



Blue Cross and Blue Shield of Illinois, A Division of Health Care Service Corporation, 300 E Randolph, Chicago, IL 60601  
 Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148

**BENEFIT PROGRAM APPLICATION (“BPA”)**

(All items are applicable to Grandfathered and Non-Grandfathered Insured Small Group Accounts unless otherwise specified.)  
 (All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Group No.(s): _____	Section No.(s): _____
Account No. (Blue Star <sup>SM</sup> ): _____	Customer No. (if different, for existing business only): _____
Employer’s Legal Name: _____ (Specify the employer applying for coverage and list the names of any subsidiary or affiliated companies to be covered below.)	
Address: _____	
City: _____	State: _____ Zip Code: _____
Billing Address (if different from above): _____	
City: _____	State: _____ Zip Code: _____
Employer Identification Number (“EIN”): _____	Standard Industry Code (SIC): _____
Wholly Owned Subsidiaries to be covered: _____	
Affiliated Companies to be covered: _____	
(Affiliated Companies must be required or permitted to be aggregated per IRS guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m), or (o), or under applicable law.)	
Administrative Contact: _____	Email: _____
Phone: _____	Fax: _____
Blue Access for Employers <sup>SM</sup> (“BAE <sup>SM</sup> ”) Contact: _____ (The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE)	
Title: _____	Email: _____
Phone: _____	Fax: _____
Policy Effective Date: _____	Policy Anniversary Date: ____/____/____

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: \_\_/\_\_/\_\_ End Date: \_\_/\_\_/\_\_ (month/day/year)

ERISA Plan Sponsor\*: \_\_\_\_\_

ERISA Plan Administrator\*: \_\_\_\_\_

ERISA Plan Administrator’s Address: \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

ERISA Plan Administrator's Email: \_\_\_\_\_

Please provide your Non-ERISA Plan Month/Year: \_\_\_/\_\_\_

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.

## ELIGIBILITY:

1. **Eligible Person:** Employer has decided that Eligible Person means a Full-Time Employee of the Employer. Full-time Employee means an Employee of the Employer who is regularly scheduled to work a minimum of thirty (30) hours per week.

The term "Employee" shall have the meaning set forth under ERISA and applicable law. Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("BCBSIL") reserves the right to audit Employer's initial and ongoing eligibility determinations.

2. **Civil Union Partner Coverage:** A Civil Union partner, as defined in the Policy, and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union partners.

3. **Domestic Partner Coverage:** Yes  No

If Employer elects "Yes" a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage. An Employer may only elect or change Domestic Partner Coverage on the Policy Effective Date or Policy Anniversary Date.

**Continuation coverage for Domestic Partners:** If Employer elects coverage for Domestic Partners, Domestic Partners are eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if the Employee elects COBRA coverage. Employer shall determine eligibility for COBRA continuation coverage for Domestic Partners, if any, on an independent basis from the Employee. Please indicate your election below:

- Yes, Employer elects to offer continuation coverage to Domestic Partners, as defined in the Certificate Booklet on an independent basis from the Employee
- No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from the Employee (Domestic Partners are not independently eligible for continuation coverage)
- Other: \_\_\_\_\_

4. **Retiree Coverage:** Yes  No  If yes, complete the following, as applicable:

- A. Retiree means those persons covered as retirees under the Employer's health care plan prior to the date the Employer initially purchased coverage from BCBSIL. Yes  No  If yes, complete item 4.B. below.

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**B. Eligible Persons:** If applicable, list the names of persons of the group who are eligible retirees as described in Item 4.A. above.

Name of Retiree	Name of Retiree

**C.** Retiree means those persons who retire on or after the effective date of this Benefit Program Application: Yes  No  If yes: Such retirees must be at least \_\_\_\_\_ years of age on the date of retirement with \_\_\_\_\_ years of continuous full-time employment with the Employer. Note: Minimum years of age is fifty-five (55); minimum years of continuous full-time employment is ten (10).

For existing groups, former employees who retired after the date the Employer initially purchased coverage from BCBSIL and prior to the initial effective date of the retiree coverage specified in item 4.C. above are not eligible. An Employer may only elect or change retiree coverage on the Policy Effective Date or Policy Anniversary Date.

