



BlueCross BlueShield of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

SECTION GA — GROUP APPLICATION

Application is hereby made

TO: Blue Cross and Blue Shield of Oklahoma, Home Offices: 1215 South Boulder, P.O. Box 3283, Tulsa, Oklahoma 74102-3283 (herein called the "Plan")

BY: APPLICANT (BUSINESS NAME) _____

CONTACT AT FIRM _____ PHONE _____

ADDRESS OF FIRM _____

CITY AND STATE _____ ZIP CODE _____

Corporation

Proprietorship

Partnership

Other (specify) _____

IT IS UNDERSTOOD AND AGREED THAT NO AGENT HAS THE AUTHORITY TO ALTER OR AMEND THE CONTRACT OR BIND THE PLAN BY MAKING ANY PROMISE OR REPRESENTATION. IT IS FURTHER UNDERSTOOD THAT NO COVERAGE WILL BECOME EFFECTIVE WITHOUT THE WRITTEN APPROVAL OF THE PLAN.

This Application is not a binder and the Group will be notified by the Plan of acceptance of this Application and the date coverage will be effective. In the event this Application is not accepted, any deposits received by the Plan will be returned to the Applicant. **Coverage shall be effective at 12:01 a.m. on the Contract Date and shall continue until terminated in accordance with the Contract.**

A. APPLICANT STATEMENTS

1. Applicant understands that, unless otherwise specified in this Contract, only full-time Employees and their Dependents are eligible for coverage. Applicant further agrees that eligibility, participation requirements, and the coverage for Preexisting Conditions have been discussed with the agent and have been explained to all Eligible Persons.
2. Applicant agrees to notify the Plan of ineligible persons immediately following their change in status from eligible to ineligible.
3. Applicant agrees to review all applications for completeness prior to submission to the Plan.

4. Applicant applies for the coverages selected and provided in the Group Contract and agrees that the obligation of the Plan shall only include the part of the Benefits described or as amended by any Amendments or Endorsements.
5. Applicant agrees to pay to the Plan, in advance, the dues specified in the Group Billing Statement on behalf of each Eligible Person covered under the Contract.
6. Applicant agrees that, in the making of this Application, it is acting for and in behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Applicant is not the agent or representative of the Plan for any purpose of this Application or any Contract issued pursuant to this Application.
7. Applicant agrees to deliver to its Eligible Persons covered under the Contract individual certificates and Identification Cards and any other relevant materials as may be furnished by the Plan for distribution.
8. Applicant agrees to receive on behalf of its covered Eligible Persons all notices delivered by the Plan and to forward such notices to the person involved at their last known address.

B. ELIGIBILITY PROVISIONS

1. Are any subsidiary or affiliated units to be included in the Contract?

No Yes If yes, list: _____

2. **Eligible Person**

a. An Eligible Person is defined as an Employee who works on a full-time basis and has a normal work week of 24 or more hours, except as specified below under "Other Eligibility Provisions".

b. The limiting age for the Eligible Person is:

None

Other (specify) _____

c. The date the person becomes eligible for coverage is:

the date of employment.

the day the person completes (specify Waiting Period below) of continuous employment.

the day following the date the person completes (specify Waiting Period below) of continuous employment.

Waiting Period = 30 Days 60 Days 90 Days 180 Days 1 Month

2 Months 3 Months 6 Months Other (specify) _____

Waiting Period waived at Group's Initial Enrollment: No Yes

d. **Effective Date** for persons who become eligible after the Group's Contract Date is:

the date the person becomes eligible.

the first billing cycle coinciding with or next following the date the person becomes eligible.

