BlueCross BlueShield of Texas

Small Group

Submission Checklist

Use these helpful tips to prepare your new small groups for enrollment.

- ☐ **Confirm Eligibility:** A business may qualify as a small group if it has between one and 50 employees currently on the payroll and during most business days in the past calendar year.
- ☐ **Apply for Group Coverage:** Submit a completed, signed BPA at least two weeks before the requested effective date. Need a BPA? Visit bcbstx.com/producer.
- ☐ **Enroll your Members*:** An application or declination is required for each eligible employee. You can upload paper applications – or try our Smart Census in the ACA Enrollment tool on Blue Access for Producers℠ to see how easy submitting your enrollment census can be!
- ☐ **Submit a Signed Small Group Proposal:** Include the signature page from the Small Group proposal with the group's enrollment.
- ☐ **Proof of Wages:** Submit the group's most current quarterly wage and tax report or other payroll documents from the Texas Workforce Commission (TWC).
- ☐ **Texas Supplemental Employment Verification Form:** New hires aren't listed on the TWC report? No problem – submit a supplemental employment verification form.
- ☐ **Proof of Business:** If a quarterly wage and tax report isn't available, other state-filed documents can be used as proof of business:
  - Articles of incorporation or organization
  - Certificates of organization
- ☐ **Employer Group Information Form (EGI):** Submit a signed EGI form along with the BPA.
- ☐ **The Participation Requirement is 75%, Less Valid Waivers:** Identify employees with valid waivers – like proof of other coverage. Identifying part-time, seasonal and terminated employees can also help the group meet minimum participation requirements.

Submit all your new small groups online.

Log on at bcbstx.com/producer. Then click quotes/enroll a group/ACA Small Group Enrollment. For quickest processing, have your completed enrollment documents ready to upload.

How can we help? Call your sales executive for questions about new group sales.

Call 800-399-5831 for questions about quoting or enrollment.

*Employee Enrollment applications are not required when you use the Blue Directions enrollment tool.

BlueCross BlueShield of Texas

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,
a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("BCBSTX")

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 (1) of the following billing methods. ☐ 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 (first (1st) or fifteenth (15th)): __/__/____ (mm/dd/yyyy)		

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* (mm/dd/yyyy): Beginning Date:__/__/____ End Date:__/__/____

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 (mm/dd/yyyy): __/__/____

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations.

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.

ELIGIBILITY

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 to the Employee or Dependent, based on the Waiting Period and eligibility conditions the Policyholder provided to BCBSTX, BCBSTX reserves the right to retroactively adjust the coverage date for such person.

a. Newly eligible individuals will become effective on:

☐ The first (1st) or fifteenth (15th) day of the contract/participation month following:
☐ Zero (0) days ☐ Thirty (30) days ☐ Sixty (60) days; or

☐ The date of employment (date of hire).

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. In no event can the substantive eligibility criteria result in a delay of coverage for eligible Employees, as defined under Texas law, longer than ninety (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 (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 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).

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. Is the company headquartered in Texas? ☐ Yes ☐ No

5. **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. Such person's Individual Coverage Date, Family Coverage Date and/or Dependent's Coverage Date will be the Contract Anniversary Date following the Open Enrollment Period, provided the application is dated and signed prior to that date.

For all lines of coverage, enrollment period will be held thirty-one (31) days prior to the Contract Anniversary Date of the program.

6. **Domestic Partners covered:** ☐ Yes ☐ No
If yes, a Domestic Partner, as defined in the Certificate Booklet, 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 eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if the Employee elects COBRA coverage. Employer shall determine eligibility for COBRA continuation for Domestic Partners, if any. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to Domestic Partners, as defined in the Certificate Booklet on an independent basis from the Employee

☐ No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from the Employee (Domestic Partners are not independently eligible for continuation coverage)

☐ Other: _____

7. 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, a medical or dental 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.

8. **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). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. A disabled Dependent is eligible to add or continue coverage beyond the limiting age of twenty-six (26).

Certification Review is administered by BCBSTX; a Disabled Dependent Certification Form must be submitted to BCBSTX. Proof of incapacity and dependency may be required within thirty-one (31) days of the child's attainment of the limiting age. Subsequent recertification may occur annually, as required.

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

10. Will you have been without group coverage (uninsured) for at least two (2) months prior to the requested Contract(s)/Policy(ies) effective date of coverage? ☐ Yes ☐ No

11. 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 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
- Treatment of home health care (PPO only)

MANDATED BENEFIT OFFERS

In Vitro Fertilization Services - (must choose one (1))

☐ 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

BENEFIT PLAN SELECTIONS

Select **UP TO SIX (6)** medical plans to offer.

Preferred HSA Vendor: ☐ BenefitWallet ☐ Flex ☐ HSA Bank
☐ HealthEquity, Inc. (BCBSTX to send HSA enrollment to HealthEquity, Inc. ☐ Yes ☐ No)
Non-Preferred HSA Vendor: _____

Preferred FSA Vendor: ☐ BenefitWallet ☐ Flex ☐ HealthEquity, Inc. ☐ HSA Bank
Non-Preferred FSA Vendor: _____

An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Metallic Levels	Blue Choice PPO℠			*Blue Advantage HMO℠
	(select up to 6)			
BRONZE PLANS	☐	B660CHC	☐	B9E1ADT
	☐	B661CHC	☐	B660ADT
	☐	B662CHC	☐	B661ADT
SILVER PLANS	☐	S660CHC	☐	S640ADT
	☐	S661CHC	☐	S641ADT
	☐	S662CHC	☐	S642ADT
	☐	S663CHC	☐	S643ADT
	☐	S665CHC	☐	S644ADT
	☐	S666CHC	☐	S9E1ADT
	☐	S667CHC	☐	S9E3ADT
	☐	S9K1CHC	☐	S9E5ADT
	☐	S9L3CHC	☐	S9J3ADT
	☐	S9L5CHC	☐	S9J5ADT
	☐	S9L7CHC	☐	S9J7ADT
	☐	S9L9CHC	☐	S9J9ADT
	☐	S9M2CHC	☐	S9K2ADT
	☐	S9M4CHC	☐	S9L1ADT
	☐	S9N1CHC	☐	S9N1ADT
	☐	S9N3CHC	☐	S9N3ADT
GOLD PLANS	☐	G650CHC	☐	G660ADT
	☐	G651CHC	☐	G661ADT
	☐	G652CHC	☐	G662ADT
	☐	G653CHC	☐	G663ADT
	☐	G654CHC	☐	G664ADT

	☐	G656CHC	☐	G665ADT
	☐	G9K4CHC	☐	G666ADT
	☐	G9K6CHC	☐	G9E1ADT
	☐	G9K8CHC	☐	G9E3ADT
	☐	G9L1CHC	☐	G9E5ADT
	☐	G9L5CHC	☐	G9J1ADT
	☐	G9L7CHC	☐	G9K5ADT
			☐	G9K7ADT
PLATINUM PLANS	☐	P620CHC	☐	P610ADT
	☐	P621CHC	☐	P611ADT
	☐	P9K3CHC	☐	P9K3ADT
	☐	P9M1CHC	☐	P9M1ADT

*****If a 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 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; DTXHM41 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. DTXHM45 can be freely paired with any one (1) voluntary option.

Voluntary plans and contributory plans may not be offered together.

Exception: DTXHM57 can be paired with DTXHR33. And, DTXHM59 can be paired with DTXHR42.

Participation Requirements

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

Voluntary
> twenty-five percent (25%) participation

Employers are not required to contribute to Voluntary Dental plans.

DENTAL PLAN SELECTION

	Plan #	Segment
High Coverage Allocation		
☐	DTXHR30	Contributory
☐	DTXHR31	Contributory
☐	DTXHR32	Contributory
☐	DTXHR33	Contributory
☐	DTXHR34	Contributory
☐	DTXHM39	Contributory
☐	DTXHM41	Contributory
☐	DTXHR50	Contributory
☐	DTXHM57	Contributory
☐	DTXHR42	Voluntary
☐	DTXHM43	Voluntary
☐	DTXHM45	Voluntary
☐	DTXHR51	Voluntary
☐	DTXHR52	Voluntary
☐	DTXHM59	Voluntary
Low Coverage Allocation		
☐	DTXLR35	Contributory
☐	DTXLR36	Contributory
☐	DTXLR37	Contributory
☐	DTXLM38	Contributory
☐	DTXLM40	Contributory
☐	DTXLM44	Contributory
☐	DTXLR58	Contributory
☐	DTXLR46	Voluntary
☐	DTXLM49	Voluntary
☐	DTXLR53	Voluntary
☐	DTXLM54	Voluntary
☐	DTXLR60	Voluntary

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

1. Applications/Declinations are attached for all full-time Employees as well as any COBRA or state participant continuations.

2. **Minimum Participation and Employer Contribution.** BCBSTX reserves the right to:

a. 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 Employees (less valid waivers) have enrolled for coverage; and

b. Request confirmation of and review participation and contribution on existing business and non-renew or discontinue health coverage if BCBSTX is unable to determine if the fifty percent (50%) minimum Employer contribution is not met and/or less than seventy-five percent (75%) of Eligible Persons (less valid waivers) are enrolled for coverage for six (6) 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.

3. 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.

4. After approval by BCBSTX the Health and/or Dental Benefit Plan(s) applied for, individuals will become effective on the first (1st) day of the contract/participation month following satisfaction of the Waiting Period (if any, but not to exceed ninety (90) days). Employees whose applications are received more than thirty-one (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.

5. 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.

6. 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.

7. This 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.

8. Retirees are not eligible for coverage hereunder.

9. Under Texas state law, ***eligible employee*** means an employee who works on a full-time basis and who usually works at least thirty (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 thirty (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.

