Group Application and Summary

Note to Group Administrator

For a new group application for coverage through the Companies, the following documents must be submitted with this form:

- ❑ 1. A completed Application form for each employee to be covered, including any employee who is not actively at work and/or who is waiving the coverage for which the group is applying. ***(Note:** For groups of 26 or more, if an employee waiving coverage through your group is enrolled in other coverage and provides complete information about that other coverage in Section 3 of the Employee Application form, the employee does not need to complete the health questions in Section 6 of that form.)*
- ❑ 2. A full advance deposit of the first month's group premium, based on the rates enclosed in the initial proposal. (This amount will be refunded if the application is not accepted.)
- ❑ 3. A completed group application form for life insurance and related products, if purchased.
- ❑ 4. A copy of the signed trust agreement if your group is a Taft-Hartley Health & Welfare Trust or another type of trust.
- ❑ 5. A copy of the employer's State Wage and Contribution Report for the most current quarter. (***Note:*** For groups of **26 or more** employees, the prior carrier's most recent bill will be accepted in place of the State Wage and Contribution Report.)

***Important:** If any documents material to the underwriting decision are not submitted to the Companies during the underwriting process, a rating adjustment may result.*

The Companies are Healthy Alliance® Life Insurance Company (HALIC), HMO, Missouri Inc., their parent, RightCHOICE® Managed Care Inc. (RIT), and certain affiliates. Blue Cross and Blue Shield of Missouri is the name RIT uses to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. HMO Missouri, Inc. does business as BlueCHOICE. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. RIT, HMO Missouri, Inc. and HALIC are independent licensees of the Blue Cross and Blue Shield Association.

— Please Print —

Office use only:	Group #

Employer Information Section:

Please complete all appropriate areas. Attach additional sheet(s) if needed to provide complete information for this section.

Group Name / Plan Sponsor *(Use full legal name)*

Date Group's Business was Established *(mo/day/yr)* ______/______/______

Group Executive / Agent for Legal Service

Group Administrator:

Phone No. ( ) Fax No. ( )

Membership/Billing Contact Name *(if different from Group Administrator)*

Phone No. ( ) Fax No. ( )

Designated Group Representative Name *(provide name, even if same as Group Administrator):*

Designated Group Representative's
Phone No. ( ) Fax No. ( )

Address *(billing address — street, city, state, Zip code)*

County

Address *(other than billing address — street, city, state, Zip code)*

County

Group is: ❏ Corporation ❏ Sole Proprietor ❏ Partnership ❏ Trust ❏ Association Member
(Assn. name):__________________________
____

Company Owners	% Owned*
______________________________________	_______
______________________________________	_______
______________________________________	_______

*Must total 100%.

Federal Employer ID Number (FEIN)
___ ___–___ ___ ___ ___ ___ ___ ___

Description of Business

From IRS 5500 Form: Plan Administrator Name & Address

Plan Name

Plan Number

Plan's Fiscal Year Ends: *(mo/day)* _____/_____

Has the Group ever applied for relief in Bankruptcy Court, or does the Group anticipate applying for bankruptcy or materially reducing active business operations? ❏ Yes ❏ No

Name of Workers' Compensation carrier:
____

Total no. of employees: _______ Total no. of *eligible* employees: _______ / How many employees are: Union: _______ Non-union: _______

No. in each classification: Permanent Full time*: _______ Permanent Part time: _______ Seasonal: _______ Temporary: _______

Individually contracted: _______ **How many hours per week do you require for a full-time employee?* _______

At this time, are any employees **not** actively at work? ❏ Yes ❏ No *If "Yes," completed applications must be submitted for these employees also.*

Are any employees located at a worksite other than that indicated above? ❏ Yes ❏ No If YES, please complete the following:

City	State* *(see box at right)*	Zip Code	County	# of Employees

**If state is not Missouri, are any of these employees Missouri residents?* Yes/No

Is more than one company to be enrolled in this program? ❏ Yes ❏ No If YES, you or your company must have controlling interest (at least 51%). Also, if YES, please complete the following:

Subsidiaries and/or Affiliates also Covered

Name	Address	Description of Business	# of Employees	% Interest	Subgroup

Important: *Companies that are affiliated companies, or that are eligible to file a combined state tax return, shall be considered one employer. If the Plan Sponsor is affiliated with other companies, this definition applies regardless of whether the affiliated companies are to be enrolled with the Plan Sponsor in this program.*

Enrollment Information Section:

Provide the following information for the primary group plus any subsidiaries and/or affiliates.

