BlueCross BlueShield of Oklahoma

BlueLincs
Blue Cross and Blue Shield of Oklahoma

1400 South Boston, Tulsa, OK 74119

Mid-Market (51-150) EMPLOYER BENEFIT PROGRAM APPLICATION
(Employer Application)

Blue Cross and Blue Shield of Oklahoma (herein called "BCBSOK")
BlueLincs HMO (herein called "BlueLincs")

Employer's Legal Name: _____		
Account Status: ☐ New ☐ Former ASO (converting to Fully Insured)		
Account Number (6-digits): _____	Group Number(s): _____	
Requested Group Contract(s) Effective Date (first (1st) or fifteenth (15th)): _____/_____/_____ (Month/Day/Year)		
Anniversary Date (AD): _____		
Employer Identification Number (EIN): _____	Standard Industry Code (SIC): _____	Company Telephone Number: _____
Primary Mailing Address: Number, Street, City, State, Zip _____		
Physical Address (required if different from primary): Number, Street, City, State, Zip _____		
Billing Address (if different from primary – If more than one, please list within Additional Provisions): Number, Street, City, State, Zip _____		
E-Mail Address of Authorized Company Official: _____		
Name, title, and phone number _____		
Billing and Correspondence to the attention of: _____	Fax Number: _____	
The Blue Access for Employers℠ ("BAE℠") contact person is the Employee authorized by the Employer to access and maintains its account/Employee information via BAE. An email address is required to access and maintain BAE. Name and title of BAE contact person: _____ Telephone Number of BAE contact person: _____ E-Mail address of BAE contact person: _____		
Subsidiary / Affiliated Companies to be covered (If more than one, please list within Additional provisions):		
Number, Street, City, State, Zip: _____		

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.

ERISA Regulated Group Health* Plan ☐ Yes ☐ No

If Yes, is your ERISA Plan Year* a period of twelve (12) months beginning on the Anniversary Date specified above? ☐ Yes ☐ No

If No, please specify your ERISA Plan Year (month/day/year): Beginning Date: ___/___/___ End Date: ___/___/___

ERISA Plan Administrator *: _____

Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your Group Health Plan, 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: _____

Is your Non-ERISA Plan Year a period of twelve (12) months beginning on the Anniversary Date specified above? ☐ Yes ☐ No

If No, please specify your Non-ERISA Plan Year (month/day/year): Beginning Date: ___/___/___ End Date: ___/___/___

For more information regarding ERISA, contact your Legal Advisor.

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

If you currently have Group health care coverage, please provide name of carrier: _____

Blue Directions℠ Purchased: ☐ Yes ☐ No
(if Yes, the Blue Directions Addendum is attached and made a part of the Group Contract.)

Are you applying for Insure Oklahoma? ☐ Yes ☐ No
If Yes, effective date must be the first (1st) of the month to receive subsidies.

ELIGIBILITY INFORMATION

1. Employer has determined Employees must routinely work _____ (minimum of twenty-four (24)) hours per week in order to be eligible for health/dental coverage under this Group Contract.

2. **Other Eligibility Provisions (check all that apply):**

☐ Retiree of the Employer
☐ Other: _____

3. **Domestic Partners covered?** ☐ Yes ☐ No

A Domestic Partner means a person with whom the Employee has entered into a domestic partnership in accordance with the Employer's plan guidelines. The Employer is responsible for providing notice of possible tax implications to those covered Employees with Domestic Partners. An Employer may only elect or change Domestic Partner Coverage on the Group Contract Effective Date or Group Contract Anniversary Date.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an eligible Employee elects COBRA coverage.

Employer may also elect whether to provide continuation coverage for Domestic Partners on an independent basis from the Employee. Please indicate your election below.

☐ Yes, Employer elects to offer continuation coverage to Domestic Partners on an independent basis from the Employee's election of COBRA.

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

☐ Other: _____

4. The Effective Date of coverage for a newly Eligible Employee who becomes effective after the Employer's initial enrollment date and any substantive eligibility criteria is:

If a person is added to the Group Contract and it is later determined that the Group reported a coverage date earlier than what would apply to the Employee or Dependent, based on the Waiting Period and eligibility conditions the Group provided to BCBSOK, BCBSOK reserves the right to retroactively adjust the coverage date for such person.