10. 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 BCBSTX 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.

11. 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 for a Life Insurance Plan (including Term Life Insurance, Accidental Death and Dismemberment (AD&D), Dependents' Life, Supplemental Life, Short-Term Disability (STD), Long-Term Disability (LTD), Specified Disease, Accident, and/or Vision)

I. Group Life Administration Information

Eligibility: ☐ All active Employees ☐ All active Employees enrolled for health insurance who work a minimum of thirty (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: ☐ twelve (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: ☐ One hundred percent (100%)
☐ Other _____% (Minimum Twenty-five percent (25%) Employer contribution required)

Life/AD&D Reductions due to Attained Age (All benefits terminate at retirement):

- ☐ Reduces by thirty-five percent (35%) at age sixty-five (65), to fifty percent (50%) of the original benefit at age seventy (70), to twenty-five percent (25%) of the original benefit at age seventy-five (75), and to fifteen (15%) of the original benefit at age eighty (80). (Standard under ten (10) eligible lives)
- ☐ Reduces by thirty-five percent (35%) at age sixty-five (65) and to fifty percent (50%) of the original benefit at age seventy (70).
- ☐ Reduces to fifty percent (50%) at age seventy (70). (Unavailable under ten (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) Live birth up to six (6) months: $ _____
Employer Contribution: _____ %	Child(ren) age six (6) months up to age twenty-six (26) & Students: $ _____

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

Wage-Based Benefit: ☐ Fifty percent (50%) ☐ Sixty percent (60%) ☐ Sixty-six and two-thirds percent (66 2/3%) of Basic Weekly Wages to a Benefit Maximum of $ _____

Flat Benefit: ☐ Fifty dollars ($50) ☐ One hundred dollars ($100) ☐ One hundred fifty dollars ($150) ☐ Two hundred dollars ($200) ☐ Two hundred fifty dollars ($250) not to exceed sixty-six and two-thirds percent (66 2/3%) of Basic Weekly Wages

Class Defined Plan: Complete STD amount in Section I

Benefits Begin:

Due to an Accident: (select one)
☐ First (1st) day ☐ Eighth (8th) day
☐ Fifteenth (15th) day ☐ Thirty-first (31st) day

Due to Sickness: (select one)
☐ Eighth (8th) day
☐ Fifteenth (15th) day
☐ Thirty-first (31st) day

Maximum Weekly Benefit Duration: ☐ Thirteen (13) weeks ☐ Twenty-six (26 weeks)

Rates: ☐ Step-Rated ☐ Composite Rated (Include a copy of the rating exhibit if rated in the field)	
Employer Contribution:	☐ One hundred percent (100%) ☐ Other _____% (Minimum twenty-five percent (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.	

V. Supplemental Life Insurance:
☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)** _____

Benefit Plan: _____ Employer Contribution _____%

VI. Long-Term Disability Insurance:
☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)** _____

Benefit Plan: _____ Employer Contribution _____%

VII. Specific Disease Insurance:
☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)** _____

Benefit Plan: _____ Employer Contribution _____%

VIII. Accident Insurance:
☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)** _____

Benefit Plan: _____ Employer Contribution _____%

IX. Vision Insurance:
☐ **No change** ☐ **New Coverage Applied For** ☐ **Upgrade** ☐ **Other (explain)** _____

Benefit Plan: _____ Employer Contribution _____%

The undersigned represents he/she is an Employer engaged in (groups with two (2) to nine (9) Employees must check ✓ one (1)): ☐ 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, Disability, Specified Disease, Accident, and/or Vision Contract(s) issued. The Employer further agrees to comply with the following requirements:

1. If coverage is contributory, a minimum of seventy-five percent (75%) of the eligible Employees must enroll. If coverage is non-contributory, one hundred percent (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 twenty-five percent (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 (1) 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 no later than the first (1st) day of each billing period. If the premium payments are not received, 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 Insurance Plan(s).

8. Coverage for the Employer may be amended from time to time, and the Employer's participation may be terminated with thirty-one (31) days written notice in accordance with the terms of the Policy. Premium rates may change 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. The Employer's participation in the Insurance Plan(s) may terminate 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 of the approval of the Employee's application for coverage.

EMPLOYER: DO NOT CANCEL CURRENT COVERAGE UNTIL NOTIFIED BY BCBSTX THAT THIS EMPLOYER APPLICATION HAS BEEN APPROVED.

ELECTRONIC RECEIPT OF BENEFIT BOOKLETS AND CONTRACTS

Electronic Issuance: Delivery of insurance documents, including but not limited to the Group Administration Document, Benefit Booklet, SBC, and other required forms and amendments thereto, will be delivered via an electronic file or access to an electronic file to the Employer for delivery to each Employee. The Employer agrees that it is solely responsible for providing each Employee access to the most current version of any E-file Benefit Booklet, SBC, 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 will hold BCBSTX harmless from any misuse of the E-file provided by BCBSTX. You can request paper delivery of insurance documents by indicating below. You may also go back to paper delivery at any time with no penalty. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports mobile browsing. If the method to access electronic files is revised, BCBSTX will notify you and give an opportunity to request paper delivery. Notice of cancellation or termination of a Contract will be delivered both electronically and in paper form.

☐ **Opt-Out –** Employer declines to receive electronic versions of insurance documents, Benefit Booklets, and SBCs for covered Employees or the Contract and desires BCBSTX to print and distribute hard copy versions.

EMPLOYER STATEMENTS:

1. 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.

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

3. 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 accepts this Employer Application and issues a Group Contract/Policy/Agreement to the Employer, BCBSTX 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 in connection with the issuance of a Group Contract/Policy, they should contact the producer(s)/agency(ies).

4. I certify that all statements contained in this Employer Application and all information required to be furnished to BCBSTX is complete and true to the best of my knowledge and belief. I understand that BCBSTX 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. The requested Contract(s)/Policy(ies) effective date (as listed on page 1) is subject to change by BCBSTX 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 sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure 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. 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) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder), and/or (c) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

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

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

☐ Employer consents to BCBSTX transmitting MCC reports on its behalf. Further, Employer attests that the information submitted is true and compliant with all relevant MCC Regulations.

☐ Employer will transmit MCC reports and any other documentation as may be required to comply with the Massachusetts Health Care Reform Act.

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

E. **Third Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services):** BCBSTX 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.

The provisions of paragraphs A-E (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

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

PRODUCERS

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 has 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)

Producer #: _____ Percentage of Split**: _____

Complete Address: _____ FAX #: _____

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): _____

Producer #: _____ Percentage of Split**: _____

Street, City, ZIP: _____ FAX #: _____

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

3. General Agent Name (if applicable): _____

Producer #: _____ FAX #: _____

Street, City, ZIP: _____

Contact name and telephone # for this case: _____

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

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 total commissions paid must equal one hundred percent (100%).

PROXY (OPTIONAL)

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

HCSC pays indemnification or advances expenses to its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No(s).: _____ By: _____

Print Signer's Name Here

➡ _____

Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____, _____

Month Year

BlueCross BlueShield of Texas

Consumer Choice Plan Disclosure Statement

This health plan does not include the same level of benefits required in other plans.

This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	This plan:	A health plan with required benefits (state-mandated plan):
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for participating provider care.
Out-of-Pocket Costs The amount you pay when you receive covered services, up to a calendar year maximum**.**	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
Habilitative and Rehabilitative Care Care that helps you improve skills for daily living.	Includes a limit on the number of visits per year for speech therapy, occupational therapy, physical therapy and chiropractic care. Limits do not apply for the treatment of acquired brain injury and autism spectrum disorder.	Has no limits on the amount of care if it is needed for medical reasons.
Home Health Services	Includes a limit for home health services.	Has no limits on home health services.
Therapies for Children with Developmental Delays	Does not cover therapies for treatment of developmental delay in children	Covers certain development delay therapies for children with developmental delay, up to age three.

BlueCross BlueShield of Texas

If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits. This plan is not on Healthcare.gov and does not allow you to get help with premiums and out-of-pocket costs. To learn more about this plan, call 1-877-299-2377or visit https://www.bcbstx.com/shop-plans-and-products.

By signing this form, you acknowledge the following:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, https://www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

Do not sign this document if you don't understand it.
No firme este documento si no lo comprende.

Signature of Applicant	**Date**
Name of Applicant (print name)	
Name of Business, if applicable	
Address	
City **State**	**Zip**

HMO must give you a copy of this statement upon request.

BlueCross BlueShield of Texas

An Independent Licensee of the Blue Cross and Blue Shield Association

TEXAS SUPPLEMENTAL EMPLOYMENT VERIFICATION

To be used with the TWC Report

Employer's Name	SIC Code	Group Policy Number

Address	City	State	Zip

EMPLOYEE CENSUS INFORMATION

Under our Small Group Employer products, BCBSTX verifies employment information. **We require the submission of a current TWC Report.** The TWC Report is used to verify the SIC Code applicable to your company and to assist us in verifying employment. Please utilize the status codes listed below to denote the employment status of all employees listed on your TWC Report. Employees who are not indicated on the TWC Report should be reported using this Supplemental Employment Verification Form. All full-time employees must complete a BestChoice Application indicating (1) they are requesting coverage or (2) they are declining coverage. Applications for individuals requesting coverage cannot be processed without verification of employment. If this information is missing, the effective date of coverage may be delayed.

