# BCBSOK and BlueLincs

# Large (151+) EMPLOYER BENEFIT PROGRAM APPLICATION

**(Employer Application)**

# Blue Cross and Blue Shield of Oklahoma (herein called BCBSOK)

**BlueLincs HMO (herein called BlueLincs)**

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| *(For internal use only)*  Account Status:  New  Renewing  Benefit Change  Former HCSC ASO (converting to Fully Insured) | | | | | |
| Account Number (6-digits): | Group Number(s): | | | | Section Number(s): |
| Group Contract/Agreement Date: | Group Contract/Agreement Date Anniversary: | | | | |
| Legal Name of Company: | | | | | |
| Company name will appear on member ID cards. 32 character spaces are allowed. If variation from legal name of company is necessary or desired, please indicate specifics here: | | | | | |
| Requested Group Contract(s) / Agreement(s) Effective Date (1st or 15th):       /     /  Month Day Year | | | | AAnniversary Date (AD): | |
| Employer Identification Number (EIN): | | Standard Industry Code (SIC): | | Company Telephone Number: | |
| Primary Mailing Address: Number, Street, City, State, Zip | | | | | |
| Physical Address (required if different from primary): Number, Street, City, State, Zip | | | | | |
| Billing Address (if different from primary – If more than one, please list within Additional provisions): Number, Street, City, State, Zip | | | | | |
| Name and Title of Authorized Company Official:  Email and Phone Number | | | | | |
| Billing to the attention of: | | | Fax Number: | | |
| The Blue Access® for Employers (BAE) contact person is the Employee authorized by the Employer to access and maintains its account/Employee information via BAE. An email address is required to access and maintain BAE.  Name and title of BAE contact person:  Telephone Number of BAE contact person:  E-Mail address of BAE contact person: | | | | | |
| Subsidiary / Affiliated Companies (If more than one, please list within Additional provisions): Name and Address Number, Street, City, State, Zip | | | | | |

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| 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, is your ERISA Plan Year\* a period of 12 months beginning on the Anniversary Date specified above?  Yes  No  If No, please specify your ERISA Plan Year: Beginning Date:      /     /      End Date:      /     /      (month/day/year)  ERISA Plan Administrator \*:       Plan Administrator’s Address:  If you maintain that ERISA is not applicable to your Group Health Plan, 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 (complete and attach a Medical Loss Ratio Assurance form)  Other; please specify:  Is your Non-ERISA Plan Year a period of 12 months beginning on the Anniversary Date specified above?  Yes  No  If No, please specify your Non-ERISA Plan Year: Beginning Date:      /     /      End Date:      /     /      (month/day/year)  **For more information regarding ERISA, contact your Legal Advisor.**  \*All as defined by ERISA and/or other applicable law/regulations. |
|  |

**NO CHANGES** **ELIGIBILITY AND EMPLOYEE EFFECTIVE DATE INFORMATION**

1. Eligible Person (please check all boxes that apply):

A full-time Employee of the Employer.

A part-time Employee of the Employer.

An Eligible Person may also include a retiree of the Employer. (please specify):

Other (please specify):

1. Employer has determined Employees must routinely work       (minimum of 24) hours per week and who is on the permanent payroll of Employer in order to be eligible for health/dental coverage under this Group Contract/Agreement.
2. DomesticPartnerscovered?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.

If yes, are Domestic Partners eligible for continued coverage equivalent to COBRA continuation?  Yes  No

If yes, are Dependents of Domestic Partners eligible for coverage?  Yes  No If yes, the Limiting Age for covered children of Domestic Partners means twenty-six (26) years, regardless of presence or absence of a child’s financial dependency, residency, student status, employment, marital status or any combination of those factors.

4. The Effective Date of coverage for a newly Eligible Employee who becomes effective after the Employer’s initial enrollment date is:

The date of employment.

The first billing cycle following the date of employment.

The first billing cycle following       days of continuous employment. (select, 30 or 60 days)

The first billing cycle following       months of continuous employment. (select 1 or 2 months)

The       day of employment (Select 1, 2, 30, 60 or 90 days)

Other (please specify):

5. 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, 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).