**5. Eligibility Date:** All current and new employees must satisfy the substantive eligibility criteria and required waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

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 BCBSIL, BCBSIL reserves the right to retroactively adjust the Coverage Date for such person.

**A. For Health and Dental PPO Coverage:**

<input type="checkbox"/> The date of employment.	<input type="checkbox"/> The _____ day of employment. <b>Note:</b> This may not exceed ninety-one (91) calendar days	<input type="checkbox"/> The first (1 <sup>st</sup> ) day of the month following the date of employment.
<input type="checkbox"/> The _____ day of the month following _____ month(s) of employment		
<input type="checkbox"/> The _____ day of the month following _____ days of employment (option of up to sixty (60) days)		
Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.		
Waive the Waiting Period on initial group enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Number of employees serving Waiting Period: _____		

**B. For Life, Short-term or Long-term Disability, Accident, Critical Illness, or Vision Coverage: (If purchasing life or other coverage, the account must have a first (1<sup>st</sup>) of the month effective date):**

<input type="checkbox"/> The date of employment.	<input type="checkbox"/> The _____ day of employment. <b>Note:</b> This may not exceed ninety-one (91) calendar days	<input type="checkbox"/> The first (1 <sup>st</sup> ) day of the month following the date of employment.
<input type="checkbox"/> The _____ day of the month following _____ month(s) of employment		
<input type="checkbox"/> The _____ day of the month following _____ days of employment (option of up to sixty (60) days)		
Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.		
Waive the Waiting Period on initial group enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Number of employees serving Waiting Period: _____		

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- C. 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. If any of these eligibility conditions change, Employer is required to submit a new BPA to reflect that new information.

Check all that apply:

- An Orientation Period that:
- 1) Does not exceed one (1) month (calculated by adding one (1) calendar month and subtracting one (1) 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 (1<sup>st</sup>) day after the orientation period.
- A Cumulative hours of service requirement that does not exceed twelve hundred (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 (1<sup>st</sup>) day of the following month;
  - 2) Does not exceed twelve (12) months; and
  - 3) Taken together with other eligibility conditions does not result in coverage becoming effective later than thirteen (13) months from the employee's start date plus the number of days between a start date and the first (1<sup>st</sup>) day of the next calendar month (if start day is not the first (1<sup>st</sup>) day of the month).
- Other substantive eligibility criteria not described above; please describe: \_\_\_\_\_

- 6. Limiting Age for covered children:** Hereafter, covered children means a natural child, a stepchild, an eligible foster child, an adopted child (including a child involved in a suit for adoption), a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet. For health and dental Plans, coverage will terminate at the end of the period for which premium has been accepted. For Life Plans, coverage will terminate on the birthday. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

- 7. Disabled Dependent:** Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Civil Union partner and/or Domestic Partner, if elected). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered as a dependent under the Plan or as a dependent child under another employer plan, but before the child attains the limiting age with no break in coverage. A disabled Dependent is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled Dependent is eligible to add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled Dependent is provided.

Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

**8. Enrollment:**

**Special Enrollment:** An Eligible Person may apply for coverage, Family coverage or add dependents within thirty (30) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so; provided, however, if a newborn is added as a dependent, such addition must be within thirty-one (31) days. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage. In the case of a Special Enrollment event due to loss of coverage under

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Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

**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. The Open Enrollment Period is to be held thirty (30) days prior to the Policy Anniversary Date of the program. Such person's Individual Coverage Date, Family Coverage Date and/or dependent's Coverage Date will be the Policy Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

**Late Enrollment:** For Life, Accidental Death and Dismemberment (AD&D), and Long and Short-Term Disability Plans only, an Eligible Person who did not apply under Timely Enrollment may apply for Individual coverage, Family coverage or add dependents during the Annual Open Enrollment. Late enrollees must furnish acceptable evidence of insurability.

9. **Extension of Benefits:** An Extension of Benefits will be provided for a period of thirty (30) days in the event of Temporary Layoff, Disability or Leave of Absence. However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. For Life Plans, an extension of benefits will be provided as follows: Due to Disability - until the end of the twelfth (12<sup>th</sup>) month following the month in which the disability began; Due to Layoff and Leave of Absence - until the end of the month following the month during which the layoff or leave of absence began. The extension will apply, provided all premiums are paid when due.