STATUS CODES

Please use the appropriate code indicating applicable status of the person listed on the TWC Report or this form:

F	Full-time employee who works 30 or more hours per week
P	Part-time employee who works less than 30 hours per week
I	Independent contractor working 30 or more hours per week
O	Owners, Partners and Officers who work 30 or more hours per week
D	Totally disabled employee
C	Continued employee under State or Federal law
T	Terminated employee no longer employed by the company
W	Full-time employees in Waiting Period

EMPLOYEES NOT LISTED ON THE TWC REPORT

Please list the following persons employed by you:

- New employees who do not appear on your TWC Report and work a minimum of 30 hours per week
- Owners, Partners and Officers who work a minimum of 30 hours per week
- Independent contractors who work a minimum of 30 hours per week
  (List only if offering coverage. It is not necessary for you to offer coverage to Independent Contractors; however, you must offer coverage to all Independent Contractors who work for you if you wish to cover any Independent Contractors.)
- Other
  (Please define employees who fall into this category so BCBSTX may determine if they are eligible for coverage.)

These Persons Must Be Listed Even If They Decline Coverage

	NAME	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK	STATUS CODE	APPLYING FOR COVERAGE (YES) DECLINING COVERAGE (NO) ATTACH APPLICATION
1					☐ Yes ☐ No
2					☐ Yes ☐ No
3					☐ Yes ☐ No
4					☐ Yes ☐ No
5					☐ Yes ☐ No
6					☐ Yes ☐ No
7					☐ Yes ☐ No
8					☐ Yes ☐ No
9					☐ Yes ☐ No
10					☐ Yes ☐ No
11					☐ Yes ☐ No
12					☐ Yes ☐ No
13					☐ Yes ☐ No
14					☐ Yes ☐ No
15					☐ Yes ☐ No
16					☐ Yes ☐ No
17					☐ Yes ☐ No
18					☐ Yes ☐ No
19					☐ Yes ☐ No
20					☐ Yes ☐ No
21					☐ Yes ☐ No
22					☐ Yes ☐ No
23					☐ Yes ☐ No
24					☐ Yes ☐ No
25					☐ Yes ☐ No

I HEREBY CERTIFY I HAVE READ THIS DOCUMENT AND THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE. I ALSO CERTIFY THE INFORMATION PROVIDED HERE CAN BE SUBSTANTIATED BY BUSINESS RECORDS MAINTAINED BY ME. UPON REQUEST, I AGREE TO PROVIDE THE DOCUMENTATION REQUESTED BY BCBSTX VERIFYING PARTICIPATION AND ELIGIBILITY REQUIREMENTS. I UNDERSTAND PROVIDING INCOMPLETE, INACCURATE, OR UNTIMELY INFORMATION MAY VOID, REDUCE OR TERMINATE THE GROUPS COVERAGE.

Signature of Authorized Company Official _____ Title _____ Date _____

Print Name of Authorized Company Official _____

Signature of Agent _____

BCBSTX does reserve the right to randomly request documents verifying the above information. In addition, we reserve the right to reverify employment information at any time during the course of your contract with us.

BlueCross BlueShield of Texas

Employer Group Information (EGI)

Indicate N/A in any sections that do not apply to your group.

Revised – August, 2023

SECTION A: GROUP INFORMATION	
Employer Name – Legal Name of Company:	
Employer Identification Number (EIN):	
Physical Address (number & street), City, State, ZIP:	
Account Number(s):	Group Number(s):

MEDICARE SECONDARY PAYER (MSP) EMPLOYER ACKNOWLEDGEMENT FORM (EAF)

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the instructions and more frequently asked questions that follow this form for more details on how to complete this Medicare Secondary Payer section.

Employers should provide this information ANNUALLY during the data collection period and submit their information through Blue Access for Employers℠ (BAE℠) or submit a completed stand-alone MSP form to data_collection@bcbsil.com.

Understand that you are obligated to notify Blue Cross and Blue Shield of Texas (BCBSTX) if and when your status changes, by completing a stand-alone MSP EAF as a CHANGE or ERROR CORRECTION. Email to data_collection@bcbsil.com.

IMPORTANT: In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Therefore, the failure to timely provide this information and to submit annual employee count reports could impact the coverage and benefits your Medicare-enrolled plan enrollees experience.

Please indicate the effective year for which the form is being completed. Effective Year:	
My company is a NEW client of BCBSTX (check one):	
☐ My company was NOT in business in the last calendar year	☐ My company WAS in business in the last calendar year
Do you have any affiliates or subsidiaries? ☐ Yes ☐ No If "yes", list name of each:	

BlueCross BlueShield of Texas

Definitions to know for the further completion of this form:

Multi-employer group health plan: Any trust, plan, association or any other arrangement made by two or more employers or by employers and unions to offer, contribute to, sponsor, or directly provide health benefits.

Total Employees: Full-time, part-time, seasonal, or partners.

Some of the following responses are based on the current calendar year, while others are based on the prior year. Unless making an update or error correction, please use the CURRENT CALENDAR YEAR of your ANNUAL renewal as 'current year' when answering the following questions. Changes for the current calendar year cannot be made until the beginning of the annual data collection period. Reporting can be done in Blue Access for Employers (BAE) or with this form. If your company is a new client to BCBSTX **AND** there have not yet been 20 weeks in the current calendar year, base your answer on current employee count.

1. In the year immediately prior to the current calendar year, did you file a separate federal tax return, that is, not consolidated with another individual or entity? If you are not required to file a federal tax return, please check N/A.	☐ Yes ☐ No ☐ N/A
2. How many employees did all the entities on the prior calendar year's tax return have on the payroll during the prior calendar year?	Enter number of employees.
3. Are you part of a multi-employer group health plan?	☐ Yes ☐ No
4. Did you have 20 or more total employees for each working day in each of 20 or more calendar weeks: • In the CURRENT calendar year? – If you checked "Yes" for the current calendar year, and the threshold was met during the current year, please enter the date the threshold was met here (using the mm/dd/yyyy format): _____ – If you checked "No" for the current year and your answer changes to "Yes" at any time, you must promptly notify BCBSTX by completing a stand-alone EAF as a CHANGE, and entering the date the threshold was met above. • In the PRIOR calendar year?	☐ Yes ☐ No ☐ Yes ☐ No
5. In the CURRENT calendar year, are you part of a multi-employer group health plan, where any ONE employer has 20 or more total employees for each working day in each of 20 or more calendar weeks? In the PRIOR calendar year, were you part of a multi-employer group health plan, where any ONE employer had 20 or more total employees for each working day in each of 20 or more calendar weeks?	☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No
6. Did you have 100 or more total employees on 50 percent or more of your business days during the prior calendar year?	☐ Yes ☐ No
7. If you are part of a multi-employer group health plan, did any one employer that is part of the multi-employer group health plan have 100 or more total employees on 50 percent or more of your business days during the prior calendar year?	☐ Yes ☐ No ☐ N/A

BlueCross BlueShield of Texas

SECTION C: COBRA AND CONTINUATION OF COVERAGE

CONTINUATION OF COVERAGE: COBRA IS FEDERALLY MANDATED AND APPLIES TO EMPLOYERS WITH 20 OR MORE FULL-TIME OR PART-TIME EMPLOYEES. IN ADDITION, TEXAS LAW REQUIRES GROUP PLANS, WHEN SUBJECT TO TEXAS INSURANCE LAW, TO OFFER CONTINUATION OF COVERAGE TO EMPLOYEES AND THEIR SPOUSES/DEPENDENTS SHOULD A SPECIFIC QUALIFYING EVENT OCCUR. WHERE APPLICABLE, THE REQUIREMENTS UNDER STATE LAW MAY OPERATE IN ADDITION TO ANY FEDERAL COBRA CONTINUATION OF COVERAGE REQUIREMENTS.

EMPLOYER PENALTIES FOR NONCOMPLIANCE MAY APPLY.

1. 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
2. Are you subject to the Consolidated Omnibus Reconciliation Act (COBRA)?	☐ Yes ☐ No
3. Are any employees/former employees or their spouses/dependents currently receiving Continuation of Coverage benefits?	☐ Yes ☐ No

If "yes", list names and number of individuals (qualified beneficiaries) currently on continuation of coverage (i.e., COBRA):

Name of COBRA/ Continuation of Coverage Individual	**COBRA/State Continuation**	**Coverage Type** (Individual or Family)	**Projected COBRA/ Continuation Qualifying Event Date** (MM/DD/YYYY)	**Type of Coverage Extended**
	☐ COBRA ☐ State	☐ Individual ☐ Family		☐ Health ☐ Dental
	☐ COBRA ☐ State	☐ Individual ☐ Family		☐ Health ☐ Dental
	☐ COBRA ☐ State	☐ Individual ☐ Family		☐ Health ☐ Dental

It is your responsibility to annually inform BCBSTX of whether COBRA is applicable to you based upon your full and part-time employee count in the prior calendar year. Failure to advise BCBSTX of a change of status could subject you to governmental sanctions.

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

Workers' Compensation

Are any employees currently receiving Workers' Compensation benefits? ☐ Yes ☐ No

If "yes", list names and date last worked:

Employee Name	**Date Last Worked** (MM/DD/YYYY)

BlueCross BlueShield of Texas

SECTION D: MLR AVERAGE EMPLOYEE COUNT / WRITTEN ASSURANCE

FOR MLR AND MARKET SEGMENT PURPOSES ONLY

The Affordable Care Act (ACA) established Medical Loss Ratio (MLR) standards for health insurers. Generally, the MLR is the percentage of earned premiums that the insurer spends on health care services and quality improvement activities. If the insurer's MLR is less than the ACA's MLR standards for a group market in the state, the insurer may be required to provide premium rebates in that market. The ACA requires that BCBSTX report annually whether coverage it issues in the individual, small group or large group markets in Texas meet MLR standards. Your assistance is needed to classify your coverage for each MLR reporting year.

