BlueCross BlueShield of Oklahoma

1400 South Boston ● P.O. Box 3283 ● Tulsa, OK 74102-3283

SMALL EMPLOYER BENEFIT PROGRAM APPLICATION ("BPA")
(Employer Application)

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (herein called "BCBSOK")

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 Contract(s) Policy(ies) Effective Date (first (1st) or fifteenth (15th)): __/__/____ (mm/dd/yyyy)		
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 _____		
E-Mail Address of Authorized Company Official: _____		
Billing Address (if different from primary): Number, Street, City, State, Zip _____		
Billing and Correspondence to the attention of: _____		Fax Number: _____
Billing Method Selection: Please select one (1) of the following billing methods. ☐ Composite Billing ☐ Age Billing		
The Blue Access for Employers℠ ("BAE℠") contact person is the employee authorized by the Employer to access and maintain 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: _____		
Will your Group utilize Insure Oklahoma* subsidies? ☐ Yes ☐ No *Must select an Insure Oklahoma eligible plan		
Have you been without group coverage (uninsured) for at least two months prior to the requested Group Contract Date? ☐ Yes ☐ No		
If you currently have group health care coverage, please provide name of carrier: _____		

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

ELIGIBILITY AND EMPLOYEE EFFECTIVE DATE INFORMATION

1. Employer has determined Employees must routinely work _____ (minimum of twenty-four (24)) hours per week in order to be eligible for health/dental coverage under this Group Contract.

2. **Select a Waiting Period:** If a person is added to the Group Contract and it is later determined that the Group reported a coverage date earlier than what would apply to the Employee or Dependent, based on the Waiting Period and eligibility conditions the Group provided to BCBSOK, BCBSOK reserves the right to retroactively adjust the coverage date for such person.

a. Newly Eligible Persons will become effective on the first (1st) day of the contract/participation month following: ☐ Zero (0) days ☐ Thirty (30) days ☐ Sixty (60) days

Employee and Dependent Health and/or Dental Benefit Plans will become effective on the first (1st) day of the contract/participation month following satisfaction of the Waiting Period and any substantive eligibility criteria.

b. Waive the Waiting Period on initial group enrollment? ☐ Yes ☐ No

c. Number of Employees serving Waiting Period: _____

d. Substantive eligibility criteria. Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. 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 (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 (1st) 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 (1st) 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 (1st) day of the next calendar month (if start day is not the first (1st) day of the month).

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

3. **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 Group Contract Anniversary Date of the program. Such person's Individual Coverage Date, Family Coverage Date and/or Dependent's Coverage Date will be the Group Contract Anniversary Date following the open enrollment period, provided the application is dated and signed prior to that date.

4. **Domestic Partners covered**: ☐ Yes ☐ No
If yes, a Domestic Partner, as defined in the Certificate of Benefits, 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 may be eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of

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1985 (COBRA). Employer shall determine eligibility for COBRA continuation for Domestic Partners, if any. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to Domestic Partner, as defined in the Certificate Booklet

☐ No, Employer does not elect to offer continuation coverage to Domestic Partner coverage (Domestic Partners are not eligible for continuation coverage)

☐ Other: _____

5. **Limiting Age for covered children**: Dependent children are eligible for coverage until their twenty-sixth (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 Eligible Person 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 Eligible Person 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.

6. **Disabled Dependent:** Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Domestic Partner if Domestic Partner coverage is elected). 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 BCBSOK; a Disabled Dependent Certification Form must be submitted to BCBSOK.

CONTRIBUTION AND PARTICIPATION

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

Medical -- %	
Employee Only Coverage (Single Coverage)	_____%

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

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

Dental -- %	
Employee Only Coverage (Single Coverage)	_____%

Minimum Participation and Employer Contribution. BCBSOK reserves the right to:

1) Restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the fifty percent (50%) minimum Employer contribution is met and at least seventy-five percent (75%) of Eligible Persons (less valid waivers) have enrolled for coverage; and

2) Review participation and contribution on existing business and non-renew or discontinue health coverage unless the fifty percent (50%) minimum Employer contribution is met and at least seventy-five percent (75%) of Eligible Persons (less valid waivers) have enrolled for coverage.