Other (specify) _____

- c. BlueChoice PPO Office Visit Copayment
 \$10 \$20 Other (specify) \$ _____
- d. Benefit Percentage Amount (applicable to most Covered Services)
 80% BlueChoice PPO Provider Services/60% Out-of-Network Provider Services
 50% BlueChoice PPO Provider Services/40% Out-of-Network Provider Services
 Other (specify) _____% BlueChoice PPO Provider Services/_____ % Out-of-Network Provider Services
- e. Stop-Loss Limit
 \$5,000 for BlueChoice PPO Provider Services/\$10,000 for Out-of-Network Provider Services
 \$10,000 for BlueChoice PPO Provider Services/\$20,000 for Out-of-Network Provider Services
 Other (specify) \$ _____ BlueChoice PPO Provider Services/\$ _____ Out-of-Network Provider Services
- f. Optional Accidental Injury Services No Other (complete below)
 \$500 Other (specify) \$ _____
2. **No Office Visit Copayment Option** No Yes (complete below)
- a. Deductible Amount per Benefit Period per Subscriber
 \$200 \$300 \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$5,000
 Other (specify) \$ _____
- b. Out-of-Network Hospital Deductible \$500 (Applies to each admission to a Hospital which is not a BlueChoice PPO Provider, except for: Routine Nursery Care, Plan-approved Referral Care or Emergency Care)
- c. Benefit Percentage Amount (applicable to most Covered Services)
 80% for BlueChoice PPO Provider Services/60% Out-of-Network Provider Services
 50% for BlueChoice PPO Provider Services/40% Out-of-Network Provider Services
 Other (specify) _____% BlueChoice PPO Provider Services/_____ % Out-of-Network Provider Services
- d. Stop-Loss Limit
 \$5,000 for BlueChoice PPO Provider Services/\$10,000 for Out-of-Network Provider Services
 \$10,000 for BlueChoice PPO Provider Services/\$20,000 for Out-of-Network Provider Services
 Other (specify) \$ _____ BlueChoice PPO Provider Services/\$ _____ Out-of-Network Provider Services

e. Optional Accidental Injury Services No Other (complete below)

\$500 Other (specify) \$ _____

D. **BLUEPREFERRED BENEFITS** No Yes (complete below)

1. Deductible Amount per Benefit Period per Subscriber

\$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

Other (specify) \$_____ BluePreferred Provider Services Deductible/\$_____ Out-of-Network Provider Services Deductible

2. Out-of-Network Hospital Deductible: \$300 (Applies to each admission to a Hospital which is not a BluePreferred Provider)

3. Office Visit Copayment

\$10 Other (specify) \$ _____

4. Benefit Percentage Amount (applicable to most Covered Services)

80% BluePreferred Provider Services/60% Out-of-Network Provider Services

50% BluePreferred Provider Services/40% Out-of-Network Provider Services

Other (specify) _____% BluePreferred Provider Services/_____% Out-of-Network Provider Services

5. Stop-Loss Limit

\$5,000 BluePreferred Provider Services/\$10,000 Out-of-Network Provider Services

\$10,000 BluePreferred Provider Services Deductible/\$20,000 Out-of-Network Provider Services Deductible

Other (specify) \$_____ BluePreferred Provider Services/\$_____ Out-of-Network Provider Services

6. Optional Accidental Injury Services No Other (complete below)
 \$500 Other (specify) \$ _____

E. BLUETRADITIONAL BENEFITS No Yes (complete below)

1. Deductible Amount per Benefit Period per Subscriber
 \$200 \$300 \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$5,000
 Other (specify) \$ _____
2. Benefit Percentage Amount (applicable to most Covered Services)
 80% 50% Other (specify) _____%
3. Stop-Loss Limit
 \$5,000 \$10,000 Other (specify) \$ _____
4. Optional Accidental Injury Services No Other (complete below)
 \$500 Other (specify) \$ _____