This section and the information you provide will assist us in completing our ACA-MLR report and distributing any ACA-MLR rebates that may be provided for an ACA-MLR reporting year. Please complete the information requested below. This section and the information you provide will also assist us in determining your market segment, products and rates.

1. Average Employee Count – Employer Size

For the purpose of determining employer size:

- An "employee" is defined as any individual employed by an employer. An employee includes full-time, part-time and seasonal employees.
- Employers treated as a single employer under Internal Revenue Code Section 414(b), (c), (m) or (o) should be treated as a single employer.
- If your company is wholly owned by an individual (or an individual and his/her spouse), do not include the individual and his/her spouse in your response below.
- Partners in a partnership should not be counted as employees.

Check the box that applies to your company (employer):

☐ My company (employer) **existed** during the preceding calendar year.
What is the average number of employees that your company (employer) employed on business days during the calendar year (January 1–December 31) preceding the effective date of coverage? For example, if your effective date is July 1, 2021 then you would base your answer on calendar year 2020. _____

☐ My company (employer) **did not exist** at any time during the preceding calendar year.
What is the average number of employees that your company (employer) is reasonably expected to employ on business days during the current calendar year? _____

Is your company a partnership? ☐ Yes ☐ No

2. Church Plan Written Assurance (Substitute MLR Written Assurance Form)

To provide a rebate to a policyholder that sponsors a church plan, the MLR regulations require that an insurer obtain a written assurance from the policyholder that any rebate will be used for the benefit of subscribers as described in the MLR regulations (45 C.F.R. 158.242(b)(3)). **If the written assurance is not provided, the MLR regulations require that an insurer distribute any rebate directly to certain subscribers of the plan (rather than to the policyholder).**

Does the policyholder listed below sponsor a church plan in connection with the policyholder's Blue Cross and Blue Shield of Texas (BCBSTX) coverage? Church plan has the meaning given the term in Internal Revenue Code Section 414(e).

☐ **No, the group health plan is NOT a church plan. (If "no", proceed to Section E: Signature / Attestation.)**

OR

☐ **Yes, the group health plan is a church plan. If "yes" (check one of the following):**

- ☐ The policyholder WILL use any MLR rebate for the benefit of subscribers as described in the MLR regulations (45 C.F.R. 158.242(b)(3)).
- ☐ The policyholder WILL NOT use any MLR rebate for the benefit of subscribers as described above. I understand that, if this option is selected, BCBSTX will distribute any MLR rebate directly to certain subscribers of the plan.

If this Written Assurance Form is not completed, signed and received from a church account, BCBSTX will provide any MLR rebate directly to certain subscribers of the plan.

BlueCross BlueShield of Texas

SECTION E: SIGNATURE / ATTESTATION

By signing below, I:

(1) Represent that I am a duly authorized representative of the employer and that the information contained in this form is true, accurate and complete;

(2) Certify that should any of the answers or information I provided above change in any way, I will inform BCBSTX of such change as soon as I am able. I understand that failure to timely notify BCBSTX of such changes may impact the coverage/eligibility of the group, its members, or any other persons who now or who may then be eligible for coverage under such plan and/or may impact the compliance of the group with respect to specific state or federal requirements;

(3) Understand and agree that the information contained in this form prospectively supersedes any prior information provided to BCBSTX (including for the purposes of 45 C.F.R. 158.242(b)(3)); and

(4) Agree that the answers or information I provided above should be considered accurate and complete unless or until a subsequent stand-alone version of the corrected Average Employee Count, Church Plan Written Assurance, or Medicare Secondary Payer form is submitted either in a subsequent calendar year or in the event of a change in such information.

Date (MM/DD/YYYY) _____ Name: (Please Print) _____

Signature: _____ Position/Title: _____

BlueCross BlueShield of Texas

Instructions

COMPLETING THE ANNUAL MSP EMPLOYER ACKNOWLEDGEMENT FORM

Important Note

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the attached instructions for more details. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare.**

Employers should provide this information ANNUALLY during the data collection period and submit their information through Blue Access for Employers℠ (BAE℠) or submit a completed stand-alone MSP form to data_collection@bcbsil.com.

Understand that you are obligated to notify BCBSTX if and when your status changes, by completing a stand-alone MSP EAF as a CHANGE or ERROR CORRECTION. Email to data_collection@bcbsil.com.

Background

When an individual is covered by both Medicare and an employer's group health plan (GHP), Medicare secondary payer (MSP) rules specify that the employer's total size, not group health plan enrollment size, is a factor in determining whether Medicare benefits are primary or secondary. Employer size is a factor in MSP order of payment determinations when the covered individual is Medicare-entitled due to either age ("working aged") or disability.

Employer Information — Who is the Employer?

For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. In some situations, it may not be clear which corporation or individual is the employer for MSP purposes. In these cases, employers must use Internal Revenue Service aggregation rules provided in the Internal Revenue Code [IRC 26 U.S.C. Sections 52(a), 52(b), 414(n) (2)]. In general, these rules specify that single employers include:

- all employees of all corporations that are members of the same controlled group of corporations, and
- all employees of trades or business (whether incorporated or not), e.g., employees of partnerships, LLCs, proprietorships that are under common control.

The Centers for Medicare & Medicaid Service's (CMS) MSP Manual provides additional guidance about aggregation for affiliated service groups and religious orders, as well as authoritative information about employer size and other MSP topics. The MSP Manual is available online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017

For purposes of this MSP EAF, please understand that you are obligated to notify BCBSTX if and when your status changes, by completing a stand-alone MSP EAF as a **CHANGE** or **ERROR CORRECTION** and email to data_collection@bcbsil.com.

An **Error Correction** is necessary when a previous MSP EAF was submitted TIMELY during the data collection time frame and a correction is needed.

Question 1 — Did you file a separate Federal Tax Return?

If you filed a federal tax return that did not include information about any other individual or entity, check "Yes." If you filed a federal tax return consolidated with another individual or entity, check "No." If you are not required to file a federal tax return, check "N/A."

Question 2 — Employer Size from Your Federal Tax Return Information

How many employees did all the entities listed on the tax return have on the payroll (whether full-time, part-time, seasonal or partners) during the prior calendar year? It is important that you enter the total number of employees for all entities (including parent,

subsidiaries and affiliated entities) listed on the tax return, since this may determine whether or not Medicare will be the primary payer of claims. Subsidiaries of foreign companies must count the number of employees of the organization worldwide.

Question 3 — Are you part of a multi-employer group health plan?

Authoritative guidance for determining multiple employer group health plan participation can be found in the Code of Federal Regulations at 29 CFR § 2510.3-37.

Questions 4 and 5 — Working Aged Rule & Employer Size

Under the MSP "working aged" rule, Medicare is secondary to the employer's GHP coverage if the employer's size equals 20 or more employees for each working day in each of 20 or more calendar weeks in the current or prior calendar year. (Question 4 refers to this standard as "the threshold.") Note: The year of your upcoming renewal is the 'current' year. If your company is a new client to BCBSTX AND if there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSTX if and when your status changes, by completing a stand-alone MSP EAF as a CHANGE and submitting it to data_collection@bcbsil.com. This also applies to multi-employer and multiple employer group health plans in which at least one employer employs 20 or more employees.

- Counting individuals for the "20-or-more" employer size
  - Employees counted in the 20-or-more employer size include the total number of nationwide full-time employees, part- time employees, seasonal employees and partners who work or who are expected to report for work on a particular day.
  - Those not counted in the 20-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer's group health plan.
- Employer size increases to 20 or more during the year

If the employer's size was below 20 during the prior year, the employer's GHP coverage becomes primary as soon as the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The 20 calendar weeks do not have be consecutive. Then, the employer's GHP coverage is primary for the remainder of the year and during the following year.

For example, the employer's size meets the 20-or-more employee threshold as of October 1 of the current calendar year. The employer's GHP coverage becomes primary for services provided from October 1 of the current calendar year through December 31 of the following year.

Please note: If you check "No" for the current year in EAF **Question 4** and your answer changes to "Yes" at any time, you must promptly notify BCBSTX by completing a stand-alone MSP form and indicating the date the change occurred in the space provided in **Question 4**.

- Employer size fails to meet the threshold of '20 or more employees during 20 or more weeks' during the year

If the employer's size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks for the prior year, but during the current calendar year the employer size never meets that threshold, the employer's group health plan remains primary until the end of the current year.

For example, during the last calendar year the employer's size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks. However, during the current calendar year the employer's size never meets this threshold. The employer's group health plan coverage remains primary through the current year, ending on December 31.

- Individuals affected by the working aged rule

The "working aged rule" applies to individuals who are Medicare-entitled due to age (age-65 or older) and

  - Are covered under their employer's GHP and have "current employment status" and the employer meets the "20-or-more" employer size requirements (above), or
  - Are covered under their spouse's (of any age) employer's GHP and the spouse has current employment status and the employer meets the "20-or-more" employer size requirements (above).

BlueCross BlueShield of Texas

Questions 6 and 7 — Disability Rule & Employer Size

Under the MSP "disability" rule, Medicare benefits are secondary to an employer's large group health plan (LGHP) benefits when the employer size equals 100 or more full-time and/or part-time employees on 50 percent or more of the employer's business days during the prior calendar year. The business days do not have to be consecutive.

For multi-employer plans, Medicare is the secondary payer for all individuals enrolled in the plan as long as at least one of the employers employs 100 or more employees. The 100-employee threshold is not based on the aggregate number of employees of all employers. If you are a multi-employer, please keep this in mind when completing questions 6 and 7.

