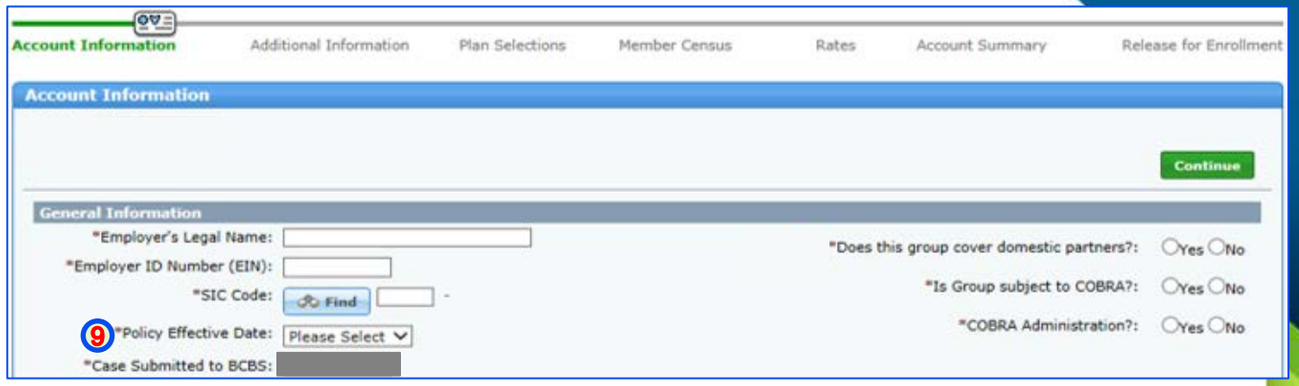
e. ☐ Other substantive eligibility criteria not described above; please describe:

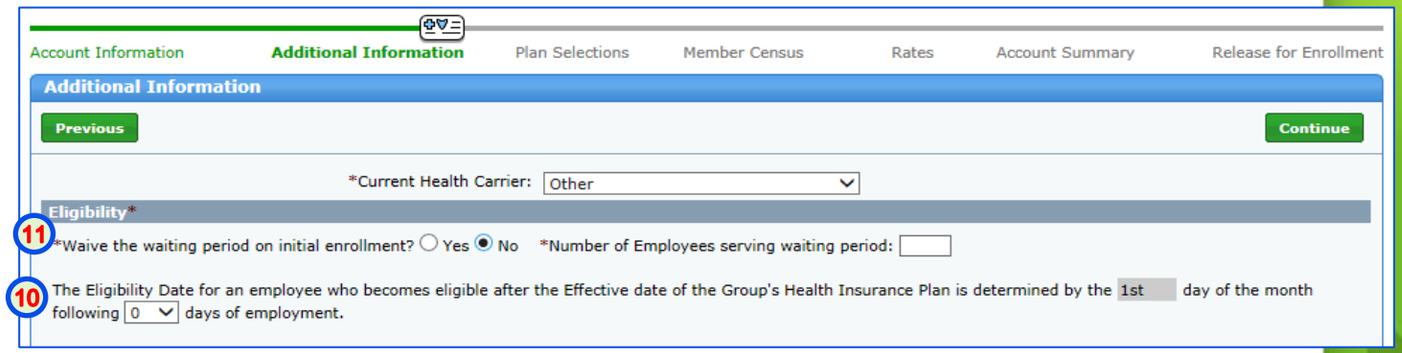
_____
_____
_____
_____

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

TXBPASG-OFF-EX01.17 Page 2 7.2016

Small Group ACA Enrollment Tool





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12 4. Domestic Partners covered: ☐ Yes ☐ No

If yes: A Domestic Partner, as defined in the Plan, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those covered Employees with Domestic Partners.

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

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

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

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

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

LEGISLATIVE REQUIREMENTS

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

13 Please provide your ERISA Plan Year*: Beginning Date: ____/____/____ End Date: ____/____/____
Month Day Year Month Day Year

ERISA Plan Sponsor*: _____

If you maintain that ERISA is not applicable to your account, please give the legal reason for exemption*:
☐ Federal Governmental plan (e.g., the government of the United States or agency of the United States)
☐ Non-Federal Governmental plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
☐ Church plan
☐ Other; please specify: _____

Please provide Non-ERISA Plan Year: ____/____/____
Month Day Year

For more information regarding ERISA, contact your Legal Advisor.

