BlueCross BlueShield of Texas

dearborn national®*

1001 E. Lookout Drive
Richardson, Texas 75082

SMALL EMPLOYER BENEFIT PROGRAM APPLICATION
(Employer Application)

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

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

Legal Name of Company:		
Employer Identification Number (EIN):	Nature of Business:	Standard Industry Code (SIC):
Physical Address (number & street), City, State, ZIP:		
E-Mail Address of Authorized Company Official:		Telephone Number:
Secondary E-Mail Address, if different from Authorized Company Official:		FAX Number:
Complete Mailing Address, if different from physical address:		
Billing and Correspondence to the attention of:		
Billing Method Selection: Please select one of the following billing methods. (If no selection is made, your benefit plan(s) will default with their current billing method) ☐ Composite Billing ☐ Age Billing		
The Blue Access for Employers (BAE) contact person is the individual authorized by the Employer to access and maintain its account/employee information. Name and title of the BAE contact person: _____ E-mail address of BAE contact person: _____		

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

A copy of your most recent Texas Workforce Commission (TWC) Report(s) or other supporting documentation must be submitted with this Employer Application (please identify part-time employees and terminations). W4s, 1099s, or a Texas Supplemental Employment Verification form must be submitted for any applicants not included on the TWC Report.

1. Select a Waiting Period:
   If a person is added to the Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply, based on the Waiting Period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the coverage date for such person.

   a. Newly eligible individuals will become effective on:

   ☐ The first day of the contract/participation month following ☐ 0 days ☐ 30 days ☐ 60 days
   Employee and dependent Health and/or Dental Benefit Plans will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period and any substantive eligibility criteria.

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

   c. Number of employees serving Waiting Period: _____

   d. Substantive eligibility criteria:

   Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. In no event can the substantive eligibility criteria result in a delay of coverage for eligible employees, as defined under Texas law, longer than 90 days inclusive of the Waiting Period. If any of these eligibility conditions change, you are required to submit a new BPA to reflect that new information.
   Check all that apply:

   ☐ An Orientation Period that:

   1) Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
   2) If used in conjunction with a waiting period the waiting period begins on the first day after the orientation period.

   ☐ A Cumulative hours of service requirement that does not exceed 1200 hours

   ☐ An hours of service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:

   1) Starts between the employee's date of hire and the first day of the following month;
   2) Does not exceed 12 months; and
   3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

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

_____
_____
_____
_____

2. Total number of enrollment applications submitted: _____ Total number of declinations submitted: _____

3. Do all employees reside in Texas? ☐ Yes ☐ No
   If no, is Texas the state with the greatest number of employees eligible to enroll in this group plan? ☐ Yes ☐ No

4. Domestic Partners covered: ☐ Yes ☐ No

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

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

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

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

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

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

LEGISLATIVE REQUIREMENTS

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

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

Month Day Year Month Day Year

ERISA Plan Sponsor*: _____

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

Please provide Non-ERISA Plan Year: _____ / _____ / _____

Month Day Year

For more information regarding ERISA, contact your Legal Advisor.

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

BENEFIT PLAN SELECTIONS

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

Health Products/Benefit Plan Selection:

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

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

Benefit Design (select up to 6)		**Blue Choice PPO**		***Blue Advantage HMO℠**		**Blue Essentials Access HMO**		***Blue Premier Access℠**	
		(select up to 6)							
☐	B601					☐	B601HMO		
☐	B640							☐	B640HMH
☐	B660	☐	B660CHC	☐	B660ADT				
☐	B661	☐	B661CHC	☐	B661ADT				
☐	B662	☐	B662CHC						
☐	S601					☐	S601HMO		
☐	S602					☐	S602HMO		
☐	S603					☐	S603HMO		
☐	S604					☐	S604HMO		
☐	S605					☐	S605HMO		
☐	S620							☐	S620HMH
☐	S621							☐	S621HMH
☐	S622							☐	S622HMH
☐	S623							☐	S623HMH
☐	S624							☐	S624HMH
☐	S640			☐	S640ADT				
☐	S641			☐	S641ADT				
☐	S642			☐	S642ADT				
☐	S643			☐	S643ADT				
☐	S644			☐	S644ADT				