☐ The date of employment

☐ The first (1st) billing cycle following the date of employment

☐ The first (1st) billing cycle following select one days of continuous employment.

☐ The first (1st) billing cycle following select one months of continuous employment.

5. 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.

If any of these eligibility conditions change, you are required to submit a new Employer Application 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).

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

6. Is the waiting period requirement to be waived on initial Group enrollment? ☐ Yes ☐ No

7. Are there multiple new hire waiting periods? ☐ Yes ☐ No

If yes, specify eligibility and contribution details for each section: _____

8. Did you have a waiting period requirement with the prior carrier? ☐ Yes ☐ No

If Yes, please state waiting period requirement of the prior carrier. _____

If Yes, number of Employees serving the waiting period: _____

9. Rehire provision? ☐ Yes ☐ No

☐ The date of rehire if hired within six (6) months of original termination.

☐ The first (1st) billing cycle following the date of rehire if hired within six (6) months of original termination.

10. **Limiting Age for covered children:** 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, 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.

11. **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. The disability must begin while the child is covered as a dependent under the Plan or as a dependent child under another employer plan before the child attains the limiting age with no break in coverage. A disabled Dependent is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled Dependent is eligible to add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled Dependent is provided.

Certification Review is administered by BCBSOK; a Disabled Dependent Certification Form must be submitted to BCBSOK.

12. Other Eligibility Provision (please explain):

_____

CURRENT ELIGIBILITY INFORMATION

Total number of Employees (Please indicate the total number of actual Employees, not enrollees):

1. On payroll _____

2. On COBRA continuation coverage _____

3. With retiree coverage (if applicable) _____

4. Who work part-time and are not eligible _____

5. Serving the new hire probationary waiting period (if not waived per section #6 above) _____

6. Declining because of other coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____

7. Declining coverage (not covered elsewhere) _____

CONTRIBUTION AND PARTICIPATION

Health Employer Contribution, the percentage***** of health premium to be paid by the Employer is:

Medical -- %	
Employee Only Coverage (Single Coverage)	_____%

*The minimum contribution amount which is required from the Employer is fifty percent (50%) of the premium for Employee Only (Single Coverage).

BlueCare Dental℠ Employer Contribution if applicable, the percentage of BlueCare Dental premium to be paid by the Employer is:

Dental -- %	
Employee Only Coverage (Single Coverage)	_____%

BlueCare Dental minimum contribution amount which is required from the Employer is fifty percent (50%) of the premium for the Employee Only (Single Coverage).

+Voluntary Group Dental product does not require an Employer contribution.

- **Participation & Contribution.** BCBSOK/BlueLincs reserves the right to take any or all of the following actions:

  Commercial Business

  a) Initial rates for new Groups will be finalized for the Effective Date of the Group Contract based on the enrolled participation and Employer contribution levels;

  b) After the Group Contract Effective Date, the Group will be required to maintain a minimum Employer contribution of fifty percent (50%), and at least a seventy-five percent (75%) participation of Eligible Employees (less valid waivers). In the event the Group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or

  c) Non-renew or discontinue coverage 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.

  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. BCBSOK/BlueLincs reserves the right to change premium rates when a substantial change occurs in the number or composition of Subscribers covered.

Employer will promptly notify BCBSOK/BlueLincs of any change in participation and Employer contribution.

Blue Select Dental℠ has specific participation requirements. The Group Contract and endorsements contain the terms and conditions.

PRODUCT OPTIONS

HEALTH – Please check all products for which you are applying and indicate the applicable health plan or package number(s) below.

☐ Blue Advantage PPO℠

☐ Blue Options PPO℠

☐ Blue Choice PPO℠

☐ Blue Preferred PPO℠

☐ Blue Preferred PPO HSA (Vendor:**Select Vendor**)

☐ BlueLincs HMO℠

☐ Blue Options HSA℠ (Vendor:**Select Vendor**)

☐ HSA Blue℠ (Vendor:**Select Vendor**)

Preferred HSA Vendor:**Select Vendor**
If HealthEquity, Inc. is selected, BCBSOK to send HSA enrollment to HealthEquity, Inc.: ☐ **Yes** ☐ **No**
Non-Preferred Vendor: _____

Preferred FSA Vendor: **Select Vendor**
Non-Preferred Vendor: _____

Preferred Health Reimbursement Account (HRA) Vendor:**Select Vendor**
Non-Preferred 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.