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

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Small Group ACA Enrollment Tool

General Information

*Employer's Legal Name:
*Employer ID Number (EIN):
*SIC Code: Find -
*Policy Effective Date: Please Select
*Case Submitted to BCBS:

12 *Does this group cover domestic partners?: Yes No
*Is Group subject to COBRA?: Yes No
*COBRA Administration?: Yes No

Blue Access for Employers (BAE)

Contact Name:
Phone (numbers only): Ext.
Contact Title:
E-Mail Address:

Employee Retirement Income Security Act (ERISA)

13 *ERISA Regulated Group Health Plan : Yes No

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BENEFIT PLAN SELECTIONS

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

14 Health Products/Benefit Plan Selection:

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

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

Benefit Design (select up to 3)		Blue Choice PPO		*Blue Advantage HMO℠		*Blue Premier Access℠	
		(select up to 6)					
☐	B600	☐	B600CHC				
☐	B633	☐	B633CHC				
☐	B634	☐	B634CHC	☐	B634ADT	☐	B634HMH
☐	B635					☐	B635HMH
☐	B651			☐	B651ADT		
☐	B652	☐	B652CHC	☐	B652ADT		
☐	S606	☐	S606CHC	☐	S606ADT	☐	S606HMH
☐	S607	☐	S607CHC	☐	S607ADT	☐	S607HMH
☐	S608	☐	S608CHC	☐	S608ADT		
☐	S609	☐	S609CHC	☐		☐	S609HMH
☐	S610	☐	S610CHC	☐	S610ADT	☐	S610HMH
☐	S611	☐	S611CHC	☐	S611ADT		
☐	G613	☐	G613CHC				
☐	G617	☐	G617CHC	☐	G617ADT		
☐	G618			☐	G618ADT		
☐	G619	☐	G619CHC				
☐	G620	☐	G620CHC	☐	G620ADT	☐	G620HMH
☐	G622	☐	G622CHC	☐	G622ADT		
☐	G623	☐	G623CHC	☐	G623ADT		
☐	G632			☐	G632ADT		

Small Group ACA Enrollment Tool

Account Information | Additional Information | **Plan Selections** | Member Census | Rates | Account Summary | Release for Enrollment

Plan Selections

Previous | Continue

14 Health ◉ Yes ○ No

In-Vitro Coverage: ○ Yes ◉ No

Blue Choice PPO Network

Plan #	Ded In/Out	Office Visit/ Specialist	Coins In/Out	OPX In/Out	ER Copay*†/ER Coins	IP In/Out	OP Surg In/Out	Ped Dental In/Out	Rx**
PPO Plans									
Blue Platinum Plans									
☐ P600CHC	$250/$500	$25/$45	80%/60%	$1250/$2500	$300/80%	$150/ $250	$100/$200	70%/70%	$5/$15/$45/$85/$150
☐ P601CHC	$1250/$2500	$25/$45	100%/100%	$1250/$2500	$300/100%	$150/ $250	$100/$200	100%/100%	$5/$15/$45/$85/$150
Blue Gold Plans									
☐ G620CHC	$1000/$2000	$20/$40	80%/60%	$3900/$7800	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$50/$65/$65
☐ G623CHC	$1250/$2500	$20/$60	100%/80%	$4500/$9000	$300/100%	$150/ $250	$100/$200	70%/70%	$5/$15/$60/$110/$150
☐ G622CHC	$1250/$2500	$30/$50	80%/60%	$3500/$7000	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$40/$55/$55
☐ G617CHC	$3000/$6000	$30/$50	100%/100%	$3000/$6000	$400/100%	$200/ $300	$150/$250	100%/100%	$5/$15/$60/$110/$150

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☐	G653			☐	G653ADT		
☐	P600	☐	P600CHC	☐	P600ADT		
☐	P601	☐	P601CHC	☐	P601ADT		

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

Additional Information: _____

DENTAL PRODUCTS/BENEFIT PLAN SELECTION:

Plan Pairings (Groups 10+)
True Group
Any one true group high option can be paired with any one true group low option; DTXHM11 can be freely paired with any true group.