☐	S660	☐	S660CHC						
☐	S661	☐	S661CHC						
☐	S662	☐	S662CHC						
☐	S663	☐	S663CHC						
☐	S665	☐	S665CHC						
☐	S666	☐	S666CHC						
☐	S667	☐	S667CHC						
☐	G610					☐	G610HMO		
☐	G630							☐	G630HMH
☐	G650	☐	G650CHC						
☐	G651	☐	G651CHC						
☐	G652	☐	G652CHC						
☐	G653	☐	G653CHC						
☐	G654	☐	G654CHC						
☐	G656	☐	G656CHC						
☐	G660			☐	G660ADT				
☐	G661			☐	G661ADT				
☐	G662			☐	G662ADT				
☐	G663			☐	G663ADT				
☐	G664			☐	G664ADT				
☐	G665			☐	G665ADT				
☐	G666			☐	G666ADT				
☐	P610			☐	P610ADT				
☐	P611			☐	P611ADT				
☐	P620	☐	P620CHC						
☐	P621	☐	P621CHC						

*****If a Blue Premier Access or Blue Advantage HMO product/benefit plan (with the **exception** of G665ADT plan) is selected, please complete, sign and submit a Disclosure Statement with this Application for Amendment.

Additional Information: _____

DENTAL PRODUCTS/BENEFIT PLAN SELECTION:

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

High Option	Low Option
DTXHR01	DTXLR06
DTXHR02	DTXLR07
DTXHR03	DTXLM08

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

High Option	Low Option
DTXHR12	DTXLR23
DTXHR21	DTXLM24

Participation Requirements
True Group
>75% participation
>50% employer contribution
Voluntary
>25% participation
Employers are not required to contribute to Voluntary Dental plans

DENTAL PLAN SELECTION

	Plan #	Segment
	High Coverage Allocation	
☐	DTXHR01	True Group
☐	DTXHR02	True Group
☐	DTXHR03	True Group
☐	DTXHR04	True Group
☐	DTXHM09	True Group
☐	DTXHM11	True Group
☐	DTXHR20	True Group
☐	DTXHR12	Voluntary
☐	DTXHM13	Voluntary
☐	DTXHM15	Voluntary
☐	DTXHR21	Voluntary
☐	DTXHR22	Voluntary
	Low Coverage Allocation	
☐	DTXLR05	True Group
☐	DTXLR06	True Group
☐	DTXLR07	True Group
☐	DTXLM08	True Group
☐	DTXLM10	True Group
☐	DTXLR23	Voluntary
☐	DTXLM24	Voluntary

The following mandated benefit offers are made by BCBSTX in compliance with Texas regulations. Please mark your acceptance or declination. Acceptance may result in a rate adjustment.

THE FOLLOWING MANDATED BENEFIT OFFERS ARE ALREADY INCLUDED IN THE PPO AND HMO PLANS

- Treatment of mental or emotional illness
- Treatment of loss or impairment of speech or hearing
- Treatment of serious mental illness

MANDATED BENEFIT OFFERS
In Vitro Fertilization Services - (must choose one) ☐ Accept – Outpatient benefits are paid same as any other pregnancy-related expense **(Note: If selected an additional charge will be added to your rates.)** ☒ Decline – If declined, no benefits are available

The Employer understands and agrees to comply with the following requirements regarding the Health Benefit Plan(s) elected:

- Applications/Declinations are attached for all full-time employees as well as any COBRA or state participant continuations.
- **Minimum Participation and Employer Contribution**:

  BCBSTX reserves the right to: 1) restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the 50% minimum employer contribution is met and at least 75% of eligible employees (less valid waivers) have enrolled for coverage; and 2) review participation and contribution on existing business and non-renew or discontinue health coverage if the 50% minimum employer contribution is not met and/or less than 75% of Eligible Persons (less valid waivers) are enrolled for coverage for six consecutive months.

  If applicable, BCBSTX reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of Employees/Subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

  Employer will promptly notify BCBSTX of any change in participation and Employer contribution.