10. **Premium Period:** The Premium Period must be consistent with the Policy Effective Date and/or Policy Anniversary Date. *Note:* Groups with Life and/or Disability, Accident, Critical Illness, Vision coverage and having less than one hundred dollars (\$100.00) monthly combined premium for those coverages will be billed on a quarterly basis.

11. **Employer Contribution:**

A. **The following elections apply to both Grandfathered and Non-Grandfathered Groups: Health and Dental Plans:**

<input type="checkbox"/> _____ % for Employee Coverage	<input type="checkbox"/> _____ % for Employee plus Spouse Coverage
<input type="checkbox"/> _____ % for Employee plus Child(ren) Coverage	<input type="checkbox"/> _____ % for Family Coverage
<input type="checkbox"/> One hundred percent (100%) of the Employee Coverage Premium will be applied toward the Family Coverage Premium.	<input type="checkbox"/> Other (specify): _____

B. **The following applies to Grandfathered Groups:** The required minimum employer contribution is twenty-five percent (25%). No policy will be issued or renewed unless at least seventy percent (70%) of eligible employees have enrolled for coverage. This applies to health and dental business separately. This does not include those eligible employees waiving coverage under BCBSIL due to other creditable coverage. In no event, however, shall the policy be renewed unless at least one (1) eligible employee has enrolled for coverage.

C. **The following applies to Non-Grandfathered Groups:** BCBSIL reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of twenty-five percent (25%), and at least a seventy percent (70%) participation of eligible employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the twenty-five percent (25%) minimum employer contribution is met and at least seventy percent (70%) participation of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify BCBSIL of any change in participation and Employer contribution.

D. **The following applies to both Grandfathered and Non-Grandfathered Groups:** BCBSIL 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 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.

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**E. The following elections apply to both Grandfathered and Non-Grandfathered Groups: Life, Accidental Death & Dismemberment (AD&D), Supplemental Life and AD&D, and Short-Term Disability, Long-Term Disability, Critical Illness, Accident, or Vision Plans:**

<input type="checkbox"/> Group Life, AD&D Plan Selected: _____ Employer Contribution: _____%	<input type="checkbox"/> Dependent Life Employer Contribution: _____%	<input type="checkbox"/> Supplemental Life Insurance and AD&D Employer Contribution: _____%
<input type="checkbox"/> Short-Term Disability Plan Selected: _____ Employer Contribution: _____%	<input type="checkbox"/> Long-Term Disability Plan Selected: _____ Employer Contribution: _____%	<input type="checkbox"/> Critical Illness Plan Selected: _____ Employer Contribution: _____%
<input type="checkbox"/> Accident Insurance Plan Selected: _____ Employer Contribution: _____%	<input type="checkbox"/> Vision Plan Selected: _____ Employer Contribution: _____%	

If the employer contributes one hundred percent (100%) toward the cost of coverage, no policy will be issued or renewed unless at least one hundred percent (100%) of eligible employees have enrolled for that coverage. If both the employer and employee contribute toward the cost of coverage, no policy will be issued or renewed unless at least seventy-five percent (75%) of eligible employees have enrolled for that coverage. Eligible employees are those who meet the definition of an Eligible Person, regardless of if an eligible employee waives coverage under BCBSIL medical due to having coverage elsewhere.

**12. Wellbeing Management (included)**

**EMPLOYER STATEMENTS:**

1. The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the proposal document submitted to the Employer by the Sales Representative. It is understood and agreed that the actual terms and conditions are those contained in the Policy. It is further understood and agreed that the terms of the BPA may be subject to change. The final terms may be specified in a benefit program and premium notification letter or the applicable rate summary(ies) for the plan number(s) selected which may be attached hereto and made a part of the BPA. Payment of the first (1<sup>st</sup>) premium due under the Policy constitutes acceptance of such terms.
2. This BPA is subject to acceptance by BCBSIL as to coverage it underwrites. We certify that all the information and all attestations provided to BCBSIL is correct and complete. Upon acceptance of this BPA, BCBSIL shall issue a Policy to the Employer and this BPA and the benefit program and premium notification letter or the applicable rate summary (ies) for the plan number(s) selected shall be incorporated and made a part of the Policy. Upon acceptance of this BPA by BCBSIL and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the proposal document and the Policy, the provisions of the Policy shall prevail.
3. The undersigned representative acknowledges that any producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if BCBSIL accepts this BPA and issues a Policy to the Employer, BCBSIL may pay the Employer's producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid to the producer by BCBSIL in connection with the issuance of a Policy, the Employer should contact its producer.
4. The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the

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purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities there under. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Employer is effective with respect to or accepted by BCBSIL except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by BCBSIL.