Other substantive eligibility criteria not described above; please describe:

6. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person will be the end of the coverage period (billing cycle) during which the person ceases to meet the definition of Eligible Person.

Other (please specify):

7. Is the waiting period requirement to be waived on initial group enrollment?  Yes  No

8. Did you have a waiting period requirement with the prior carrier?  Yes  No

If Yes, please state waiting period requirement of the prior carrier.

9. Limiting Age for covered children:

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, 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.

A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

Other:       (Indicate Maximum Age) Age twenty-six (26) and over are available options. Please explain any limitations or requirements for extension of coverage beyond the minimum required age of twenty-six (26).

Termination of coverage upon reaching the Limiting Age:

* Coverage is terminated at the end of the coverage period (billing cycle) during which the Dependent ceases to be eligible, subject to any applicable federal or state law.

10. Late Enrollment and Open Enrollment:

*Late Enrollment:*An Eligible Person may apply for coverage, coverage to include his/her Dependents or add Dependents if he/she did not apply during his/her Initial Enrollment Period. The Effective Date for such person and/or his/her Dependent(s) will be the next Group Contract/Agreement Date Anniversary.

Other (please specify):

Open Enrollment:An Eligible Person may apply for coverage, coverage to include his/her Dependents or add Dependents if he/she did not apply during the Initial Enrollment Period, during the Employer’s Open Enrollment Period.

* Specify Open Enrollment Period:

31 days immediately preceding the Group Contract/Agreement Date Anniversary.

Other (please specify):

The Effective Date for such person and/or his/her Dependent(s) will be:

The Group Contract/Agreement Date Anniversary.

A date mutually agreed to by BCBSOK/BlueLincs and the Employer. Such date shall be subsequent to the Open Enrollment Period. (please explain):

11. EHB Election:

Employer elects EHBs based on the following:

1. EHBs based on an HCSC state benchmark:

Illinois  Oklahoma

Montana  Texas

New Mexico

2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

If so, indicate the state's benchmark that Employer elects:

12. Other Eligibility Provisions (Please explain)

**CONTRIBUTION AND PARTICIPATION**

**STANDARD PREMIUM INFORMATION**

(a) Premium Period:

The first day of each calendar month through the last day of each calendar month.

The 15th day of each calendar month through the 14th day of the next calendar month.

Other (please specify):      .

(b) Premium Change Notice:

31 days (standard)

Other (please specify):

(c) Health Employer Contribution, the percentage**\*** of health premium to be paid by the Employer is:

|  |  |  |
| --- | --- | --- |
| **Medical -- % or $** | | |
| **Employee Only Coverage** | % | $ |
| **Employee/Spouse Coverage** | % | $ |
| **Employee/Children Coverage (i.e. Employee plus one or more Children Coverage)** | % | $ |
| **Family Coverage** | % | $ |
|  | % | $ |

\*The minimum contribution amount which is required from the Employer is 50% of the premium for Employee Only (Single Coverage).

(d) BlueCare Dental Employer Contribution if applicable, the percentage of BlueCare Dental premium to be paid by the Employer is:

|  |  |  |
| --- | --- | --- |
| **Dental -- % or $** | | |
| **Employee Only Coverage** | % | $ |
| **Employee/Spouse Coverage** | % | $ |
| **Employee/Children Coverage (i.e. Employee plus one or more Children Coverage)** | % | $ |
| **Family Coverage** | % | $ |
|  | % | $ |

BlueCare Dental minimum contribution amount which is required from the Employer is 50% of the premium for the Employee Only (Single Coverage).

+Voluntary Group Dental product does not require an Employer contribution.

(e) **Minimum Participation and Employer Contribution:**

BCBSOK/BlueLincs reserves the right to take any or all of the following actions:

a) initial rates for new groups will be finalized for the Effective Date of the Group Contract/Agreement based on the enrolled participation and Employer contribution levels; b) after the Group Contract/Agreement Effective Date the group will be required to maintain a minimum Employer contribution of 50%, and at least a 75% 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 c) non-renew or discontinue coverage unless the 50% minimum Employer contribution is met and at least 75% of eligible Employees (less valid waivers) have enrolled for coverage.