F. BLUEOPTIONS BENEFITS No Yes (complete below)

1. Office Visit Copayment
 \$20 \$30 \$35 Other (specify) \$ _____
2. Deductible Amount per Benefit Period per Subscriber
 \$500 \$750 \$1,000 \$1,500
 \$2,000 \$2,500 \$5,000 Other (specify) \$ _____
3. Hospital Admission Deductible (applies to each admission to a Hospital)
 \$250 \$375 \$500 \$750 Other (specify) \$ _____
4. Outpatient Surgery Deductible (applies to each visit to an Outpatient facility for Surgery)
 \$200 Other (specify) \$ _____
5. Emergency Room Deductible (applies to each visit to a Hospital emergency room)
 \$100 Other (specify) \$ _____
6. Benefit Percentage Amount (applicable to most Covered Services)
 80% BluePreferred Provider Services/70% BlueChoice Provider Services/60% BlueTraditional Provider Services/50% Out-of-Network Provider Services
 Other (specify) _____% BluePreferred Provider Services/_____% BlueChoice PPO Provider Services/_____% BlueTraditional Provider Services/_____% Out-of-Network Provider Services
7. Stop-Loss Limit
 \$10,000 per Benefit Period per Subscriber
 Other (specify) \$ _____

G. **HSA BLUE BENEFITS** No Yes (complete below)

Option 1:

- \$1,500 Deductible per Benefit Period for Member-Only (Single) Coverage
- \$3,000 Deductible per Benefit Period for Family Coverage
- Benefit Percentage Amount applicable to most Covered Services: 80% for BlueChoice PPO Provider Services; 60% for Out-of-Network Provider Services
- \$3,000 Out-of-Pocket Limit for Member-Only (Single) Coverage
- \$6,000 Out-of-Pocket Limit for Family Coverage

Option 2:

- \$1,500 Deductible per Benefit Period for Member-Only (Single) Coverage
- \$3,000 Deductible per Benefit Period for Family Coverage
- Benefit Percentage Amount applicable to most Covered Services: 80% for BlueChoice PPO Provider Services; 60% for Out-of-Network Provider Services
- \$5,000 Out-of-Pocket Limit for Member-Only (Single) Coverage
- \$10,000 Out-of-Pocket Limit for Family Coverage

Option 3:

- \$2,000 Deductible per Benefit Period for Member-Only (Single) Coverage
- \$4,000 Deductible per Benefit Period for Family Coverage
- Benefit Percentage Amount applicable to most Covered Services: 80% for BlueChoice PPO Provider Services; 60% for Out-of-Network Provider Services
- \$3,000 Out-of-Pocket Limit for Member-Only (Single) Coverage
- \$6,000 Out-of-Pocket Limit for Family Coverage

Option 4:

- \$2,500 Deductible per Benefit Period for Member-Only (Single) Coverage
- \$5,000 Deductible per Benefit Period for Family Coverage
- Benefit Percentage Amount applicable to most Covered Services: 80% for BlueChoice PPO Provider Services; 60% for Out-of-Network Provider Services
- \$3,000 Out-of-Pocket Limit for Member-Only (Single) Coverage
- \$6,000 Out-of-Pocket Limit for Family Coverage

Option 5:

- \$3,000 Deductible per Benefit Period for Member-Only (Single) Coverage
- \$6,000 Deductible per Benefit Period for Family Coverage
- Benefit Percentage Amount applicable to most Covered Services: 80% for BlueChoice PPO Provider Services; 60% for Out-of-Network Provider Services
- \$5,000 Out-of-Pocket Limit for Member-Only (Single) Coverage
- \$10,000 Out-of-Pocket Limit for Family Coverage

Option 6:

- \$5,000 Deductible per Benefit Period for Member-Only (Single) Coverage
- \$10,000 Deductible per Benefit Period for Family Coverage
- Benefit Percentage Amount applicable to Covered Services: 100% for BlueChoice PPO Provider Services; 100% for Out-of-Network Provider Services
- \$5,000 Out-of-Pocket Limit for Member-Only (Single) Coverage
- \$10,000 Out-of-Pocket Limit for Family Coverage

H. **PRESCRIPTION DRUG CARD** No Yes (complete below)

1. Copayment/Coinsurance Amount Applicable to each Prescription Order

30% (\$12 minimum) Generic/\$25 Preferred Drugs/30% (\$25 minimum) Non-Preferred Brand Drugs