5. **With respect to Life, and Short-Term Disability, Long-Term Disability, Critical Illness, Accident, and Vision coverage applied for:** We agree to comply with and participate in all provisions of the Group Policy providing the coverage applied for. We understand that BCBSIL intends to rely on this information in determining whether the enrolling employees may become insured.

#### OTHER PROVISIONS:

1. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.
2. **Massachusetts Health Care Reform Act:** Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

If elected below, BCBSIL will provide required written statements of Minimum Credible Coverage (MCC) to Covered Persons residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSIL by Employer and coverage under the Plan(s) during the term of this Policy. By electing to have BCBSIL transmit these creditable coverage reports on Employer's behalf, Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that BCBSIL is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

- Employer consents to BCBSIL transmitting MCC reports on its behalf Further, Employer attests that the information submitted is true and compliant with all relevant MCC Regulations.
- Employer will transmit MCC reports and any other documentation as may be required to comply with the Massachusetts Health Care Reform Act.

3. **Reimbursement:** It is understood and agreed that in the event BCBSIL makes a recovery on a third-party liability claim, BCBSIL 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.
4. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services):** BCBSIL engages with third-party recovery vendors and law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.

#### ADDITIONAL PROVISIONS:

- A. **Grandfathered Health Plans:** Policyholder shall provide BCBSIL with written notice prior to renewal (and during the plan year, at least sixty (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

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to provide timely notice thereof) can result in retroactive and/or prospective changes by BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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 Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide BCBSIL with any requested grandfathered health plan information, BCBSIL 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 Policyholder represents and warrants that one (1) 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 BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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.** Policyholder shall indemnify and hold harmless BCBSIL 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 BCBSIL in connection with (a) any plan’s grandfathered health plan status, (b) any plan’s exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, (e) the SBC, and/or (f) any plan’s design (including but not limited to any directions, actions and interpretations of the Policyholder). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (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.

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

**Renewals Only:** If this BPA is blank, it is intentional, and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Policyholder’s first (1<sup>st</sup>) renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this BPA to eligible dependents may include Domestic Partners or Civil Union partners but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child’s financial dependency, residency, student status, employment, marital status or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the certificate booklet.

Any reference in this BPA to the “Employee plus one (1) dependent” rate structure means “Employee plus one (1) spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one (1) child.”

Any reference in this BPA to the “Employee plus Child(ren)” rate structure means “Employee plus one (1) or more children.”

**The following one (1) paragraph applies to Non-Grandfathered Groups:** BCBSIL reserves the right to restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the twenty-five percent

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(25%) minimum employer contribution is met and at least seventy percent (70%) of eligible employees (less valid waivers) have enrolled for coverage.

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\_\_\_\_\_  
Producer Agency Representative

\_\_\_\_\_  
Signature of Employer/Authorized Purchaser

\_\_\_\_\_  
Signature of Producer Agency Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Producer Agency Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer Address

\_\_\_\_\_  
Witness

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Producer Phone No.

\_\_\_\_\_  
Producer Number

\_\_\_\_\_  
Contracted Producer Tax ID No.

\_\_\_\_\_  
Other Information: \_\_\_\_\_

\_\_\_\_\_  
BCBSIL Sales Representative      District / Cluster

<b>UNDERWRITING AUTHORIZATION</b>	
<b>INTERNAL USE ONLY</b>	Benefit program and premium notification letter included: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date of Letter: _____

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# PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), or any successor thereof, 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 HCSC 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 thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked either in writing by the undersigned at least twenty (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 its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No(s): \_\_\_\_\_

By: \_\_\_\_\_  
Print Signer's Name Here



Signature and Title

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Month Year

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