If applicable, BCBSOK/BlueLincs 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/Members 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 BCBSOK/BlueLincs of any change in participation and Employer contribution.

BlueSelect Voluntary Group Dental has specific participation requirements. The contract and endorsements contain the terms and conditions.

**NO CHANGES** **HEALTH LINES OF BUSINESS**

Please check all products for which you are applying and indicate the applicable health plan or package number(s) (if available) below.

Blue Options® PPO Additional Blue Options® PPO Plan  Yes  No

Blue Choice® PPO Additional Blue Choice® PPO Plan  Yes  No

Blue Preferred® PPO Additional Blue Preferred® PPO Plan  Yes  No

Blue Traditional®

BlueLincs® HMO

HSA Blue® Plan #

Health Care Account (Complete & attach a separate HCA application.)

BlueEdge FSA (Vendor: Connect Your Care)

Blue Directions (Private Exchange) purchased  Yes  No (if Yes, the Blue Directions Addendum is attached and made a part of the Group Contract/Agreement.)

Other

**NO CHANGES** **DENTAL LINES OF BUSINESS**

Please check all products for which you are applying and indicate the applicable dental plan or package number(s) (if available) below.

BlueCare® Dental Plan #

BlueSelect® Voluntary Group Dental Plan #

Custom Voluntary BlueCare® Dental

Custom Dental Benefits

Other

**NO CHANGES VISION LINE OF BUSINESS**

Please indicate if vision coverage is elected:  Yes  No

**Other Benefit Provisions (Please explain):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **RATES (Per Benefit Agreement if different)** | | | | | | | |
| **Select rate structure:**  **2 Tier**  **3-Tier**  **4-Tier** | | | | | | | |
| **Product/Coverage** | **EE** | **EE/SP** | **EE/CH** | **Family** |  | **Medicare Carve-Out** | |
| **EO** | **ES** |
| Blue Choice |  |  |  |  |  |  |  |
| Blue Preferred |  |  |  |  |  |  |  |
| Blue Options |  |  |  |  |  |  |  |
| Blue Traditional |  |  |  |  |  |  |  |
| BlueLincs HMO |  |  |  |  |  |  |  |
| HSA Blue |  |  |  |  |  |  |  |
| Dental |  |  |  |  |  |  |  |
| Vision |  |  |  |  |  |  |  |
| Custom Benefits |  |  |  |  |  |  |  |
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The above initial monthly premium rates shall be in effect beginning on      , and are subject to change by BCBSOK/BlueLincs after the premium rates are in effect for a period of at least       months and/or there is a substantial change in the number of covered Employees.

**LEGISLATIVE REQUIREMENTS**

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| **Tax Equity and Fiscal Responsibility Act of 1982** **(TEFRA)** and the **Consolidated Omnibus Budget Reconciliation Act (COBRA)** are federally mandated requirements. Employer penalties for noncompliance may apply. It is your responsibility to annually inform BCBSOK/BlueLincs of whether **COBRA** is applicable to you based upon your full and part-time Employee count in the prior calendar year.  **Failure to advise BCBSOK/BlueLincs of a change of status could subject you to governmental sanctions.**  **TEFRA** is a Medicare secondary payer requirement that mandates Employers that employ 20 or more (full-time, part-time, seasonal, or partners) total Employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year to offer the same (primary) coverage to their age 65 or over Employees and the age 65 or over spouses of Employees of any age that they offer to younger Employees and spouses.  **Are you subject to TEFRA? Yes**  **No** |

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| **COBRA**  a. Did your company employ 20 or more full-time and/or part-time Employees for at least 50% of the workdays of the  preceding calendar year? **Yes**  **No**  b. **Are you subject to COBRA? Yes  No** |