50% Coinsurance/\$10,000 Stop-Loss

Other (specify) _____

2. Deductible Amount per Benefit Period per Subscriber

None \$300 Other (specify) _____

I. **DENTAL BENEFITS** No Yes (select option below)

1. **Dental Plus (Traditional)** No Yes (complete below)

a. Deductible Amount per Benefit Period per Subscriber

1) Diagnostic and Preventive Services

None Other (specify) \$ _____

2) Primary Services, Prosthetic and Complex Restorative Services

None \$50 \$100 Other (specify) \$ _____

b. Benefit Percentage Amounts

1) Diagnostic and Preventive Services

100% Other (specify) _____%

2) Primary Services

80% Other (specify) _____%

3) Prosthetic and Complex Restorative Services

50% Other (specify) _____%

c. Maximum Amount per Benefit Period per Subscriber

\$1,000 Other (specify) \$ _____

d. Optional Orthodontic Services No Yes (complete below)

1) Deductible Amount per Benefit Period per Dependent Child Subscriber

None Other (specify) _____

2) Benefit Percentage Amount

50% Other (specify) \$ _____

3) Maximum Amount per Lifetime per Dependent Child Subscriber

\$1,000 Other (specify) \$ _____

2. **Dental Plus PPO** No Yes (complete below)

a. Deductible Amount per Benefit Period per Subscriber

1) Diagnostic and Preventive Services

None Other (specify) _____

2) Primary Services, Prosthetic and Complex Restorative Services

None \$50 \$100 Other (specify) \$ _____

b. Benefit Percentage Amount

1) Diagnostic and Preventive Services

100% PPO Dentist Services/80% Non-PPO Dentist Services

Other (specify) % _____

2) Primary Services

80% PPO Dentist Services/60% Non-PPO Dentist Services

Other (specify) % _____

3) Prosthetic and Complex Restorative Services

50% PPO Dentist Services/30% Non-PPO Dentist Services

Other (specify) % _____

c. Maximum Amount per Benefit Period per Subscriber

\$1,000 Other (specify) \$ _____

d. Optional Orthodontic Services No Yes (complete below)

1) Deductible Amount per Benefit Period per Dependent Child Subscriber

None Other (specify) \$ _____

2) Benefit Percentage Amount

50% PPO Dentist Services/30% Non-PPO Dentist Services

Other (specify) _____

3) Maximum Amount per Lifetime per Dependent Child Subscriber

\$1,000 Other (specify) \$ _____

3. **Basic Dental Services Only** No Yes

J. **VISION BENEFITS** No Yes (complete below)

1. Frequency Option

Option 1 Option 2 Option 3

2. Benefit Option

Option 1 (Low) Option 2 (Medium) Option 3 (High)

K. SPECIAL BENEFIT PROVISIONS (specify)

I HAVE REVIEWED THE BENEFITS AND ELIGIBILITY REQUIREMENTS AS STATED IN THIS GROUP APPLICATION WITH MY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA REPRESENTATIVE. IF THIS APPLICATION IS ACCEPTED, THE CONTRACT AND ANY ENDORSEMENTS THERETO WILL CONTAIN ALL OF THE TERMS AND CONDITIONS.

APPLICANT (BUSINESS NAME) _____

AUTHORIZED SIGNATURE _____ **DATE SIGNED** _____

OFFICE OR POSITION _____

THE UNDERSIGNED BLUE CROSS AND BLUE SHIELD OF OKLAHOMA REPRESENTATIVE ACKNOWLEDGES THAT THIS GROUP APPLICATION HAS BEEN REVIEWED WITH AND EXPLAINED TO THE APPLICANT NAMED ABOVE.

REPRESENTATIVE'S SIGNATURE _____ **DATE SIGNED** _____

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.

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 East Randolph, Chicago, Illinois) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group Number: _____

By: _____
Print Signer's Name Here

Group Name & Address:

 _____
Signature and Title

Dated this _____ day of _____, 20_____.