



**BlueCross BlueShield
of Illinois**

Offer Acceptance and Initial Premium Form

Identification Case ID: [Case Number]

Group Name: [Group Name]
Rate Effective Date: [Group Rate Effective Date]

Total Contracts: [# Total Contracts]
Next Renewal Date: [Group Renewal Date]

Proposed Health Benefits Plan

The following is the proposed Blue Cross and Blue Shield of Illinois (BCBSIL) health benefits plan(s) offered to replace your current UniCare plan(s):

Plan: [BCBS Plan Code]	EO	EC	ES	EF	Total
Monthly Rates	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]
Contract Enrollment	[xxx]	[xxx]	[xxx]	[xxx]	[xxx]
Plan: [BCBS Plan Code]	EO	EC	ES	EF	Total
Monthly Rates	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]
Contract Enrollment	[xxx]	[xxx]	[xxx]	[xxx]	[xxx]
Plan: [BCBS Plan Code]	EO	EC	ES	EF	Total
Monthly Rates	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]
Contract Enrollment	[xxx]	[xxx]	[xxx]	[xxx]	[xxx]

Estimated Health Benefits Initial Premium \$ [xxx.xxx]

Proposed Dental and Vision Benefits

This offer includes an opportunity to replace your UniCare dental and vision products with dental and vision products offered by BCBSIL, only when you accept BCBSIL guaranteed health benefits coverage.

Dental [Dental Plan Code]	EO	EC	ES	EF	Total
Monthly Rates	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]
Contract Enrollment	[xxx]	[xxx]	[xxx]	[xxx]	[xxx]
Vision [Vision Plan Code]					
Monthly Rates	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]	[\$xxx.xxx]
Contract Enrollment	[xxx]	[xxx]	[xxx]	[xxx]	[xxx]

Estimated Combined Health with Dental and Vision Initial Premium \$ [xxx.xxx]

Proposed Life, Disability and AD&D Benefits

Fort Dearborn Life Insurance Company (FDL), an affiliate of BCBSIL, extends this offer to UniCare policyholders for replacement life, accidental death and dismemberment (AD&D), and disability products, only when you accept BCBSIL guaranteed health benefits coverage.

Life & AD&D	Basic	Voluntary
Monthly Rates	[\$xxx.xxx]	
x Volume	[xxx]	
Total:	[\$xxx.xxx]	
Short Term Disability [FDL Plan]	Basic	Voluntary
Monthly Rates	[\$xxx.xxx]	
Covered Payroll	[xxx]	
Total:	[\$xxx.xxx]	
Long Term Disability [FDL Plan]	Basic	Voluntary
Monthly Rates	[\$xxx.xxx]	
Covered Payroll	[xxx]	
Total:	[\$xxx.xxx]	

Estimated Life and AD&D, Short and Long Term Disability Initial Premium \$ [xxx.xxx]

If you choose to **DECLINE** the BCBSIL (or FDL) specialty product offer and to retain your existing Unicare specialty product, you will need to **EXCLUDE** the product from your acceptance of this offer by checking the appropriate box. If excluding, **DEDUCT** the portion of the premium indicated below from the estimated initial premium payment.

Check if:	If excluded, deduct:
<input type="checkbox"/> Exclude Dental	\$ _____
<input type="checkbox"/> Exclude Vision	\$ _____
<input type="checkbox"/> Exclude Life	\$ _____
<input type="checkbox"/> Exclude Disability	\$ _____

Note: You are not required to select BCBSIL (or FDL) specialty product(s) in order to take advantage of this special offer for health benefits coverage.

You may accept this offer online at www.bcbsil.com/gobluegroup. Enter your identification case number and other group information found on your cover letter and follow the steps for completing the offer acceptance. Or, sign and fax this acceptance sheet to 312-946-3799, attention: BCBSIL Group Limited Offer. Or, sign and mail your acceptance using the enclosed envelope.

Your response is needed by **Tuesday, December 1, 2009.**

ACKNOWLEDGED AND AGREED:

Yes, I accept this exclusive, one-time only offer from BCBSIL for health coverage and specialty products, and from FDL for life, disability and AD&D products, to replace policies currently provided by UniCare (except for the specialty products I have excluded above).

With this acceptance:

- (i) I acknowledge that I have read and understand the BCBSIL offer dated October 29, 2009; and
- (ii) I agree that my UniCare group health policy and my UniCare specialty products (except for those specialty products excluded above) are terminated effective at the end of December 31, 2009; and
- (iii) I acknowledge that this BCBSIL group health policy and BCBSIL (or FDL) policies for specialty products (except for those specialty products excluded above) becomes effective 11:59 p.m. on December 31, 2009, but only after I have paid the initial premium amount due, as shown above; and
- (iv) I authorize the transfer to BCBSIL (or FDL, if applicable) of all files and records related to the subscribers and dependents covered under the UniCare health policy and other specialty products issued to our group (except for the specialty products excluded above); and
- (v) I understand that this acceptance represents my written application for new BCBSIL group policy for medical expense insurance, as outlined above; and
- (vi) I authorize the transfer by UniCare to BCBSIL of any premium paid by me to UniCare for periods after December 31, 2009.

Signature, Authorized Representative:

Print Name:

Phone Number:

Date:

Please retain a copy of this Offer Acceptance for your records.