- Counting individuals for the "100-or-more" employer size
  - Employees counted in the 100-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees and partners who work or are expected to report for work on a particular day.
  - Those not counted in the 100-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer's group health plan.
- Employer size increases to 100 or more during the year

If the employer's size meets the 100-or-more employee threshold on 50 percent or more of the employer's business days during the current year, the employer's group health plan coverage will be primary to Medicare during the following year.

For example, an employer met the 100-or-more employee threshold on 50 percent or more of the employer's business days on October 1 of the current calendar year. The employer's GHP coverage will be primary for services provided the following year from January 1 through December 31 of the following year.

Please note: If you answer "No" to **Question 6**, you must promptly notify BCBSTX by completing a stand-alone MSP form as a CHANGE if your answer changes to "Yes" at the beginning of the next calendar year and sending to data_collection@bcbsil.com.

- Employer size doesn't meet the threshold of '100 or more employees during 50 percent of business days' during the year

If the employer's size does not meet the 100-or-more employee threshold during the year, the employer's GHP coverage is secondary to Medicare during the following year.

For example, during the current calendar year the employer's size never meets the threshold of 100 or more full-time and/or part-time employees on 50 percent or more of the employer's business days. The employer's group health plan coverage will be secondary to Medicare for services provided the following year from January 1 through December 31.

- Individuals affected by the disability rule.

The "disability rule" applies to individuals who are Medicare-entitled due a Social Security Administration determination of disability and

  - Are covered under their employer's GHP and have "current employment status" and the employer meets the "100-or-more" employer size requirements (above), or
  - Are covered under their family member's (of any age) employer's GHP and the family member has current employment status and the employer meets the "100-or-more" employer size requirements (above).

BlueCross BlueShield of Texas

Group Enrollment Application | Change Form

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

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ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1 ENROLLMENT EVENTS

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all sections where applicable.

Add Dependent: Complete all sections where applicable.

- If you are enrolling a court-ordered dependent for coverage beyond the automatic 31-day period for coverage, you must submit a copy of the court order or decree.
- If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section.
- If student dependent coverage is part of your employer's plan and you are adding or enrolling a dependent child age 26 or over who is a student, you may be required to submit a completed Student Certification form.

Open Enrollment: The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership.

Special Enrollment Event: If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment.

Effective Date of Benefits: Field is mandatory.

Completion of Other Eligibility Requirements: Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period.

Cancel Enrollee/Cancel Dependent/Cancel Coverage: Complete Sections 1, 2, 4 (skip Section 4 if declining coverage) and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.

SECTION 2 YOUR INFORMATION

Complete this section with details about yourself even if you are declining coverage.

SECTION 3 YOUR COVERAGE

Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example for a small group plan: B634ADT) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.

If you are enrolling for life or disability insurance, enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.

SECTION 4 COVERAGE OPTIONS

Complete all areas that apply to you and each dependent.

For HMO Plans Only:

- Blue Essentials Access℠ or Blue Premier Access℠ plans do not require a PCP selection.
- Those applying for Blue Advantage HMO℠, Blue Essentials℠ or Blue Premier℠ plans are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at bcbstx.com. Be sure to check the appropriate box for a new patient.
- **ATTENTION FEMALE MEMBERS:** If you select an HMO plan that requires PCP selection, remember that your PCP's network may affect your choice of an OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, for HMO members, the OB/GYN from whom you receive services must belong to the same physician practice group or independent practice association (IPA) as your PCP. This is another reason to make certain that your PCP's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Change Primary Care Physician/Practitioner: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.

Change Address/Name: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.

SECTION 5 DISABLED DEPENDENT

A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if disabled dependent coverage is part of your employer's plan. A Disabled Dependent Authorization and Disabled Dependent Physician Certification form must be completed and submitted with this enrollment application, if applicable.

SECTION 6 OTHER COVERAGE

Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.

SECTION 7 MEDICARE COVERAGE

Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.

SECTION 8 DECLINATION OF COVERAGE

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 8, not just those declining because of other coverage.

IMPORTANT NOTICE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, suit for adoption or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption or placement of an eligible foster child in your home.

SECTION 9 COVERAGE CONDITIONS

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form by mail or email to: **BCBSTX • Group Accounts Dept. • PO Box 655730 • Dallas, TX 75265-5730.**

** The term "marriage" includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer's plan).*
*** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan).*
**** The use of the term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).*

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

Forms referenced above may be obtained by accessing the Blue Cross and Blue Shield of Texas website at bcbstx.com, or from your employer. If you are a current member and have questions, you may also call the Customer Service number on the back of your member ID card.

ENROLLMENT APPLICATION/CHANGE FORM

Group # | Section # | Social Security #

Account # | Category

BlueCross BlueShield of Texas

Please Note: If your group offers a Consumer Choice health plan you have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage 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 policy or evidence of coverage.

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Changes**

Are you applying as a Special Enrollment Event?

☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ New Hire ☐ Marriage* ☐ Birth
☐ Adoption or Suit for Adoption (provide legal documents)
☐ Court Order (provide court order or decree)
☐ Loss of Other Coverage
☐ Other (explain): _____

Effective Date of Benefits: ____ / ____ / ____ ☐ **Completion of Other Eligibility Requirements**

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

Cancel Coverage: ☐ Health ☐ Dental
☐ Term Life ☐ Dependent Life
☐ Short-Term Disability ☐ Long-Term Disability
List names of those canceling in Section 4 below

Event: ☐ Divorce** ☐ Death
☐ Terminated Employment ☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security # – –
Mailing Address - Street - Apt #		City		State	ZIP code
Email Address		☐ Male ☐ Female	Home/Cell Phone #		
Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? ☐ Yes ☐ No	

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: _____ ☐ COBRA Continuation
☐ State Continuation of Group Coverage (insured plans only) ☐ Dependent State Continuation of Group Coverage (insured plans only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 Employees)

Health Coverage (select one)	**Who is covered for health? (select one)**	**BlueCare Dental℠ Coverage**	**Who is covered for dental? (select one)**
☐ Blue Premier Access℠ ☐ Blue Choice PPO℠ ☐ Blue Essentials℠ ☐ Blue Advantage HMO℠ ☐ Blue Essentials Access℠ ☐ Other _____ Plan # (required) _____	☐ Employee Only ☐ Employee/Spouse*** ☐ Employee/Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family ☐ I am not applying for Dental coverage

Large Group Plans (more than 50 Employees)

Health Coverage (select one)	**Who is covered for health? (select one)**	**Dental Coverage**	**Who is covered for dental? (select one)**
☐ Blue Choice PPO℠ ☐ Blue Essentials℠ ☐ Blue Premier℠ ☐ Blue Essentials Access℠ ☐ Blue Premier Access℠ ☐ Other _____ Plan # _____	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No Plan # (required) _____	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family ☐ I am not applying for Dental coverage

Primary Language: _____ ☐ Check here to request a Spanish HMO Member Handbook
Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No
If "Yes," describe special communication materials needed: _____

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance^

☐ I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: _____ Wage Rate $_____ per ☐ hour ☐ week ☐ month ☐ year

Group Basic Term Life and AD&D	☐ I do not apply	☐ I do apply	Amount $_____
Group Dependents' Life	☐ I do not apply	☐ I do apply	
Group Supplemental Life	☐ I do not apply	☐ I do apply	
Employee Election: $_____	Spouse Election: $_____		Child Election: $_____
Short-Term Disability	☐ I do not apply	☐ I do apply	
Long-Term Disability	☐ I do not apply	☐ I do apply	

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security # – –
Primary Beneficiary						
Contingent Beneficiary						

** The term "marriage" includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer's plan).*
*** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan).*
**** The use of the term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).*
^ Life and Disability 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.

Last Name: Social Security #: — — Group #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY. PCP SELECTION IS REQUIRED FOR BLUE ADVANTAGE, BLUE PREMIER AND BLUE ESSENTIALS PLANS. PCP SELECTION IS NOT REQUIRED FOR BLUE PREMIER ACCESS AND BLUE ESSENTIALS ACCESS PLANS.

Employee/Enrollee's Name	PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Social Security # – –	Birth Date (MM/DD/YYYY)	Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N			
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N			
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N			

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Disabled Dependent Authorization and Disabled Dependent Physician Certification.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE ALL AREAS THAT APPLY

Complete this section only if you or any of your dependents have other health and/or dental coverage **that will not be canceled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage ☐ Yes ☐ No	Individual Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease		
Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease		

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for declining **Health**: ☐ Other Group Health Coverage – Carrier: _____ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage – Carrier: _____ ☐ Other (explain) _____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Employee	Reason for declining **Dental**: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any dental insurance plan, but do not want this coverage
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 9 — COVERAGE CONDITIONS

- I am an employee of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Dearborn Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s). As applies to HMO coverage, I will accept an electronic copy of my coverage documents (whether certificate of coverage or benefit booklet) if my employer requests that BCBSTX deliver the information electronically. I understand that a hard copy is available to me upon request.
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.
- I understand that written communications that are required by law may be delivered to me electronically, with my consent. I understand that if I consent to receive my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Applicant's Signature _____ Date _____

BlueCross BlueShield of Texas

Coberturas como prestación laboral Solicitud de cobertura | Solicitud de cambios

Lea detenidamente las instrucciones en el interior antes de completar esta solicitud de cobertura/cambios.

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INSTRUCCIONES PARA LA SOLICITUD DE COBERTURA/CAMBIOS

LEA DETENIDAMENTE ANTES DE COMPLETAR LA SOLICITUD DE COBERTURA/CAMBIOS.

Solo use bolígrafo negro o azul. Escriba en letra de imprenta legible. No utilice abreviaciones.