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| **MENTAL HEALTH PARITY AND ADDICTION EQUITY (MHPAE) ACT OF 2008**  Under federal law, it is the Employer’s responsibility to provide its insurer with proper Employee counts for the purpose of determining whether the Employer meets the federal definition of small Employer and, therefore, qualifies for the small Employer exemption allowed under this law. The MHPAE Act defines a small Employer as an Employer who employed an average of at least two but not more than 50 Employees on business days during the preceding calendar year.  **Financial penalties may be assessed for non-compliance with this law when the Employer**  **does not qualify for the small Employer exemption.**  If you answer “yes” to the following question, you do not qualify for the small Employer exemption allowed under the law and benefits for mental health care, serious mental illness, and treatment of chemical dependency will be paid same as any other medical-surgical benefits under the HMO and/or PPO benefit Plan selected.  **Did you have an average of more than 50 (full-time, part-time, seasonal, or partners) total Employees for each working day in the calendar year preceding the Effective Date of this coverage? Yes**  **No** |

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| **MEDICARE SECONDARY PAYER RULES**  Under the **Medicare Secondary Payer Rules**, it is your responsibility to annually inform BCBSOK/BlueLincs of proper Employee counts for the purpose of determining payment priority between Medicare and BCBSOK/BlueLincs. **To satisfy this responsibility at this time, please complete, sign, date, and return the *Annual Medicare Secondary Payer Employer Acknowledgement Form along with this application*.** |

**PRODUCER OF RECORD INFORMATION**

1. \*Primary Producer(s) or Agency(ies): Are commissions to be paid? Yes  No

Producer Name:       Producer #:

Agency Name:       Agency #:

Agency Address: Street       City       State       Zip

Phone:       Fax:       Email:

Medical Commissions:       Dental Commissions:

Standard

Other:

1. \*Producer(s) or Agency(ies): Are commissions to be paid? Yes  No

Producer Name:       Producer #:

Agency Name:       Agency #:

Agency Address: Street       City       State       Zip

Phone:       Fax:       Email:

Medical Commissions:      Dental Commissions:

Standard

Other:

If commission split\*\*, designate percentage for each Producer/Agency 1:     % Producer/Agency 2:      %

3. Other Producer Information:

A. Multiple Location Agency(ies): If servicing agency is not listed above as Item 1 or 2, specify location below:

B. Other:

\* 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 split, please provide the information requested above on both producers/agencies. BOTH must be appointed to do business with BCBSOK and/or BlueLincs.

**OTHER PROVISIONS:**

1. **Dearborn National life insurance purchased:**  Yes  No (If yes, complete separate application.)

2. **Summary of Benefits & Coverage:**

1). BCBSOK/BlueLincs will create Summary of Benefits & Coverage (SBC)?

Yes. If Yes, please answer question #2. The SBC Addendum is attached.

No. If No, then the Employer acknowledges and agrees that the Employer is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will BCBSOK/BlueLincs have any responsibility or obligation with respect to the SBC. BCBSOK/BlueLincs may, but is not required to, monitor Employer’s performance of its SBC obligations, audit the Employer with respect to the SBC, request and receive information, documents and assurances from Employer with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations. BCBSOK/BlueLincs is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer’s contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: “(e) the SBC”. (Skip question #2.)

2). BCBSOK/BlueLincs will distribute Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

No. BCBSOK/BlueLincs will create SBC (only for benefits BCBSOK/BlueLincs insures under the Group Contract/Agreement) and provide SBC to the Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

Yes. BCBSOK/BlueLincs will create SBC (only for benefits BCBSOK/BlueLincs insures under the Group Contract/Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Employer.

3. **Electronic Issuance:** At the discretion of BCBSOK (not applicable to BlueLincs) and with the consent of the Employer, the Employer agrees to receive, via an electronic file or access to an electronic file, a Certificate of Benefits provided by BCBSOK to the Employer for delivery to each Employee. The Employer further agrees that it is solely responsible for providing each Employee access, via the internet, intranet, or otherwise, to the most current version of any electronic file provided by BCBSOK to the Employer and, upon the Employee’s request, a paper copy of the Certificate of Benefits.

4. **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.