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

Participation requirements for dental coverage are specified in the Dental Products/Benefit Plan Section below.

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LEGISLATIVE REQUIREMENTS

The Employer 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, public school districts, and "church plans" as defined by the Internal Revenue Code.

Please provide your ERISA Plan Year*: Beginning Date: __/__/____ End Date: __/__/____

ERISA Plan Sponsor*: _____

If you contend ERISA is inapplicable to your 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: _____

Please provide your Non-ERISA Plan Year (mm/dd/yyyy): __/__/____

For more information regarding ERISA, please contact your Legal Advisor.

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

BENEFIT PLAN SELECTIONS

Understanding the Plan # Sample Plan #: **B718CHC**		
Metallic Level	B	Bronze, Silver, Gold, Platinum
Benefit Design	718	705, 712, 718, etc.
Network/Product Name	CHC	CHC = Blue Choice PPO℠ OPT = Blue Options PPO℠ PFR = Blue Preferred PPO℠ ADT = Blue Advantage PPO℠

Health Products/Benefit Plan Selection:

Please select the benefit design in the left-hand column. Up to three (3) selections may be selected in this column. The marketing plan IDs may be selected in the corresponding rows to the right of the benefit designs column. These marketing plan IDs indicate network choices for the specified benefit. A maximum of six (6) network options may be selected.

Please select ALL benefit plans that the group intends to offer, regardless of whether the plans are currently offered or not.

Benefit Design (select up to three (3))		**Blue Choice PPO**		**Blue Preferred PPO**		**Blue Options PPO**		**Blue Advantage PPO**	
		select up to six (6)							
☐	B710					☐	B710OPT		
☐	B730	☐	B730CHC	☐	B730PFR			☐	B730ADT
☐	B8K0			☐	B8K0PFR			☐	B8K0ADT
☐	G720					☐	G720OPT		
☐	G721					☐	G721OPT		
☐	G730	☐	G730CHC	☐	G730PFR				
☐	G731	☐	G731CHC	☐	G731PFR				
☐	G732	☐	G732CHC						
☐	G733			☐	G733PFR				

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Benefit Design		Blue Choice PPO		Blue Preferred PPO		Blue Options PPO		Blue Advantage PPO	
☐	G735			☐	G735PFR				
☐	G740							☐	G740ADT
☐	G743							☐	G743ADT
☐	G744							☐	G744ADT
☐	G745							☐	G745ADT
☐	G746							☐	G746ADT
☐	G8J2			☐	G8J2PFR				
☐	G8J3							☐	G8J3ADT
☐	G8K2			☐	G8K2PFR			☐	G8K2ADT
☐	G8K3			☐	G8K3PFR			☐	G8K3ADT
☐	G8K5			☐	G8K5PFR				
☐	G8K6			☐	G8K6PFR			☐	G8K6ADT
☐	G8M1			☐	G8M1PFR			☐	G8M1ADT
☐	G8M2			☐	G8M2PFR			☐	G8M2ADT
☐	P710			☐	P710PFR			☐	P710ADT
☐	P8E1			☐	P8E1PFR			☐	P8E1ADT
☐	P8J1	☐	P8J1CHC						
☐	P8J6							☐	P8J6ADT
☐	P8J7					☐	P8J7OPT		
☐	P8K1			☐	P8K1PFR			☐	P8K1ADT
☐	P8K4			☐	P8K4PFR				
☐	S701			☐	S701PFR				
☐	S702							☐	S702ADT
☐	S710					☐	S710OPT		
☐	S730	☐	S730CHC					☐	S730ADT
☐	S731			☐	S731PFR			☐	S731ADT
☐	S732			☐	S732PFR				
☐	S8E1			☐	S8E1PFR	☐	S8E1OPT	☐	S8E1ADT
☐	S8J0					☐	S8J0OPT		
☐	S8J4							☐	S8J4ADT
☐	S8J5			☐	S8J5PFR				
☐	S8J8							☐	S8J8ADT
☐	S8J9	☐	S8J9CHC						
☐	S8K0			☐	S8K0PFR				
☐	S8K1			☐	S8K1PFR			☐	S8K1ADT
☐	S8K2							☐	S8K2ADT
☐	S8K5			☐	S8K5PFR			☐	S8K5ADT
☐	S8K8			☐	S8K8PFR			☐	S8K8ADT
☐	S8K9			☐	S8K9PFR			☐	S8K9ADT
☐	S8L1			☐	S8L1PFR				