High Option	Low Option
DTXHR01	DTXLR06
DTXHR02	DTXLR07
DTXHR03	DTXLM08

Voluntary
Any one voluntary high option can be paired with any one voluntary low option. DTXHM15 can be freely paired with any one voluntary option.

High Option	Low Option
DTXHR12	DTXLM14
DTXHM13	

Participation Requirements
True Group
>75% participation
>50% employer contribution

Voluntary
>25% participation
Employers are not required to contribute to Voluntary Dental plans

15 **DENTAL PLAN SELECTION**

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

Small Group ACA Enrollment Tool

15 * **Ancillary Products - Dental** ◉ **Yes** ○ **No**

If Dental is purchased, select from the following Dental plans.

	Plan #	Plan Type	Deductible In/Out*2	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance		Orthodontia Lifetime Max
						In Network	Out Of Network	
	True Group							
	High Allocation							
☐	DTXHR01	Passive	$25/$25	$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000
☐	DTXHR02	Passive	$50/$50	$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000
☐	DTXHR03	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500
☐	DTXHR04	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000
☐	DTXHM09*1	Passive	$50/$50	$1500	MAC	100%/80%/50%/NA	100%/80%/50%/NA	NA
☐	DTXHM11*3	Passive	$25/$25	$750	MAC	100%/80%/NA/NA	100%/80%/NA/NA	NA
	Low Allocation							
☐	DTXLR05	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA
☐	DTXLR06	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA
☐	DTXLR07	Passive	$75/$75	$1000	90th R&C	90%/70%/50%/NA	90%/70%/50%/NA	NA
☐	DTXLM08	Passive	$50/$50	$1500	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000
☐	DTXLM10*1	Passive	$75/$75	$1000	MAC	90%/70%/50%/NA	90%/70%/50%/NA	NA

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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

16 **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

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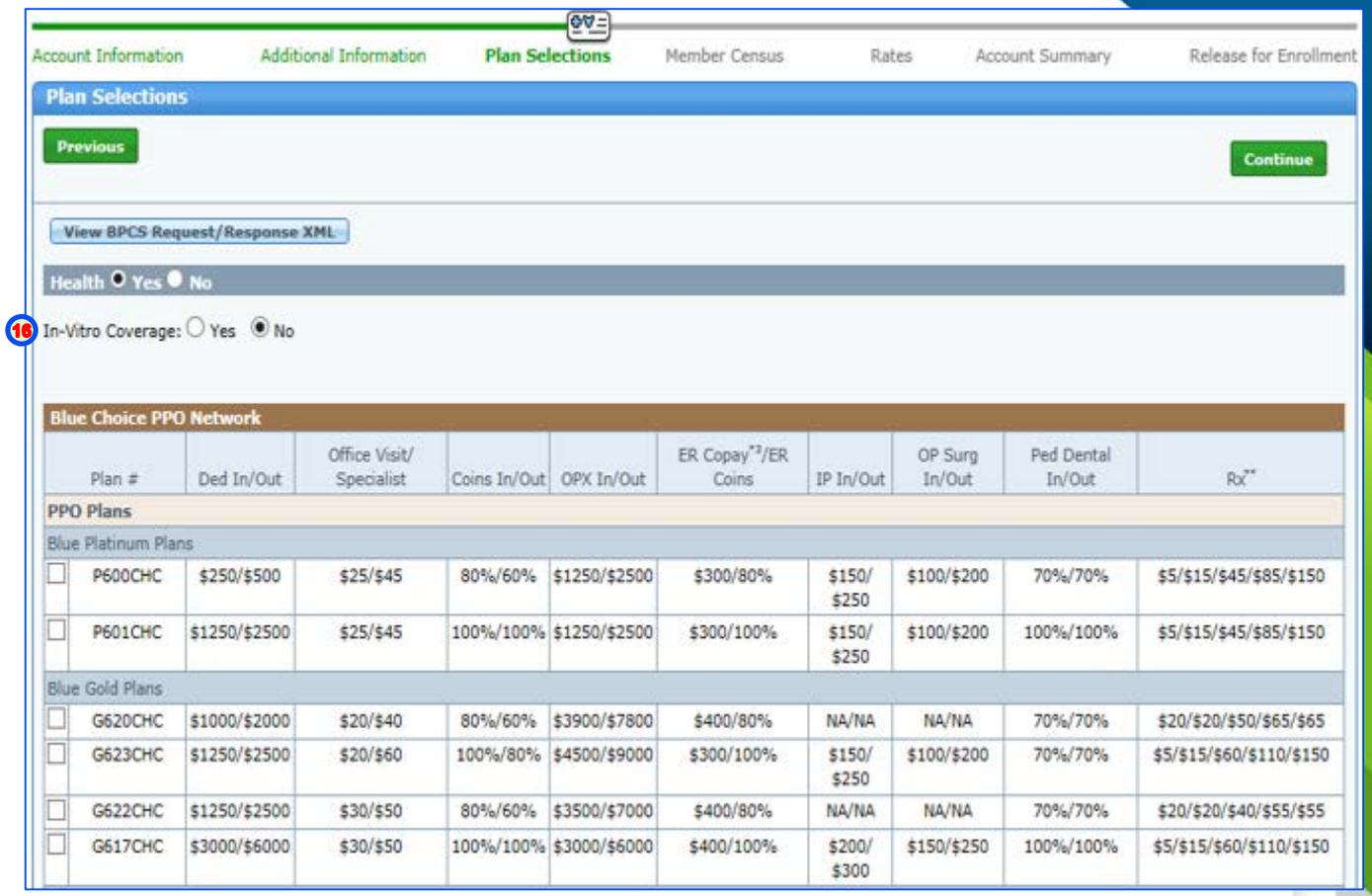