5. **This BPA is incorporated into and made a part of the Group Contract/Agreement.**

**ADDITIONAL PROVISIONS:**

**A**. **Grandfathered Health Plans: Employer shall provide BCBSOK/BlueLincs 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 BCBSOK/BlueLincs to the terms and conditions of coverage. In no event shall BCBSOK/BlueLincs 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 Large Employer Benefit Program Application and Group Contract/Agreement, and Employer represents and warrants that such Form is true, complete and accurate. If Employer fails to timely provide BCBSOK/BlueLincs with any requested grandfathered health plan information, BCBSOK/BlueLincs 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 Large Employer Benefit Program Application 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 BCBSOK/BlueLincs to the terms and conditions of coverage. In no event shall BCBSOK/BlueLincs 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.

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1. Employer shall indemnify and hold harmless BCBSOK/BlueLincs 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 BCBSOK/BlueLincs 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 Employer, (d) any provision of inaccurate information, (e) the SBC and/or (f) Employer’s selection of Essential Health Benefit (“EHB”) definition for the purposes of the Patient Protection and Affordable Care Act (“ACA”). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

**D.** **ACA FEE NOTICE:** ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or “Health Insurer Fee”; and (2) the Transitional Reinsurance Program Contribution Fee or “Reinsurance 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 involves 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 will go 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 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded Group Health Plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

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

Notwithstanding anything in the Group Contract/Agreement or Renewal(s) to the contrary, BCBSOK/BlueLincs 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 BCBSOK/BlueLincs to pay, submit or forward, on its own behalf or on the Employer’s behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

The provisions of paragraphs A-D (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.

**APPLICANT STATEMENTS**

* Applicant understands that, unless otherwise specified in the Group Contract/Agreement, only eligible Employees and their Dependents are eligible for coverage. Applicant further agrees that eligibility and participation requirements have been discussed with the agent and have been explained to all Eligible Persons.
* Applicant agrees to notify the Plan of ineligible persons immediately following their change in status from eligible to ineligible.
* Applicant agrees to review all applications for completeness prior to submission to the Plan. Applicant applies for the coverages selected in this Large Employer Benefit Program Application and provided in the Group Contract/Agreement and agrees that the obligation of the Plan shall only include the Benefits described in the Group Contract/Agreement or as amended by any Amendments or Endorsements thereto.
* Applicant agrees to pay to the Plan, in advance, the premiums specified in the Group Billing Statement on behalf of each Eligible Person covered under the Group Contract/Agreement.
* Applicant agrees that, in the making of this Application, it is acting for and in behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Applicant is not the agent or representative of the Plan for any purpose of this Application or any Group Contract/Agreement issued pursuant to this Application.
* Applicant agrees to deliver to its Eligible Persons covered under the Group Contract/Agreement individual Certificate of Benefits/Member Handbook and Identification Cards and any other relevant materials as may be furnished by the Plan for distribution.
* Applicant agrees to receive on behalf of its covered Eligible Persons all notices delivered by the Plan and to forward such notices to the person involved at their last known address.
* Applicant agrees the producer (s) or agency(ies), specified in writing by the Employer as its Agent of Record (AOR) is authorized by the Employer to act as its representative in negotiations with and to receive commissions from BCBSOK/BlueLincs, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer’s Employee benefit programs. The AOR is authorized by the Employer to perform membership transactions on behalf of Employer, and is authorized to conduct such transactions through the Employer’s web portal known as Blue Access for Employers (BAE). The appointment will remain in effect until withdrawn or superseded in writing by Employer.

**WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.**

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| --- | --- | --- |
|  |  |  |
| Sales Representative |  | Printed Name of Authorized Employer Representative |
|  |  |  |
| District Fax No. Phone No. |  | Signature of Authorized Employer Representative |
|  |  |  |
| Producer Representative |  | Title |
|  |  |  |
| Producer Firm |  | Date |
|  |  |  |
| Producer Address |  |  |
|  |  |  |
| Tax ID No. |  |  |

(Note: The following proxy information is not applicable to BlueLincs HMO.)

PROXY

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Group No.: |  |  | By: |  |
|  |  |  |  | Print Signer's Name Here |
|  |  |  |  |  |
|  |  |  |  | Signature and Title |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Group Name: |  | | | | |
| Address: |  | | | | |
| City: |  | State: |  | Zip Code: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dated this |  | day of |  |  |
|  |  |  | Month | Year |