How many in the following classifications are enrolling in the group?	# Employees	# Dependents
Continuation of coverage (current), COBRA or State:	___________	___________
Totally disabled* (current):	___________	___________
Retirees:	___________	___________

****Total Disability:*** *A Subscriber or a dependent who had been actively working is considered to have a Total Disability if he or she is not actively working because he or she is unable to perform the material and substantial duties of his or her occupation. A retiree or a dependent who had not been actively working is considered to have a Total Disability if he or she is unable, because of an illness or injury, to perform the usual and ordinary activities of a person of like age. In any of these situations, the disability may be either permanent or temporary.*

Other Health Insurance Information: *Provide the following information about coverages either being transferred from or continuing in force:*

Type of Coverage	Transferred from (carrier name)*	Last Date Coverage in Force	Coverages Continuing in Force (indicate carriers)
Health Deduct:Ind. $ Fam. $			
HMO			
Dental Deduct:Ind. $ Fam. $			
Drug Deduct:Ind. $ Fam. $ Copay: Gen. $ Brand $			
Other			

**If no carrier, was the coverage provided through a self-funded group?* ❑ Yes ❑ No

General Provisions

Desired effective date of group coverage _____/_____/_____ Desired anniversary date _____/_____/_____

Employee Probationary Periods and Termination Dates:

❑ Coverage begins on 1st group service date following ______* days of employment. Coverage ends on 1st service date after termination of employment.

❑ Coverage begins on day following ______* days of employment. Coverage ends on day employment terminates.

❑ Other (Non-HMO: 100+ only / HMO: ASO only) ____

**Options for groups of 2-25: 30, 60, 90 or 180 days. Options for groups of 26-50: 0, 30, 60, 90 or 180 days Options for groups of 51-99: choose a number of days from 0 to 180.*

❑ Waive probationary period for existing employees

***Note:** Any change in the employee probationary period selected here will be effective on the group's next monthly service date following the Companies' receipt of a written request from the group. Such changes cannot be made retroactively.*

Employer/Employee Premium Contribution Information:

Minimum Requirement: 50% of Employee Premium. *Except:* No employer premium contribution is required for a Voluntary dental plan.

Employer Contribution *(please complete):*

Employee Rate	Medical/Rx* ______%	Dental ______%	Life products ______%
Dependent Rate	Medical/Rx* ______%	Dental ______%	Life products ______%

*For OptionBlue groups, this percentage applies to the Base plan. The employer's *dollar* contribution must be the same for both the Base and Enriched plans.

Deductible Funding: Does employer fund any portion of the deductible for employees? ❑ Yes ❑ No *"If "Yes," indicate the funding level (please complete as appropriate): ______% or $__________* ***Note:*** *Funding deductibles can affect the group's rates. In addition, if the employer intends to fund employees' deductibles, the Companies suggest that the employer's legal counsel or tax attorney be consulted in advance.*

Producer Statement ***Please print clearly. Note:*** *Group Executive must sign below if Option II is checked.*

I hereby certify that I hold a valid Insurance License issued by the State of Missouri and that all of the information contained herein is correct, to the best of my knowledge, and that, unless explained otherwise on an attached sheet, I know nothing unfavorable about the company or any individual applying for coverage. Furthermore, I certify that:

1. This company is a bona fide corporation, partnership or sole proprietorship, of a permanent nature, engaged in a legal business activity. It was not formed solely to obtain insurance.
2. Participation and contribution requirements have been met.
3. Eligibility provisions applicable to this program have been fully explained to, and are understood by, the Group.

Producer's Name: ____
First Middle Last

Agency Name: ________________________________ Tel. No: ( )________________ Fax No: ( )________________

New Group Enrollee Packets: Send the initial Identification cards and benefit materials for this group to: ❑ Producer ❑ Group Administrator

Commission Directive:

Commission Level: ❑ Option I. Standard Commission Schedule (10% Downgraded) ***or***
❑ Option II. Negotiated Commission (100+ groups only)
Provide description: ____

Commission Payable to Producer: Agent No.* ________________________ / Agency No.* ________________________

**You must provide the numbers the Companies assigned in order for this form to be processed.*

X ________________________________ X ____________________
Signature of writing producer *Date of signature*

If Option II is checked above, I agree with the commission level as described:

X ________________________________ X ____________________
Signature of officer or person authorized to make this application *Date of signature*

Please continue to Application Agreement and Signature Section on reverse. →

Application Agreement

Applicant applies to the Companies on behalf of Applicant's eligible employees and their dependents for the coverages selected, and Applicant gives authorization to offer such coverages, respectively, to said employees and dependents. (Applicant may also be applying for life insurance, and for related products if selected.)

For groups of fewer than 51 employees, Applicant understands that the following options are available:

Groups of 2 to 50 employees will be given the opportunity to qualify for our preferred rates. If a group does not qualify for preferred rates, the group may enroll at our standard rates in any product available to groups of that size.

Groups of 3 to 25 employees: Another option for groups that are eligible under state Small Employer statutes is to choose from our Basic and Standard guaranteed-issue PPO, Indemnity and HMO programs.