PLAN SELECTIONS

Health Benefit Plans

Please indicate health plan number(s) below. **Note**: only one (1) HMO selection is allowed.

Health Plan #1 _____

Health Plan #2 _____

Health Plan #3 _____

Health Plan #4 _____

Health Plan #5 _____

Health Plan #6 _____

Dental Benefit Plans

If selecting a dental benefit plan, choose one (1) option and indicate dental plan:

☐ BlueCare Dental Plan # _____

☐ Blue Select Dental Plan # _____

Vision Benefit Plan

Please indicate if vision coverage is elected: ☐ Yes ☐ No If yes, attach separate application for vision coverage.

Additional Information: _____

LEGISLATIVE REQUIREMENTS

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the **Consolidated Omnibus Budget Reconciliation Act (COBRA)**, as amended, are federally mandated requirements. Employer penalties for noncompliance may apply. It is your responsibility to annually inform BCBSOK/BlueLincs of whether **COBRA** is applicable to you based upon your full and part-time Employee count in the prior calendar year.

Failure to advise BCBSOK/BlueLincs of a change of status could subject you to governmental sanctions.

TEFRA is a Medicare secondary payer requirement that mandates Employers that employ twenty (20) or more total Employees (full-time, part-time, seasonal, or partners) for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year to offer the same (primary) coverage to their age sixty-five (65) or over Employees and the age sixty-five (65) or over spouses of Employees of any age that they offer to younger Employees and spouses.

Are you subject to TEFRA? ☐ Yes ☐ No

COBRA

a. Did your company employ twenty (20) or more full-time and/or part-time Employees for at least fifty percent (50%) of the workdays of the preceding calendar year? ☐ **Yes** ☐ **No**

b. **Are you subject to COBRA? ☐ Yes ☐ No**

MEDICARE SECONDARY PAYER RULES

Under the **Medicare Secondary Payer Rules**, it is your responsibility to annually inform BCBSOK/BlueLincs of proper Employee counts for the purpose of determining payment priority between Medicare and BCBSOK/BlueLincs. **To satisfy this responsibility at this time, please complete, sign, date, and return the *Annual Medicare Secondary Payer Employer Acknowledgement Form along with this Employer Application*.**

PRODUCER OF RECORD INFORMATION

1. ***Primary Producer(s) or Agency(ies): Are commissions to be paid**? ☐ Yes ☐ No

Producer Name: _____ Producer #: _____

Agency Name: _____ Agency #: _____

Agency Address: Street _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____ Email: _____

Medical Commissions:
☐ Standard
☐ Other: _____

Dental Commissions:
☐ Standard

2. ***Producer(s) or Agency(ies): Are commissions to be paid**? ☐ Yes ☐ No

Producer Name: _____ Producer #: _____

Agency Name: _____ Agency #: _____

Agency Address: Street _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____ Email: _____

Medical Commissions:
☐ Standard
☐ Other: _____

Dental Commissions:
☐ Standard

If commission split**, designate percentage for each Producer/Agency

1. _____% Producer/Agency

2. _____%

3. Other Producer Information:

A. Multiple Location Agency(ies): If servicing agency is not listed above as Item 1 or 2, specify location below: _____

B. Other: _____

* 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 split, please provide the information requested above on both producers/agencies. BOTH must be appointed to do business with BCBSOK and/or BlueLincs.

OTHER PROVISIONS:

1. **Massachusetts Health Care Reform Act:** If elected below, BCBSOK will provide required written statements of Minimum Creditable Coverage ("MCC") to Subscribers residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSOK by Employer and coverage under the Plan(s) during the term of the Group Contract. By electing to have BCBSOK 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 BCBSOK is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Subscribers 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 BCBSOK 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.

2. This Employer Application is incorporated into and made a part of the Group Contract.

3. **Transition Credit:** BCBSOK will provide a one-time transition credit of _____ for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with transitioning medical, prescription, ancillary health or other coverage to BCBSOK and/or costs and expenses associated with transitioning to a new product design with BCBSOK. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the transition credit.

4. **Wellness Credit:** BCBSOK will provide a one-time wellness credit of _____ for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with the implementation of a new or to operate an existing wellness program for the benefit of Members. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the wellness credit.

5. **Communication Credit:** BCBSOK will provide a one-time communication credit of _____ for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with Member communications and other communication costs associated with electing coverage through BCBSOK. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the communication credit.