If HSA/HDHP is selected, provide name of HSA administrator/trustee: _____
Vendor: ☐ BenefitWallet ☐ Flex ☐ HealthEquity ☐ HSA Bank ☐ Other: _____

FSA purchased: ☐ Yes ☐ No (If yes, select vendor)
Vendor: ☐ BenefitWallet ☐ Flex ☐ HealthEquity ☐ HSA Bank ☐ Other: _____

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Dental Products / Benefit Plan Selection:

Plan Pairings
Groups with two (2) to nine (9) enrollees may select one (1) plan. Groups with ten (10)+ enrollees may select up to two (2) plans.

Contributory
Any one (1) contributory high option can be paired with any one (1) contributory low option; DOKHM42 can be freely paired with any contributory option.

Voluntary
Any one (1) voluntary high option can be paired with any one (1) voluntary low option. DOKHM46 can be freely paired with any one (1) voluntary option.

Voluntary plans and contributory plans may not be offered together.

Exception: DOKHM57 can be paired with DOKHR33. And, DOKHM59 can be paired with DOKHR43.

Participation Requirements

Contributory
> seventy-five percent (75%) participation
> fifty percent (50%) employer contribution

Voluntary
> twenty-five percent (25%) participation
< fifty percent (50%) employer contribution

Employers are not required to contribute to Voluntary dental plans.

DENTAL PLAN SELECTION

	Plan #	Segment
	High Coverage Allocation	
☐	DOKHR30	Contributory
☐	DOKHR31	Contributory
☐	DOKHR32	Contributory
☐	DOKHR33	Contributory
☐	DOKHR34	Contributory
☐	DOKHR35	Contributory
☐	DOKHM38	Contributory
☐	DOKHM40	Contributory
☐	DOKHM42	Contributory
☐	DOKHR50	Contributory
☐	DOKHM57	Contributory
☐	DOKHR43	Voluntary
☐	DOKHM44	Voluntary
☐	DOKHR45	Voluntary
☐	DOKHM46	Voluntary
☐	DOKHR52	Voluntary
☐	DOKHR53	Voluntary
☐	DOKHM59	Voluntary
	Low Coverage Allocation	
☐	DOKLR36	Contributory
☐	DOKLR37	Contributory
☐	DOKLM41	Contributory
☐	DOKLM51	Contributory
☐	DOKLR58	Contributory
☐	DOKLM49	Voluntary
☐	DOKLR54	Voluntary
☐	DOKLM55	Voluntary
☐	DOKLM56	Voluntary
☐	DOKLR60	Voluntary

Additional Information: _____

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LIFE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D), SUPPLEMENTAL LIFE AND AD&D AND SHORT-TERM DISABILITY LONG-TERM DISABILITY, CRITICAL ILLNESS, ACCIDENT AND VISION PLANS (EMPLOYER CONTRIBUTION):

☐ _____% for Group Life, AD&D	☐ _____% for Dependent Life	☐ _____% for Supplemental Life Insurance, AD&D
☐ _____% for Short-Term Disability	☐ _____% for Long-Term Disability	☐ _____% for Critical Illness
☐ _____% for Accident Insurance	☐ _____% for Vision	

With respect to the coverage applied for, Employer agrees to comply with and participate in all provisions of the Group Policy providing the coverage applied for. Employer understands BCBSOK intends to rely on this information in determining whether the enrolling employees may become insured.

