



REP NUMBER: _____

GROUP APPLICATION FOR CHANGE TO EXISTING GROUP CONTRACT

It is intended that this application be completed by the Group's Producer of Record or Account Consultant and be verified by an officer of the Company. Except as amended below, the Group Contract and Group Application remain unchanged.

GROUP NUMBER		GROUP NAME			EFFECTIVE DATE OF CHANGE	
MAILING ADDRESS				CITY		STATE
ZIP CODE	PHONE NO.	GROUP LEADER			PRODUCER NUMBER	
BENEFIT OPTION(S) TO BE ADDED OR CHANGED:						
<input type="checkbox"/> BLUECHOICE (OVC <input type="checkbox"/> None <input type="checkbox"/> \$10 <input type="checkbox"/> \$20) <input type="checkbox"/> BLUEPREFERRED (OVC <input type="checkbox"/> \$10 <input type="checkbox"/> \$20) <input type="checkbox"/> BLUETRADITIONAL <input type="checkbox"/> BLUEOPTIONS (OVC <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$35) <input type="checkbox"/> HSA BLUE						
BENEFIT OPTION(S) TO BE CANCELED:						
<input type="checkbox"/> BLUECHOICE <input type="checkbox"/> BLUEPREFERRED <input type="checkbox"/> BLUETRADITIONAL <input type="checkbox"/> BLUEOPTIONS <input type="checkbox"/> CHAMBER CHOICE <input type="checkbox"/> HSA BLUE						
DEDUCTIBLE:		STOP-LOSS LIMIT:		PRESCRIPTION CARD:		HSA BLUE DEDUCTIBLE:
<input type="checkbox"/> \$200 <input type="checkbox"/> \$750 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$300 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$5,000		<input type="checkbox"/> \$5000 / \$10,000 <input type="checkbox"/> \$10,000 / \$20,000 <input type="checkbox"/> \$10,000 BlueOptions		<input type="checkbox"/> 4 Tier <input type="checkbox"/> 50/50 <input type="checkbox"/> \$300 Deductible 4 Tier <input type="checkbox"/> \$300 Deductible 50/50		<u>Single</u> <u>Family</u> <input type="checkbox"/> \$1,500 / \$3,000 Option 1 <input type="checkbox"/> \$1,500 / \$3,000 Option 2 <input type="checkbox"/> \$2,000 / \$4,000 Option 3 <input type="checkbox"/> \$2,500 / \$5,000 Option 4 <input type="checkbox"/> \$3,000 / \$6,000 Option 5 <input type="checkbox"/> \$5,000 / \$10,000 Option 6
DENTAL:						
<input type="checkbox"/> DentalPlus PPO <input type="checkbox"/> DentalPlus Traditional <input type="checkbox"/> Basic Dental <input type="checkbox"/> \$0 Deductible <input type="checkbox"/> \$50 Deductible <input type="checkbox"/> \$100 Deductible <input type="checkbox"/> Orthodontia <input type="checkbox"/> Remove Dental Coverage <input type="checkbox"/> Remove Orthodontia ONLY						
WAITING PERIOD:						
ELIGIBILITY DATE (Days / Months following the date of employment.)						
<input type="checkbox"/> 0 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months						
EFFECTIVE DATE:						
<input type="checkbox"/> Date of Employment <input type="checkbox"/> Date of Eligibility <input type="checkbox"/> First Billing Coinciding With Or Next Following The Date Of Eligibility						
As a Company Officer or Owner of the above group, I am requesting these changes be made to our existing Group Contract. By signing this form I am agreeing that the requested changes will be made, subject to approval by Blue Cross and Blue Shield of Oklahoma. If this application is accepted, the contract and any endorsements thereto will contain all of the terms and conditions. I have reviewed the changes we are requesting with my Producer of Record or assigned Account Consultant and understand the changes we are requesting.						
SIGNATURE DATE		COMPANY OFFICER OR OWNER			SIGNATURE DATE	
					ACCOUNT CONSULTANT OR PRODUCER	

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# EMP	# ELIG	COBRA FLAG	MED COB	WP	WP CODE	BILL CYCLE	SM B PKG.	BILL TYPE	RATE SEGMENT			
RATE NOTICE		RENEWAL DATE		RATE CALL		PRIOR TIER CODE	TIER CODE	PL/PN	OVC \$	COV OPT		
EFFECTIVE DATE	LOB	TERM DATE	ID CARD CODE	ELIG CERT	TOB	RATE CLASS	MKT. SEG	BENEFIT TABLE NO.	ADS	PRC	MHP DEF.	DPF
DATE RECEIVED		STOP DATE		REASON								
DATE RELEASED		RESTART DATE										

ENS. BILL. I.A. M.I. M.S.E. M.S.W. ENS. RPT.

Changes made with this document may result in a new contract being issued to your group. Please review the summary information on the back of this form.

This is only a summary of available Group Benefits; this is not a contract. If this application is accepted, the details of the terms and conditions will be listed in the Group Contract.

BluePreferred Benefit Deductibles carry an out-of-network penalty based on the following schedule:

\$200 BluePreferred Provider Services Deductible/\$300 Out-of-Network Provider Services Deductible
\$300 BluePreferred Provider Services Deductible/\$500 Out-of-Network Provider Services Deductible
\$500 BluePreferred Provider Services Deductible/\$800 Out-of-Network Provider Services Deductible
\$1,000 BluePreferred Provider Services Deductible/\$1,500 Out-of-Network Provider Services Deductible
\$1,500 BluePreferred Provider Services Deductible/\$2,500 Out-of-Network Provider Services Deductible
\$2,000 BluePreferred Provider Services Deductible/\$3,500 Out-of-Network Provider Services Deductible
\$2,500 BluePreferred Provider Services Deductible/\$4,000 Out-of-Network Provider Services Deductible
\$5,000 BluePreferred Provider Services Deductible/\$7,500 Out-of-Network Provider Services Deductible

BlueOptions Benefits are subject to the following provisions:

A Hospital Admission Deductible equal to \$500 or 50% of Benefit Period Deductible amount, whichever is less (Applies to each admission to a hospital).

An Outpatient Surgery Deductible of \$200 (applies to each visit to an Outpatient facility for Surgery).

An Emergency Room Deductible of \$100 (applies to each visit to a Hospital emergency room).

A Benefit Coinsurance Percentage Amount of 80% for BluePreferred Provider Services/70% for BlueChoice Provider Services/60% for BlueTraditional Provider Services/50% for Out-of-Network Provider Services.

DentalPlus Benefits:

Deductible applies to Primary, Prosthetic and Complex Restorative Services. Diagnostic and Preventative Services are not subject to a Deductible.

Diagnostic and Preventative Services are paid at 100% of Allowable Charges.

Primary Services are paid at 80% of Allowable Charges.

Prosthetic and Complex Restorative Services are paid at 50% of Allowable Charges.

HSA Blue Benefits:

Options 1, 3 & 4

Single Coverage is subject to a \$3,000 Out-of-Pocket limit.

Family Coverage is subject to a \$6,000 Out-of-Pocket limit.

Options 2, 5 & 6

Single Coverage is subject to a \$5,000 Out-of-Pocket limit.

Family Coverage is subject to a \$10,000 Out-of-Pocket limit.

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