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

7. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: BCBSOK 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.

8. **Wellbeing Management (WBM) (included)**

9. ☐ **Medical and Ancillary Package Pricing:** The rates shown in this Group Contract reflect a volume-based discount in an amount up to three percent (3%) of the medical premium for the twelve (12) month period beginning on the Group Contract Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness, Hospital Indemnity and/or

Vision product(s)) lapses during this twelve (12) month period, BCBSOK reserves the right to remove the volume-based discount attributable to the lapsed product on medical premium. In such event, upon sixty (60) days prior written notice to Employer, the premium payment will be adjusted to reflect the removal of the discount attributable to the lapsed product.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide BCBSOK/BlueLincs 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 the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by BCBSOK/BlueLincs to the terms and conditions of coverage. In no event shall BCBSOK/BlueLincs 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 made part of the Mid-Market Employer Benefit Program Application and Group Contract, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSOK/BlueLincs with any requested grandfathered health plan information, BCBSOK/BlueLincs may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the Mid-Market Employer Benefit Program Application includes any retiree only plans and/or excepted benefits, then Employer represents and warrants that one (1) or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by BCBSOK/BlueLincs to the terms and conditions of coverage. In no event shall BCBSOK/BlueLincs be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Employer shall indemnify and hold harmless BCBSOK/BlueLincs 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 inquires or actions, settlements or judgments brought or asserted against BCBSOK/BlueLincs in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) religious or moral exemption and eligible organization accommodation, (d) any plan's design (including but not limited to any directions, actions and interpretations of the Employer, and/or (e) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Notwithstanding anything in the Group Contract or Renewal(s) to the contrary, BCBSOK/BlueLincs 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 BCBSOK/BlueLincs to pay, submit or forward, on its own behalf or on BCBSOK/BlueLincs's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

The provisions of paragraphs A-C (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.

EMPLOYER STATEMENTS:

1. Employer understands that, unless otherwise specified in the Group Contract, only Eligible Employees and their Dependents are eligible for coverage. Employer further agrees that eligibility and participation requirements have been discussed with the agent and have been explained to all Eligible Persons.

2. Employer agrees to notify BCBSOK of ineligible persons immediately following their change in status from eligible to ineligible.

3. Employer agrees to review all applications for completeness prior to submission to BCBSOK. Employer applies for the coverages selected in this Mid-Market Employer Benefit Program Application and provided in the Group Contract and agrees that the obligation of BCBSOK shall only include the Benefits described in the Group Contract or as amended by any Amendments or Endorsements thereto.

4. Employer agrees to pay to BCBSOK, in advance, the premiums specified in the Group Billing Statement on behalf of each Eligible Person covered under the Group Contract.

5. Employer agrees that, in the making of this Application, it is acting for and on behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Employer is not the agent or representative of BCBSOK for any purpose of this Application or any Group Contract issued pursuant to this Application.

6. Employer agrees to deliver to its Eligible Persons covered under the Group Contract individual Certificate of Benefits/Member Handbook and Identification Cards and any other relevant materials as may be furnished by BCBSOK for distribution.

7. Employer agrees to receive on behalf of its covered Eligible Persons all notices delivered by BCBSOK and to forward such notices to the applicable recipient(s) at their last known address.

8. Employer agrees the producer (s) or agency(ies), specified in writing by the Employer as its Agent of Record (AOR) is authorized by the Employer to act as its representative in negotiations with and to receive commissions from BCBSOK/BlueLincs and/or corporate subsidiaries, as applicable, for procuring fully insured coverage for Employer's Employee benefit program(s). The AOR is authorized by the Employer to perform membership transactions on behalf of Employer and is authorized to conduct such transactions through the Employer's web portal known as BAE. The appointment will remain in effect until withdrawn or superseded in writing by Employer.

9. Employer understands the effective date of termination for a person who ceases to meet the definition of Eligible Person is the end of the coverage period (billing cycle) during which the person ceases to meet the definition of Eligible Person.

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.

For Employer:

Name of Authorized Company Official (please print)	Title of Authorized Company Official
Signature of Authorized Company Official	City and State of Signing Official
Date	

(NOTE: THE FOLLOWING PROXY INFORMATION IS NOT APPLICABLE TO BLUELINCS HMO.)

PROXY

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.: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____ _____
Month Year