PRODUCER OF RECORD INFORMATION

1. Primary Producer or Agency Name* (to whom commissions are to be paid) _____

Percentage of Split**: _____
(Please also complete 2 below for split commissions)

Street, City, State, ZIP: _____

Producer #: _____ FAX number: _____

Name and phone number of Producer to contact for this case: _____

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

2. Producer or Agency Name* (if commissions are to be split): _____

Percentage of Split**: _____

Street, City, State, ZIP: _____

Producer #: _____ FAX number: _____

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

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

*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.

EMPLOYER STATEMENTS

1. Employer understands that, unless otherwise specified in the Group Contract, only eligible Employees and their Dependents are eligible for coverage. Employer further agrees that eligibility and participation requirements have been discussed with the producer and have been explained to all Eligible Persons.

2. Employer agrees to notify BCBSOK of ineligible persons immediately following their change in status from eligible to ineligible.

3. Employer agrees to review all applications for completeness prior to submission to BCBSOK. Employer applies for the coverages selected in this Small Employer Benefit Program Application and provided in the Group Contract and agrees that the obligation of BCBSOK shall only include the Benefits described in the Group Contract or as amended by any Amendments or Endorsements thereto.

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4. Employer agrees to pay to BCBSOK, in advance, the premiums specified in the Group Billing Statement on behalf of each Eligible Person covered under the Group Contract.

5. Employer agrees that, in the making of this Application, it is acting for and on behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Employer is not the agent or representative of BCBSOK for any purpose of this Application or any Group Contract issued pursuant to this Application.

6. Employer agrees to deliver to its Eligible Persons covered under the Group Contract individual Certificate of Benefits and Identification Cards and any other relevant materials as may be furnished by BCBSOK for distribution.

7. Employer agrees to receive on behalf of its covered Eligible Persons all notices delivered by BCBSOK and to forward such notices to the applicable recipient(s)at their last known address.

8. Employer agrees the producer(s) or agency(ies), specified in writing by the Employer as its Producer of Record ("POR") is authorized by the Employer to act as its representative in negotiations with and to receive commissions from BCBSOK and HCSC subsidiaries for Employer's Employee benefit programs. The POR 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.

9. Any reference in the eligibility section of this Small Employer Benefit Program Application to the waiting period means the waiting period an Employee must satisfy in order for coverage to become effective. The selected waiting period must not result in an effective date that exceeds ninety-one (91) days from the date an Eligible Person becomes eligible for coverage.

10. Employer understands the effective date of termination for a person who ceases to meet the definition of Eligible Person is the end of the coverage period (billing cycle) during which the person ceases to meet the definition of Eligible Person.

OTHER PROVISIONS:

1. **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.

2. **Reimbursement:** It is understood and agreed that in the event BCBSOK makes a recovery on a third-party liability claim, BCBSOK 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.

3. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: BCBSOK 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.

4. This BPA is incorporated into and made a part of the Group Contract.

ADDITIONAL PROVISIONS:

A. **Retiree Only Plans and/or Excepted Benefits:** If the Small Employer Benefit Program Application includes any retiree only plans and/or excepted benefits, then Employer 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 BCBSOK to the terms and conditions of

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coverage. In no event shall BCBSOK 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.

B. Employer shall provide BCBSOK with immediate written notice in the event Employer and/or any of the entities listed above no longer qualify for the religious employer exemption (as they may be amended, replaced or superseded from time to time). Employer shall indemnify and hold harmless BCBSOK 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 inquires or actions, settlements or judgments brought or asserted against BCBSOK in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any plan's design (including but not limited to any directions, actions and interpretations of the Employer), and/or (d) any provision of inaccurate information. In no event will BCBSOK be responsible for any legal, tax or other ramifications related to the Employer's elections. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Notwithstanding anything in the Group Contract or Renewal(s) to the contrary, BCBSOK 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 to pay, submit or forward, on its own behalf or on BCBSOK'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-B (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.

Any reference in the eligibility section of this Small Employer Benefit Program Application to the waiting period means the waiting period an Employee must satisfy in order for coverage to become effective.

_____

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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For Employer:

Name of Authorized Company Official (please print)	Title of Authorized Company Official
Signature of Authorized Company Official	City and State of Signing Official
Date	

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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.: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____
Month Year

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

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