SECCIÓN 1: MOTIVOS DE SOLICITUD

Marque todas las casillas que correspondan para indicar si usted es un nuevo asegurado o si está solicitando un cambio en la cobertura. Indique el suceso y la fecha, si corresponde. Complete las secciones adicionales conforme a su caso.

Nuevo asegurado: Complete todas las secciones, si corresponde.

Agregar derechohabiente: Complete todas las secciones, si corresponde.

- Si solicita cobertura para un derechohabiente debido a una sentencia judicial para que reciba cobertura después del período automático de 31 días para la cobertura, debe presentar una copia del decreto o de la sentencia judicial.
- Si solicita cobertura para un derechohabiente discapacitado cuya edad supera el límite de edad de la cobertura disponible como prestación laboral, proporcione la información adicional solicitada en la sección 5. También es posible que se solicite documentación adicional, como se especifica en esa sección.
- Si la cobertura disponible como prestación laboral incluye una cobertura para derechohabientes estudiantes y usted desea agregar o solicitar cobertura para un hijo derechohabiente que sea estudiante mayor de 26 años, es posible que deba presentar un formulario completo de certificación de estudiante (*Student Certification*).

Período de inscripciones: El período que se ofrece regularmente, durante el cual puede solicitar la cobertura de un seguro de gastos médicos de un grupo específico o realizar cambios en la cobertura vigente.

Período especial de inscripción: Si usted es elegible, este período le permite hacer cambios a su cobertura vigente en caso de matrimonio*, divorcio**, adopción, colocación en adopción o proceso de adopción, renuncia o despido, mudanza del área de servicio, etc. Este cambio puede realizarse fuera del período de inscripciones.

Fecha de entrada en vigor de los beneficios: El campo es obligatorio.

Cumplimiento de otros requisitos de elegibilidad: Marque esta casilla si la empresa tiene requisitos de elegibilidad que usted ha satisfecho o cumplido antes de presentar la solicitud, como un período de medición o de orientación.

Eliminar asegurado, eliminar derechohabiente o cancelar la cobertura: Complete las secciones 1, 2, 4 (omita la sección 4 si renuncia a la cobertura) y 9. En la sección 4, incluya el nombre, el número de Seguro Social y la fecha de nacimiento de las personas a las que les cancelará la cobertura.

SECCIÓN 2: SU INFORMACIÓN

Complete esta sección con sus datos personales incluso si rechaza la cobertura.

SECCIÓN 3: SU COBERTURA

Complete todos los campos relacionados con las opciones de cobertura que desea solicitar. Incluya el número de identificación de siete caracteres de la cobertura que desea solicitar (por ejemplo, para una cobertura médica para grupos pequeños: B634ADT) en el campo de n.º de cobertura. Si no conoce el tamaño de su grupo o el número de identificación de la cobertura, solicite orientación de su empresa.

Si solicita seguro de Vida y Discapacidad, ingrese la información solicitada. Cuando incluya a los beneficiarios, proporcione sus nombres y apellidos, y la relación que tienen con usted. Incluya a todos los beneficiarios que correspondan.

SECCIÓN 4: OPCIONES DE COBERTURA

Complete todas las áreas que correspondan a usted y a cada derechohabiente.

Solo para coberturas HMO:

- Para las coberturas Blue Essentials Access℠ o Blue Premier Access℠ no es necesario seleccionar un médico de cabecera o prestador principal de servicios médicos (PCP, en inglés).
- Las personas que soliciten las coberturas Blue Advantage HMO℠, Blue Essentials℠ o Blue Premier℠ deben seleccionar un médico de cabecera o prestador principal de servicios médicos (PCP) para cada asegurado. Incluya el nombre del médico o profesional médico y el número de prestador de servicios médicos del directorio de prestadores de servicios médicos o de Provider Finder®, en espanol.bcbstx.com. Marque la casilla adecuada si es paciente nuevo.
- **ATENCIÓN, ASEGURADAS:** Si selecciona una cobertura HMO que exige la selección de un médico de cabecera o prestador principal de servicios médicos (PCP), recuerde que la red de su PCP puede repercutir en sus opciones de ginecólogos-obstetras. Usted tiene derecho a recibir los servicios de un ginecólogo-obstetra sin obtener primero una orden médica de su PCP. No obstante, en el caso de las aseguradas con cobertura HMO, el ginecólogo-obstetra del cual reciben servicios tiene que pertenecer al mismo grupo médico o a la misma Asociación de Médicos Independientes (IPA, en inglés) que el PCP. Esta es otra razón por la cual debe corroborar que la red del PCP incluya especialistas (el ginecólogo-obstetra, en particular) y hospitales de su preferencia. No es necesario que designe a un ginecólogo-obstetra. Puede optar por recibir servicios de ginecología-obstetricia del PCP.

Cambiar de médico de cabecera o prestador principal de servicios médicos: En la sección 1, marque la casilla "Otros cambios" y, luego, complete las secciones 2, 3, 4 y 9. En la sección 4, incluya el nombre, el número de Seguro Social y la fecha de nacimiento del asegurado o derechohabiente, y el nombre y número del nuevo PCP.

Cambiar dirección o nombre: En la sección 1, marque la casilla "Otros cambios" y, luego, complete las secciones 2 y 9.

SECCIÓN 5: DERECHOHABIENTES DISCAPACITADOS

Los derechohabientes discapacitados deben contar con una certificación médica de discapacidad y dependencia de usted o de su cónyuge*** o pareja en unión libre para incluirlos en la cobertura si este tipo de beneficio forma parte de la prestación laboral. Si corresponde, junto con esta solicitud de cobertura médica, deberá completar y presentar la Certificación de discapacidad del derechohabiente (*Disabled Dependent Authorization*) y el Certificado de derechohabiente discapacitado emitido por el médico (*Disabled Dependent Physician Certification*).

SECCIÓN 6: OTRA COBERTURA

Complete esta sección si usted o alguno de sus derechohabientes tienen otra cobertura médica o dental como prestación laboral o para particulares (si corresponde) que no se cancelará cuando entre en vigor la cobertura solicitada por este medio.

SECCIÓN 7: COBERTURA DE MEDICARE

Complete esta sección si usted o alguno de sus derechohabientes tienen cobertura Medicare. Ingrese las fechas correspondientes de inicio y finalización de la cobertura. Debe indicar el número de Medicare (puede encontrarlo en la tarjeta de asegurado de Medicare). Marque el motivo por el cual solicita la cobertura Medicare.

SECCIÓN 8: RENUNCIA A LA COBERTURA

Complete esta sección si renuncia a la cobertura médica para usted y sus derechohabientes. **Toda persona** que, por cualquier razón, renuncie a la cobertura debe completar la sección 8; no solo quienes renuncian porque tienen otra cobertura.

AVISO IMPORTANTE: Si renuncia a su propia cobertura médica o a la de sus derechohabientes (incluido su cónyuge) porque tienen otra cobertura médica, es posible que, en el futuro, pueda solicitar cobertura para usted o sus derechohabientes si presenta su solicitud dentro de los 31 días posteriores a la finalización de su otra cobertura. Además, si tiene un derechohabiente nuevo como consecuencia de matrimonio, nacimiento, adopción u obtención de la guarda de un menor, es posible que pueda solicitar la cobertura e incluir a sus derechohabientes si presenta su solicitud dentro de los 31 días posteriores a cualquiera de estos acontecimientos.

SECCIÓN 9: CONDICIONES DE COBERTURA

Firme con su nombre y escriba la fecha en la solicitud de cobertura si está de acuerdo con las condiciones que se establecen en esta sección. Debe presentar la solicitud de cobertura al departamento de su empresa designado como **Enrollment Department,** el cual, a su vez, enviará su formulario (por correo electrónico o postal) a la siguiente dirección: **BCBSTX • Group Accounts Dept. • PO Box 655730 • Dallas, TX 75265-5730.**

** El término "matrimonio" abarca el matrimonio legal y el establecimiento de una pareja en unión libre (sujeto a la cobertura como prestación laboral).*

*** El término "divorcio" incluye el divorcio legal y la disolución equivalente de una pareja en unión libre (sujeto a la cobertura como prestación laboral).*

**** El término "cónyuge" se usa para hacer referencia al cónyuge legal. Además, abarca a una de las partes de una pareja en unión libre (sujeto a la cobertura como prestación laboral).*

Las modificaciones en las leyes o reglamentaciones federales o estatales, o en las interpretaciones de ellas, pueden modificar los términos y las condiciones de cobertura.

Puede obtener acceso a los formularios mencionados anteriormente en el sitio web de Blue Cross and Blue Shield of Texas, en espanol.bcbstx.com, o a través de su empresa. Si actualmente es uno de nuestros asegurados y tiene preguntas, puede llamar al número de Servicio al Cliente que aparece al dorso de su tarjeta de asegurado.

SOLICITUD DE COBERTURA/CAMBIOS

BlueCross BlueShield of Texas

N.º de grupo | N.º de sección | N.º de Seguro Social

N.º de cuenta | Categoría

Tenga en cuenta lo siguiente: En caso de que se le ofrezca una cobertura médica Consumer Choice (a elección del interesado) como prestación laboral, usted tiene la opción de elegir una cobertura médica Consumer Choice of Benefits o una cobertura médica Consumer Choice of Benefits HMO que, ya sea en parte o en su totalidad, no incluya servicios médicos exigidos por el estado y que, generalmente, se exigen en las pólizas de seguro por accidente y enfermedad o en las evidencias de cobertura de Texas. Esta cobertura estándar puede resultar en una póliza de seguro médico o un seguro de gastos médicos a precio módico, a pesar de que, al mismo tiempo, pudiera brindarle menos servicios que los que normalmente se incluirían como servicios médicos exigidos por el estado de Texas. Si elige esta cobertura estándar, consulte a su agente de seguros para saber cuáles son los servicios médicos exigidos por el estado excluidos en esta evidencia de cobertura.