Plan #	Ded In/Out	Office Visit/ Specialist	Coins In/Out	OPX In/Out	ER Copay*3/ER Coins	IP In/Out	OP Surg In/Out	Ped Dental In/Out	Rx**
PPO Plans									
Blue Platinum Plans									
P600CHC	$250/$500	$25/$45	80%/60%	$1250/$2500	$300/80%	$150/ $250	$100/$200	70%/70%	$5/$15/$45/$85/$150
P601CHC	$1250/$2500	$25/$45	100%/100%	$1250/$2500	$300/100%	$150/ $250	$100/$200	100%/100%	$5/$15/$45/$85/$150
Blue Gold Plans									
G620CHC	$1000/$2000	$20/$40	80%/60%	$3900/$7800	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$50/$65/$65
G623CHC	$1250/$2500	$20/$60	100%/80%	$4500/$9000	$300/100%	$150/ $250	$100/$200	70%/70%	$5/$15/$60/$110/$150
G622CHC	$1250/$2500	$30/$50	80%/60%	$3500/$7000	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$40/$55/$55
G617CHC	$3000/$6000	$30/$50	100%/100%	$3000/$6000	$400/100%	$200/ $300	$150/$250	100%/100%	$5/$15/$60/$110/$150

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

I. Group Life Administration Information

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

Benefit: All employees according to the following schedule:

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

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

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

17 **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:

18 **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:	$

19 **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		
20 Benefits Begin:	Due to an Accident: (select one) ☐ 1st day ☐ 8th day ☐ 15th day ☐ 31st day	Due to Sickness: (select one) ☐ 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