Applicant understands and agrees that if the Companies offered Applicant an HMO program, the Companies also offered Applicant an open-referral program, as required by law. An Applicant with more than 50 employees also understands that if an HMO is offered, each employee may choose between an HMO and an open-referral program.

Advance Deposit: To apply for coverage, Applicant will submit an advance deposit to the Companies. Applicant understands that this payment does not guarantee acceptance of the Group by the Companies.

Applicant understands that if the Application is accepted, the coverage applied for shall be effective on the date assigned by the Companies and specified in the Group Policy† to be issued by the Companies.

Applicant understands and agrees that a cancellation notice should not be submitted to the current carrier until Applicant has received an approval letter from the Companies indicating the group number and the effective date of group coverage.

Applicant understands and agrees to the following: The Companies reserve the right to adjust the rates to the maximum allowed by law if any material facts provided by the applicant were inaccurate or incomplete, or if any information material to the underwriting decision was not provided for consideration during the underwriting process. All applications for current employees* must be submitted to the Companies no later than 15 days prior to the effective date. If any applications for current employees are received by the Companies after the Group has submitted the original applications but within 31 days after the effective date, the effective date may be changed and the entire group may be underwritten** again, and rerated if necessary. Current employees whose applications are received more than 31 days after the effective date of the Group will be considered Late Enrollees and the Companies will apply the appropriate waiting period for coverage of preexisting health conditions.

**and for any persons who have elected Continuation Coverage; totally disabled persons; retirees; and employees still in their probationary period.*

***for groups of 2-50, the effective date would not be changed and underwriting would be done only for purposes of rerating.*

Newly Hired Employees: If Applicant hires any employees between the date when the final rates are signed by the authorized representative of the Group and the effective date of the Group, **and** their applications are submitted to the Companies within 31 days after the effective date of the Group, the following will apply:

For groups of 2-9 employees, the entire group may be underwritten again and rerated if necessary.

For groups of 10-99 employees, the new employee(s) will be added to the group without re-underwriting or rerating, provided that the new employee(s) do not make up more than 10% of the already-submitted applications (excluding applications for persons waiving coverage). However, if the new employee(s) make up more than 10% of the already-submitted applications, the group will be re-underwritten and rerated if necessary. In addition, for groups over 50, the Companies may change the effective date of the group or reconsider their decision to issue coverage to the group.

Important for Large Groups: If the coverage applied for is a "standard" benefits program, any changes that the Companies make in that standard program will also be made to the coverage purchased by the Group. This applies regardless of group size, funding arrangement or rates.

Producer Information: No agent, broker or consultant is authorized to waive a complete answer to any question in the application, determine membership eligibility, make or alter any contract, or waive any of the Companies' other rights or requirements. All contract terms must be in writing, and signed or accepted in writing, by an authorized employee of the Companies, to be binding upon the Companies.

Any future assignments by the Group to independent agents, brokers or consultants giving them "Agent of Record" status will be subject to acceptance by the Companies.

Payment of Premium: Premiums are payable monthly on the due date indicated on the billing statement. Applicant understands and agrees that if premium is not paid when due, or within the allowable grace period, the Group's coverage will terminate without notice as of midnight on the due date following the most recent paid-to date. **Note:** If a check issued by the Group for premium payment is *returned for insufficient funds,* the Companies will charge a fee to the Group. If the group is *cancelled for nonpayment of premium,* the Companies will charge a fee to the Group for reinstatement, if the reinstatement is approved.

Terminating Coverage: If, for any reason, Applicant decides not to enroll either: 1) during the application process (after receipt of the approval letter from the Companies and prior to the effective date of the Group Policy) or 2) within 31 days after the effective date of the Group Policy, a retention charge of 15% of the Group's advance deposit will be retained by the Companies.

State-Legislated Optional Benefits: *Please check the appropriate box, below.*
Important: If neither box is checked, the Companies will assume that Applicant is not interested in receiving a quote for the benefit(s) offered.

❑ Applicant has reviewed the state-legislated optional benefit information enclosed with this Group Application and Summary, or received during the proposal process, and *would like to receive a quote* for the benefit(s) selected on the information sheet.

❑ Applicant has reviewed the state-legislated optional benefit information enclosed with this Group Application and Summary, or received during the proposal process, and *does not want to receive a quote* for the benefit(s) offered.

†For PPO groups, the Group Policy includes the Certificate and the Group Agreement. For HMO groups, the Group Policy is the Group Master Contract.

The information provided by Applicant on this form and in any attachments is accurate and complete. Applicant understands that if any of this information is found by the Companies to be fraudulent or a material misrepresentation, the group's coverage can be canceled.

By ____ ____________________

Signature of officer or person authorized to make this application — *Title*

____ ____________________

Printed name of person signing application — *Date signed*