SECCIÓN 1: MOTIVOS DE SOLICITUD

MARQUE TODAS LAS OPCIONES QUE CORRESPONDAN. SI DESEA RENUNCIAR A LA COBERTURA, COMPLETE SOLO LAS SECCIONES 2, 8 Y 9.

☐ **Nuevo asegurado** ☐ **Agregar derechohabiente** ☐ **Período de inscripciones** ☐ **Otros cambios**

¿Está solicitando cobertura debido a un suceso que resulte en un período especial de inscripción?

☐ **No** ☐ **Sí. Fecha del suceso:** ____ / ____ / ____

Suceso: ☐ Nuevo empleado ☐ Matrimonio* ☐ Nacimiento
☐ Adopción o proceso de adopción (proporcione los documentos legales)
☐ Sentencia judicial (proporcione el decreto o la orden judicial)
☐ Pérdida de otra cobertura
☐ Otro (explique): _____

Fecha de entrada en vigor de los beneficios: ____ / ____ / ____ ☐ **Cumplimiento de otros requisitos de elegibilidad**

☐ **Eliminar asegurado**
☐ **Eliminar derechohabiente**
Cancelar la cobertura: ☐ Médica ☐ Dental
☐ Seguro de vida temporal
☐ Seguro de vida para derechohabientes
☐ Seguro por discapacidad a corto plazo
☐ Seguro por discapacidad a largo plazo
Incluya los nombres de las personas a quienes les cancelará la cobertura en la sección 4.
Suceso: ☐ Divorcio** ☐ Muerte
☐ Finalización del empleo ☐ Otro
Indique la fecha del suceso: ____ / ____ / ____

SECCIÓN 2: INFORMACIÓN PERSONAL

DEBE COMPLETAR ESTA SECCIÓN INCLUSO SI RENUNCIA A LA COBERTURA.

Apellido	Nombre	Inicial del segundo nombre (opcional)	Sufijo	Fecha de nacimiento (MM/DD/AAAA)	N.º de Seguro Social – –

Dirección postal, n.º y calle, n.º de apto	Ciudad	Estado	Código postal

Correo electrónico	☐ Hombre ☐ Mujer	N.º de teléfono particular/celular

Nombre de la empresa	Cargo	N.º de teléfono en el trabajo	Fecha de contratación (MM/DD/AAAA)	¿Usted generalmente trabaja un mínimo de 30 horas a la semana para esta empresa? ☐ Sí ☐ No

Condición de elegibilidad: ☐ Empleado en activo ☐ Empleado jubilado; fecha de jubilación: _____ ☐ Continuación de cobertura COBRA
☐ Continuación de la cobertura grupal por parte del estado (solo para seguros de gastos médicos financiados)
☐ Continuación de la cobertura grupal para derechohabientes por parte del estado (solo para seguros de gastos médicos financiados)

SECCIÓN 3: SELECCIÓN DE COBERTURA

MARQUE TODO LO QUE CORRESPONDA.

Seguros de gastos médicos para pequeñas empresas (de entre 2 y 50 empleados)

Cobertura médica (seleccione una opción)	**Incluir en la cobertura médica (seleccione una opción)**	**Cobertura BlueCare Dental℠**	**Incluir en la cobertura dental (seleccione una opción)**
☐ Blue Premier Access℠ ☐ Blue Choice PPO℠ ☐ Blue Essentials℠ ☐ Blue Advantage HMO℠ ☐ Blue Essentials Access℠ ☐ Otra _____ N.º de cobertura (campo obligatorio): _____	☐ Solo el empleado ☐ Empleado y cónyuge*** ☐ Empleado e hijo(s) ☐ Familia ☐ No estoy solicitando cobertura médica	☐ Sí ☐ No	☐ Solo el empleado ☐ Empleado y cónyuge ☐ Empleado e hijo(s) ☐ Familia ☐ No estoy solicitando cobertura dental

Seguros de gastos médicos para grandes empresas (a partir de 50 empleados)

Cobertura médica (seleccione una opción)	**Incluir en la cobertura médica (seleccione una opción)**	**Cobertura dental**	**Incluir en la cobertura dental (seleccione una opción)**
☐ Blue Choice PPO℠ ☐ Blue Essentials℠ ☐ Blue Premier℠ ☐ Blue Essentials Access℠ ☐ Blue Premier Access℠ ☐ Otra _____ N.º de cobertura: _____	☐ Solo el empleado ☐ Empleado y cónyuge ☐ Empleado e hijo(s) ☐ Familia ☐ No estoy solicitando cobertura médica	☐ Sí ☐ No N.º de cobertura (campo obligatorio): _____	☐ Solo el empleado ☐ Empleado y cónyuge ☐ Empleado e hijo(s) ☐ Familia ☐ No estoy solicitando cobertura dental

Lengua materna: _____ ☐ Marque aquí para solicitar el *Manual para asegurados con cobertura HMO* en español
¿Tiene alguna discapacidad que limite sus habilidades de comunicación o lectura? ☐ Sí ☐ No
Si la respuesta es "Sí", describa los materiales de comunicación especial que necesita: _____

Seguro de vida temporal, Seguro por muerte accidental y pérdida de extremidades (AD&D, en inglés), y Seguro por discapacidad

☐ No solicito alguna de estas coberturas grupales: Seguro de vida temporal, Seguro por muerte accidental y pérdida de extremidades (AD&D) o Seguro por discapacidad.
Puesto/Cargo del empleado: _____ Tarifa salarial $_____ por ☐ hora ☐ semana ☐ mes ☐ año

Cobertura grupal: Seguro básico de vida temporal y por muerte accidental y pérdida de extremidades (AD&D)	☐ No solicito cobertura.	☐ Solicito cobertura.	Monto $_____
Cobertura grupal: Seguro de vida para derechohabientes	☐ No solicito cobertura.	☐ Solicito cobertura.	
Cobertura grupal: Seguro de vida complementario Monto para el empleado: $_____	☐ No solicito cobertura. Monto para el cónyuge: $_____	☐ Solicito cobertura.	Monto para el hijo: $_____
Seguro por discapacidad a corto plazo	☐ No solicito cobertura.	☐ Solicito cobertura.	
Seguro por discapacidad a largo plazo	☐ No solicito cobertura.	☐ Solicito cobertura.	

	Nombre	Inicial del segundo nombre	Apellido	Relación	Fecha de nacimiento (MM/DD/AAAA)	N.º de Seguro Social – –
Beneficiario principal						
Beneficiario secundario						

** El término "matrimonio" abarca el matrimonio legal y el establecimiento de una pareja en unión libre (sujeto a la cobertura como prestación laboral).*
*** El término "divorcio" incluye el divorcio legal y la disolución equivalente de una pareja en unión libre (sujeto a la cobertura como prestación laboral).*
**** El término "cónyuge" se usa para hacer referencia al cónyuge legal. Además, abarca a una de las partes de una pareja en unión libre (sujeto a la cobertura como prestación laboral).*
^ Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148, es la entidad que suscribe el seguro de Vida y Discapacidad. Dearborn Life Insurance Company es una licenciataria independiente de Blue Cross and Blue Shield.

Apellido: | N.º de Seguro Social: — — | N.º de grupo

SECCIÓN 4: OPCIONES DE COBERTURA

COMPLETE TODAS LAS ÁREAS QUE CORRESPONDAN. PARA SOLICITAR LAS COBERTURAS BLUE ADVANTAGE, BLUE PREMIER Y BLUE ESSENTIALS, ES OBLIGATORIA LA SELECCIÓN DE UN MÉDICO DE CABECERA (PCP, EN INGLÉS). LAS COBERTURAS BLUE PREMIER ACCESS Y BLUE ESSENTIALS ACCESS NO EXIGEN LA SELECCIÓN DE UN PCP.

Nombre del empleado o interesado	Nombre del médico de cabecera (PCP)	N.º de PCP	¿Es paciente nuevo? ☐ Sí ☐ No	Nombre del ginecólogo-obstetra de la cobertura HMO (opcional)	N.º de ginecólogo-obstetra de la cobertura HMO
Nombre del derechohabiente ☐ Esposo ☐ Esposa ☐ Pareja en unión libre	Nombre del PCP del derechohabiente	N.º de PCP	¿Es paciente nuevo? ☐ Sí ☐ No	Nombre del ginecólogo-obstetra de la cobertura HMO (opcional)	N.º de ginecólogo-obstetra de la cobertura HMO

N.º de Seguro Social del derechohabiente – –	Fecha de nacimiento (MM/DD/AAAA)	Dirección (si es diferente): n.º y calle	Ciudad	Estado	Código postal