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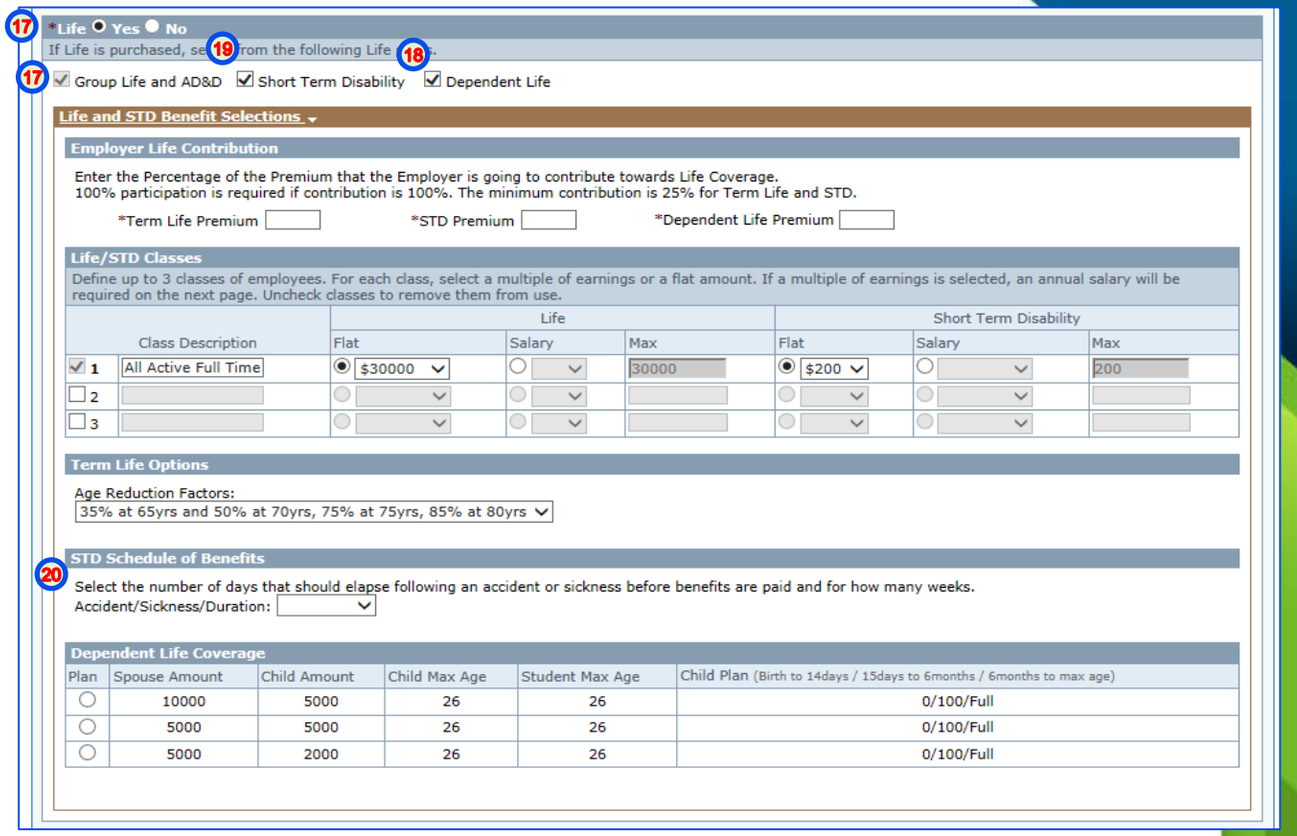

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PRODUCER'S STATEMENT
TO BE COMPLETED BY PRODUCER(S) - PLEASE PRINT

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

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

_____ ____ ____ ____
Writing Producer's signature Producer # Date Telephone #

_____ ____
BCBSTX Sales Representative Date

1. Primary Producer's or Agency Name* (to whom commissions are to be paid): _____
   (Please also use 2. below, for split commissions)
   Percentage of Split**:____
   Complete Address: _____
   Tax ID/SSN: _____ (21) Producer #:_____ FAX number: _____
   Name and phone # of agent to contact for this case: _____
   Contact's E-mail address (please print clearly): _____
2. Producer's or Agency Name* (if commissions are to be split): _____
   Percentage of Split**:____
   Street, City, ZIP: _____
   Tax ID/SSN: _____ Producer #:_____ FAX number: _____
   Contact's E-Mail address (please print clearly): _____
3. General Agent Name (if applicable): _____
   Street, City, ZIP:_____
   (22) Tax ID/SSN:_____ Producer #:_____ FAX number: _____
   Contact name and telephone number for this case: _____
   Contact's E-Mail address (please print clearly): _____
   General Agent's Signature: _____

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).
**If commissions are to be split, please provide the information requested above on both Producers or agencies. Both Producers or agencies must be appointed to do business with BCBSTX and/or Dearborn National and total commissions paid must equal 100%.

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Producer Information

Primary Producer

*Primary Producer Name: Find Clear
*Tax ID/SSN: (21) *Producer #:
*E-Mail Address: *Confirm E-Mail Address:
Telephone #: Complete Address:
Fax #:

⚠ Please reach out to your Sales Representative if there are multiple producers involved and commissions need to be split.

General Agent

General Agent Name: Find Clear
(22) Tax ID/SSN: Producer #:
E-Mail Address: Confirm E-Mail Address:
Telephone #: Complete Address:
Fax #:

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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

23 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

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