- The Employer must provide eligibility and enrollment information, effective dates of employment, and all other data necessary for the efficient administration of the Health Benefit Plan(s) elected, according to the terms and requests of BCBSTX.
- After approval by BCBSTX the Health and/or Dental Benefit Plan(s) applied for, individuals will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period (if any, but not to exceed 90 days). Employees whose applications are received more than 31 days after date-of-hire or received after expiration of the Waiting Period will be considered late enrollees and will be eligible to enroll during the next open enrollment period.
- The Employer, while not an agent of BCBSTX, will be responsible for collection of premiums from employees, will notify employees of the termination of their coverages and will forward to employees notices and/or amendments sent by BCBSTX to the Employer. The Employer will be bound by the terms of the Contract(s)/Policy(ies) issued pursuant to this Employer Application and such shall serve as the basis to resolve any conflict. When issued, the Contract(s)/Policy(ies) will include this Employer Application and any Addenda issued pursuant to this Employer Application.
- Premium rates for the coverages applied for are determined by BCBSTX and will become a part of the Contract(s)/Policy(ies) issued by BCBSTX and any amendments thereto.
- This Benefit Program Employer Application must pre-date the requested effective date and be received by BCBSTX at its Home Office no less than thirty (30) days prior to the requested effective date.
- Retirees are not eligible for coverage hereunder.
- Under Texas state law, ***eligible employee*** means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. The term does not include an Employee who: (1) works on a part-time, temporary, seasonal, or substitute basis, or (2) is covered under (a) another Health Benefit Plan, or (b) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974, or (3) elects not to be covered under the small employer's health benefit plan and is covered under (a) the Medicaid program; (b) another federal program, including the TRICARE program or Medicare program; or (c) a benefit plan established in another country.

- 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, a medical support order 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. To be eligible for coverage, a child of an employee's child must also be dependent upon employee for federal income tax purposes at the time application for coverage is made.

  A Dependent 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) is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

- The producer(s) or agency(ies), specified in the Producer's Statement section below, is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC) , a Mutual legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for Employer. The POR is authorized to perform membership transactions on behalf of Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.
- For the current year's premium and rate information, refer to the accepted finalized new group rates letter ("Letter") or the renewal exhibit ("Exhibit") for complete details. The Letter, or Exhibit, shall be incorporated by reference and made part of the BPA and Group Administration Document.

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

I. Group Life Administration Information

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

Benefit: All employees according to the following schedule:

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

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

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

II. Term Life Insurance and AD&D: ☐ Applied For ☐ Not Applied For

Complete Life and AD&D Benefit Amount in Section I	Guarantee Issue Maximum: $
Rates: ☐ Step-Rated ☐ Composite Rated	(Include a copy of the rating exhibit if rated in the field)
Employer Contribution: ☐ 100% ☐ Other %	(Minimum 25% Employer contribution required)
Life/AD&D Reductions due to Attained Age (All benefits terminate at retirement):	
☐	Reduces by 35% at age 65, to 50% of the original benefit at age 70, to 25% of the original benefit at age 75, and to 15% of the original benefit at age 80. (Standard under 10 eligible lives)
☐	Reduces by 35% at age 65 and to 50% of the original benefit at age 70. (Unavailable under 10 eligible lives)
☐	Reduces to 50% at age 70. (Unavailable under 10 eligible lives)
Term Life is ☐ in addition to, or ☐ replacement of current term life coverage	☐ no current carrier
If replacement, give current carrier:	Termination date of prior plan:

III. Dependents' Term Life Insurance: ☐ Applied For *(offered only with Term Life/AD&D)* ☐ Not Applied For

Benefits:	Spouse	$
Rate: $	Child(ren) age 15 days up to 6 months:	$
Employer Contribution: %	Child(ren) age 6 months. up to age 25 & Students:	$

IV. Short Term Disability (STD) Insurance: ☐ Applied For *(offered only with Term Life/AD&D)* ☐ Not Applied For

Wage-Based Benefit: ☐ 50% ☐ 60% ☐ 66 2/3% of Basic Weekly Wages to a Benefit Maximum of $		
Flat Benefit: ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 not to exceed 66 2/3% of Basic Weekly Wages		
Class Defined Plan: Complete STD amount in Section I		
Benefits Begin:	Due to an Accident: (select one)	Due to Sickness: (select one)
	☐ 1st day ☐ 8th day ☐ 15th day ☐ 31st day	☐ 8th day ☐ 15th day ☐ 31st day
Maximum Weekly Benefit Duration: ☐ 13 weeks ☐ 26 weeks		
Rates: ☐ Step-Rated ☐ Composite Rated (Include a copy of the rating exhibit if rated in the field)		
Employer Contribution: ☐ 100% ☐ Other % (Minimum 25% Employer contribution required)		
STD is ☐ in addition to, or ☐ replacement of current STD coverage ☐ no current STD carrier		
If replacement, give current carrier:	Termination date of prior plan:	
STD benefits are payable for non-occupational disabilities only.	STD benefits terminate at retirement.	