Nombre del derechohabiente ☐ Hijo ☐ Hija ☐ Otro derechohabiente elegible	N.º de Seguro Social del derechohabiente – –	Nombre del PCP del derechohabiente	N.º de PCP	¿Es paciente nuevo? ☐ Sí ☐ No	Nombre del ginecólogo-obstetra de la cobertura HMO (opcional)	N.º de ginecólogo-obstetra de la cobertura HMO
Fecha de nacimiento (MM/DD/AAAA)	Dirección (si es diferente): Calle/Ciudad/Estado/Código postal	¿Este derechohabiente es un hijo biológico, hijastro, menor en guarda, hijo adoptivo o menor en proceso de adopción? ☐ Sí ☐ No	Si no es un hijo biológico, hijastro, menor en guarda, hijo adoptivo o menor en proceso de adopción que cumpla con los requisitos, ¿usted (o su cónyuge) es responsable de este derechohabiente? ☐ Sí ☐ No			
Nombre del derechohabiente ☐ Hijo ☐ Hija ☐ Otro derechohabiente elegible	N.º de Seguro Social del derechohabiente – –	Nombre del PCP del derechohabiente	N.º de PCP	¿Es paciente nuevo? ☐ Sí ☐ No	Nombre del ginecólogo-obstetra de la cobertura HMO (opcional)	N.º de ginecólogo-obstetra de la cobertura HMO
Fecha de nacimiento (MM/DD/AAAA)	Dirección (si es diferente): Calle/Ciudad/Estado/Código postal	¿Este derechohabiente es un hijo biológico, hijastro, menor en guarda, hijo adoptivo o menor en proceso de adopción? ☐ Sí ☐ No	Si no es un hijo biológico, hijastro, menor en guarda, hijo adoptivo o menor en proceso de adopción que cumpla con los requisitos, ¿usted (o su cónyuge) es responsable de este derechohabiente? ☐ Sí ☐ No			
Nombre del derechohabiente ☐ Hijo ☐ Hija ☐ Otro derechohabiente elegible	N.º de Seguro Social del derechohabiente – –	Nombre del PCP del derechohabiente	N.º de PCP	¿Es paciente nuevo? ☐ Sí ☐ No	Nombre del ginecólogo-obstetra de la cobertura HMO (opcional)	N.º de ginecólogo-obstetra de la cobertura HMO
Fecha de nacimiento (MM/DD/AAAA)	Dirección (si es diferente): Calle/Ciudad/Estado/Código postal	¿Este derechohabiente es un hijo biológico, hijastro, menor en guarda, hijo adoptivo o menor en proceso de adopción? ☐ Sí ☐ No	Si no es un hijo biológico, hijastro, menor en guarda, hijo adoptivo o menor en proceso de adopción que cumpla con los requisitos, ¿usted (o su cónyuge) es responsable de este derechohabiente? ☐ Sí ☐ No			

SECCIÓN 5: DERECHOHABIENTES DISCAPACITADOS

COMPLETE LA SIGUIENTE SECCIÓN, SI CORRESPONDE.

Nombre del derechohabiente discapacitado	Tipo de discapacidad
Nombre del derechohabiente discapacitado	Tipo de discapacidad

Si la edad de un hijo discapacitado supera el límite de edad para derechohabientes de la cobertura de la empresa, complete y adjunte la Declaración de hijo derechohabiente con discapacidad.

SECCIÓN 6: INFORMACIÓN DE OTRAS COBERTURAS

COMPLETE TODAS LAS ÁREAS QUE CORRESPONDAN.

Complete esta sección solo si usted o alguno de sus derechohabientes tienen otra cobertura médica o dental **que no se cancelará** cuando entre en vigor la cobertura solicitada por este medio. **Incluya los nombres de todas las personas con cobertura**:

Cobertura como prestación laboral ☐ Sí ☐ No	Cobertura para particulares ☐ Sí ☐ No	Nombre y dirección de la otra compañía de seguros	Fecha de entrada en vigor (MM/DD/AAAA)	Tipo de póliza ☐ Solo el empleado ☐ Empleado y cónyuge ☐ Empleado e hijo(s) ☐ Familia

Nombre del titular de la póliza	Fecha de nacimiento (MM/DD/AAAA)	☐ Hombre ☐ Mujer	Relación con el solicitante ☐ Solicitante ☐ Cónyuge ☐ Derechohabiente

Empresa	Fecha de contratación (MM/DD/AAAA)	N.º del grupo médico	N.º de cobertura médica	N.º del grupo dental	N.º de cobertura dental

SECCIÓN 7: INFORMACIÓN DE COBERTURA MEDICARE

COMPLETE LA SIGUIENTE SECCIÓN, SI CORRESPONDE.

Beneficiario:	Parte A de Medicare (hospital) Fecha de entrada en vigor: _____ Fecha de finalización: _____ Parte B de Medicare (médica) Fecha de entrada en vigor: _____ Fecha de finalización: _____ Parte D de Medicare (medicamentos) Fecha de entrada en vigor: _____ Fecha de finalización: _____ Parte D de Medicare (medicamentos) Compañía aseguradora: _____	N.º de Medicare (en su tarjeta de Medicare)

Indique la razón de la elegibilidad para Medicare: ☐ Edad autorizada ☐ Discapacidad autorizada ☐ Enfermedad renal en etapa terminal ☐ Discapacidad y enfermedad renal

Beneficiario:	Parte A de Medicare (hospital) Fecha de entrada en vigor: _____ Fecha de finalización: _____ Parte B de Medicare (médica) Fecha de entrada en vigor: _____ Fecha de finalización: _____ Parte D de Medicare (medicamentos) Fecha de entrada en vigor: _____ Fecha de finalización: _____ Parte D de Medicare (medicamentos) Compañía aseguradora: _____	N.º de Medicare (en su tarjeta de Medicare)

Indique la razón de la elegibilidad para Medicare: ☐ Edad autorizada ☐ Discapacidad autorizada ☐ Enfermedad renal en etapa terminal ☐ Discapacidad y enfermedad renal

SECCIÓN 8: RENUNCIA A LA COBERTURA

COMPLETE SI RENUNCIA A LA COBERTURA.

Acepto que se me ha explicado la cobertura que tengo a mi disposición. He tenido la posibilidad de solicitar la cobertura que se ofrece para mí y mis derechohabientes elegibles, pero he decidido voluntariamente renunciar a la cobertura, como se indica a continuación. Si decido solicitar la cobertura en otro momento, entiendo que la fecha de entrada en vigor de la cobertura se puede retrasar.

Nombre ☐ Empleado	Razón de la renuncia a la **cobertura médica**: ☐ Otra cobertura médica como prestación laboral; compañía de seguros: _____ ☐ Medicare ☐ Medicaid ☐ Otra cobertura médica individual (particular); compañía de seguros: _____ ☐ Otra (explique) _____ ☐ No estoy asegurado con ningún seguro de gastos médicos, pero no deseo recibir esta cobertura.
Nombre ☐ Empleado	Razón de la renuncia a la **cobertura dental**: ☐ Otra cobertura dental como prestación laboral ☐ Medicaid ☐ Cobertura dental para particulares ☐ Otra (explique): _____ ☐ No estoy asegurado con ninguna cobertura dental, pero no deseo recibir esta cobertura.
Nombre ☐ Cónyuge	Razón de la renuncia: ☐ Otra cobertura médica como prestación laboral ☐ Medicare ☐ Medicaid ☐ Otra cobertura médica para particulares ☐ Otra (explique): _____ ☐ No estoy asegurado con ningún seguro de gastos médicos, pero no deseo recibir esta cobertura.
Nombre ☐ Derechohabiente	Razón de la renuncia: ☐ Otra cobertura médica como prestación laboral ☐ Medicare ☐ Medicaid ☐ Otra cobertura médica para particulares ☐ Otra (explique): _____ ☐ No estoy asegurado con ningún seguro de gastos médicos, pero no deseo recibir esta cobertura.
Nombre ☐ Derechohabiente	Razón de la renuncia: ☐ Otra cobertura médica como prestación laboral ☐ Medicare ☐ Medicaid ☐ Otra cobertura médica para particulares ☐ Otra (explique): _____ ☐ No estoy asegurado con ningún seguro de gastos médicos, pero no deseo recibir esta cobertura.

SECCIÓN 9: CONDICIONES DE COBERTURA

- Soy empleado de la empresa que se menciona en esta solicitud. Reúno los requisitos para participar en la cobertura disponible como prestación laboral, la cual está asegurada o es administrada por Blue Cross and Blue Shield of Texas (BCBSTX) o Dearborn Life Insurance Company. Solicito la(s) cobertura(s) para la(s) que soy elegible en nombre propio y de mis derechohabientes, que aparecen en esta solicitud de cobertura. Declaro que la información proporcionada en esta solicitud de cobertura es verdadera y correcta. Entiendo y acepto que cualquier declaración falsa sobre algún hecho importante que realice de manera intencional invalidará mi(s) cobertura(s).
- Solo estarán disponibles para mí las coberturas y los montos para los cuales soy elegible. Entiendo que, si se aprueba esta solicitud de cobertura, los beneficios entrarán en vigor de acuerdo con las estipulaciones establecidas en el contrato o la cobertura.
- Acepto que mi empresa actúe como mi agente de seguros. Autorizo que mi empresa deduzca de mi nómina el monto necesario, si corresponde, para cubrir el costo de mi(s) cobertura(s). Como corresponde para la cobertura HMO, aceptaré una copia electrónica de los documentos de mi cobertura (ya sea el certificado de cobertura o el certificado de beneficios) si mi empresa solicita que BCBSTX envíe la información electrónicamente. Entiendo que puedo solicitar una copia impresa.
- Entiendo que mi participación en la cobertura queda sujeta a cualquier modificación futura. También entiendo que todos los avisos dirigidos a mi empresa rigen para mí.
- Entiendo que las comunicaciones por escrito que exige la ley se me pueden enviar electrónicamente, con mi consentimiento. Entiendo que, si doy mi consentimiento para recibir mis documentos electrónicamente, tengo derecho a obtener una copia impresa y a retirar mi consentimiento.

ADVERTENCIA: CUALQUIER PERSONA QUE DELIBERADAMENTE PRESENTE UNA RECLAMACIÓN FALSA O FRAUDULENTA DE INDEMNIZACIÓN POR PÉRDIDA ES CULPABLE DE UN DELITO Y PUEDE ESTAR SUJETA A MULTAS Y ENCARCELAMIENTO EN UNA PRISIÓN ESTATAL.

Firma del solicitante _____ Fecha _____