The undersigned represents he/she is an Employer engaged in *(groups with 2 to 9 employees must check ✓ one):*

☐ Wholesale, Retail, or Distribution Business; or ☐ Service Business; or ☐ Manufacturing Business

The Employer agrees to comply with all terms and provisions of the Group Life and/or Disability Contracts(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Dearborn National trust policy(ies), if applicable. The Employer further agrees to comply with the following requirements:

1. For Life and STD, if coverage is contributory, a minimum of 75% of the eligible employees must enroll. If coverage is non-contributory, 100% of the eligible employees must enroll.
2. Group term life, for groups with less than ten (10) eligible employees, may be sold on a contributory basis, however, in no event may the contribution by the insured employee exceed forty cents ($0.40) per thousand dollars of coverage per month.
3. STD may be sold on a contributory basis; however, the Employer must contribute a minimum of 25%. STD is available only if group term life and AD&D is selected.
4. Coverage for employees who are not actively at work, as defined in the policy, on the date their coverage would otherwise become effective will be deferred until the date they return to active work.
5. If life and AD&D benefits are selected by occupational class, there must be at least one eligible employee in each class, and no class may have a benefit greater than 2½ times the amount for the next lower class.
6. The Employer shall remit all required premium payments to Dearborn National no later than the first day of each billing period. If the premium payments are not received by Dearborn National, insurance for the Employer and all covered employees shall cease in accordance with the terms of the Policy.
7. The Employer shall provide eligibility and enrollment information, dates of employment, and all other data necessary for the efficient administration of the Dearborn National Life and/or Disability Insurance Plan.
8. Coverage for the Employer may be amended from time to time, and the Employer's participation may be terminated with 31 days written notice by Dearborn National in accordance with the terms of the Policy. Dearborn National reserves the right to change premium rates for reasons including, but not limited to, change in benefit design or Policy terms, change of industry, utilization within the industry, or other factors bearing on the assumed risk.
9. Dearborn National reserves the right to terminate the Employer's participation in the Life Insurance Plan if the Employer fails to maintain compliance with the requirements set forth herein.
10. Benefit amounts in excess of the guarantee issue and all late applications for contributory coverage are subject to satisfactory evidence of insurability. The Employer agrees not to collect any premium from employees on amounts for which satisfactory evidence of insurability is required until notified by Dearborn National of the approval of the employee's application for coverage.

EMPLOYER: DO NOT CANCEL CURRENT COVERAGE UNTIL NOTIFIED BY BCBSTX AND/OR DEARBORN NATIONAL
THAT THIS EMPLOYER APPLICATION HAS BEEN APPROVED.

ELECTRONIC RECEIPT OF CERTIFICATE-BOOKLETS AND CONTRACTS

Electronic Issuance: The Employer consents to receive, via an electronic file or access to an electronic file, any Certificate Booklet provided by BCBSTX to the Employer for delivery to each Employee. The Employer further agrees that it is solely responsible for providing each Employee access to the most current version of any E-file Certificate Booklet, amendment, or other revised form provided by BCBSTX, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and holds BCBSTX harmless from any misuse of the E-file provided by BCBSTX.

☒**Accept –** Employer consents to receive electronic versions of certificate-booklets for covered Employees. If accepted, please ensure that a valid email address is entered in the Email Address of Authorized Company Official field on page 1.

☐**Decline –** Employer does not consent to receive electronic versions of certificate-booklets for covered Employees or the Contract and desires BCBSTX to print and distribute hard copy versions.

I have read and understand this Employer's Application, and the producer, if any, named below is authorized to represent the Employer in the purchase of the Benefit Plan(s). This Employer Application is incorporated into and made a part of the Contract entered into and agreed upon by BCBSTX and the Employer. For HMO, the title of the contract is HMO Group Agreement. For non-HMO, the title of the contract is Group Administration Document. For dental, the title of the contract is Dental Group Administration Document.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

I acknowledge that the producer(s) or agency(ies) named on the producer's Statement page is/are is acting on behalf of the Employer for purposes of purchasing Employer insurance, and that if BCBSTX/Dearborn National accept this Employer Application and issues a Group Contract/Policy/Agreement to the Employer, BCBSTX/Dearborn National may pay the producer(s)/agency(ies) a commission and/or other compensation in connection with the issuance of such Group Contract/Policy. The undersigned further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the producer(s)/agency(ies) by BCBSTX/Dearborn National in connection with the issuance of a Group Contract/Policy, they should contact the producer(s)/agency(ies).

I certify that all statements contained in this Employer Application and all information required to be furnished to BCBSTX/ Dearborn National are complete and true to the best of my knowledge and belief. I understand that BCBSTX/Dearborn National will rely on the statements made and information furnished, as the basis in determining the appropriate rate level and/or approval of this Employer Application. I understand that no insurance or changes will become effective without approval of BCBSTX/Dearborn National. The requested Contract(s)/Policy(ies) effective date (as listed on page 1) is subject to change by BCBSTX/Dearborn National if all required documents are not completed and received by the date requested. If documents are not received by the date requested, the Employer will be required to complete a new Employer Application.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans: Employer shall provide BCBSTX 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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX 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 Employer represents and warrants that such Form is true, complete and accurate. If Employer fails to timely provide BCBSTX with any requested grandfathered health plan information, BCBSTX 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 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 BCBSTX to the terms and conditions of coverage. In no event shall BCBSTX 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. Religious Employer Exemption or Eligible Organization Accommodation: Although federal regulations describe a limited exemption for certain group health plans from the Affordable Care Act requirement to cover contraceptive services under guidelines supported by the Health Resources and Services Administration (HRSA), your insurance Policy must comply with applicable state requirements regarding contraceptive coverage. Accordingly, your Policy currently includes coverage for contraceptives consistent with the state and federal coverage requirements and applicable exemptions. Some contraceptives may be covered without cost to the employee."

D. Policyholder will provide BCBSTX with immediate written notice in the event Employer and/or any of the entities referenced above no longer qualify for the religious employer exemption and/or eligible organization accommodation (as they may be amended, replaced or superseded from time to time). Employer shall indemnify and hold harmless BCBSTX 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 BCBSTX in connection with (a) any plan's exempt status, (b) religious employer exemption and/or eligible organization accommodation, (c) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder, and/or (d) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

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.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. One of those fees is: the Annual Fee on Health Insurers or "Health Insurer 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 currently 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 and/or other applicable laws may provide for the establishment of a temporary reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees or Amounts") collected from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how these Reinsurance Fees or Amounts are calculated. Federal regulations

establish a flat per member per month fee. The temporary reinsurance programs funded by these Reinsurance Fees or Amounts 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 or Amounts, if any. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees or Amounts, if any.

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

For Employer:

Name of Authorized Company Official (please print) **Title**

Signature of Authorized Company Official **City and State of signing official**

Date

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

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

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

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

_____ _____
BCBSTX Sales Representative Date

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

   (Please also use 2. below, for split commissions)
   Percentage of Split**:_____
   Complete Address: _____

   Tax ID/SSN: _____ **Producer #**:_____ FAX number: _____

   Name and phone # of agent to contact for this case: _____

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

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

   Percentage of Split**:_____
   Street, City, ZIP: _____

   Tax ID/SSN: _____ **Producer #**:_____ FAX number: _____
   Contact's E-Mail address (please print clearly): _____

3. General Agent Name (if applicable): JME Insurance Agency & Investments, Inc.

   Street, City, ZIP: 5495 Belt Line Rd Ste 333 Dallas TX 75254

   Tax ID/SSN: 75-2861611 **Producer #**:008011929 FAX number: 972-245-2455
   Contact name and telephone number for this case: 972-245-0266

   Contact's E-Mail address (please print clearly): @JMEinsurance.com

   General Agent's Signature:

* The **Producer** or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

If commissions are to be split, please provide the information requested above on both **Producers or agencies. **Both Producers** or agencies must be appointed to do business with BCBSTX and/or Dearborn National and total commissions paid must equal 100%.

PROXY (OPTIONAL)

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.

HCSC pays indemnification or advances expenses to 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