



**BlueCross BlueShield
of Texas**

May 12, 2008

Multiple Dependent Applications

Below are instructions to follow when completing multiple dependent applications on the Hallmark Online Sales Channel (OSC) Web site.

NOTE: There are two purposes for these instructions – 1) To allow you to submit multiple dependent applications without being charged multiple application fees; 2) To keep the applications together with the same source code for underwriting purposes.

- After you have submitted the first dependent application and you are on the **Receipt** page, go to the bottom of the page and click on the **Another Quote/Application** button. You will be directed to the landing page to start another quote/application.
- Go through the application process again. If you have more dependent applications, repeat the process above. If not, click on the **My Account** or **Log Out** button.
- If you have more dependent applications to complete on the same account but do not want to complete them at that time, get to a screen in the application process that has a **Save and Exit** button and click on it before quitting. This will allow you to log back in on the same account at a later time to retrieve your saved application and complete it.

Example screen prints of three dependent applications using the instructions above are attached.

Questions regarding this change should be directed to the Producer Service Representatives at 1-888-697-0679 (option 2), Monday through Friday, between 8:00 am and 4:30 pm Central Time.

Sincerely,

Randy Starns
Director, Consumer Markets

EXAMPLE: APPLICATION 1

SECTION B – COVERAGE APPLIED FOR (please choose only one plan)

PPO Select Blue Advantage

Deductible Plan: I \$250 II \$500 III \$1,000 IV \$1,500
V \$2,500 VI \$3,500 VII \$5,000 VIII \$10,000

PPO Select Saver

Deductible Plan: I \$500 II \$1,000 III \$1,500 IV \$2,500
V \$3,500 VI \$5,000 VII \$10,000

PPO Select Choice

Deductible Plan: I \$250 II \$500 III \$1,000 IV \$1,500
V \$2,500 VI \$3,500 VII \$5,000 VIII \$10,000

DENTAL INSURANCE COVERAGE I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage. **I understand this will be my only opportunity to purchase dental insurance.**

SECTION C – PAYOR AND BILLING INFORMATION

Requested Effective Date (mo./day/yr.) 05/03/2008

Premium Mode: Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
 Monthly Direct Bill Two Month Direct Bill Quarterly Direct Bill
 List Bill Monthly (Available for two or more applicants billed at the same address)

A \$30.00 NONREFUNDABLE Application Fee must be submitted with completed application. Please make check payable to Blue Cross and Blue Shield of Texas.

Application Fee	\$30.00
Premium (if enclosed)	\$93.00
TOTAL enclosed	\$123.00

Payor of premium (if different than applicant)
Will your employer be contributing towards the premium for this policy? Yes No

Name: Jane Jones Address/City/State/ZIP: DOB: 01-01-1960 SSN:

FORM NO. IND-APP/MCF-1 TEST E-APP 000007275 Please complete all pages 1-4. 1 Source: WEBTX00202 41745.0106

EXAMPLE: APPLICATION 2

SECTION B – COVERAGE APPLIED FOR (please choose only one plan)

PPO Select Blue Advantage

Deductible Plan: I \$250 II \$500 III \$1,000 IV \$1,500
V \$2,500 VI \$3,500 VII \$5,000 VIII \$10,000

PPO Select Saver

Deductible Plan: I \$500 II \$1,000 III \$1,500 IV \$2,500
V \$3,500 VI \$5,000 VII \$10,000

PPO Select Choice

Deductible Plan: I \$250 II \$500 III \$1,000 IV \$1,500
V \$2,500 VI \$3,500 VII \$5,000 VIII \$10,000

DENTAL INSURANCE COVERAGE I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage. **I understand this will be my only opportunity to purchase dental insurance.**

SECTION C – PAYOR AND BILLING INFORMATION

Requested Effective Date (mo./day/yr.) 05/03/2008

Premium Mode: Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
 Monthly Direct Bill Two Month Direct Bill Quarterly Direct Bill
 List Bill Monthly (Available for two or more applicants billed at the same address)

A \$30.00 NONREFUNDABLE Application Fee must be submitted with completed application. Please make check payable to Blue Cross and Blue Shield of Texas.

Application Fee	N/C	\$30.00
Premium (if enclosed)		\$67.00
TOTAL enclosed		\$67.00

Payor of premium (if different than applicant)
Will your employer be contributing towards the premium for this policy? Yes No

Name: Jane Jones Address/City/State/ZIP: DOB: 01-01-1960 SSN:

FORM NO. IND-APP/MCF-1 TEST E-APP 000007276 Please complete all pages 1-4. 1 Source: WEBTX00202 41745.0106

EXAMPLE: APPLICATION 3

SECTION B – COVERAGE APPLIED FOR (please choose only one plan)

PPO Select Blue Advantage

Deductible Plan: I \$250 II \$500 III \$1,000 IV \$1,500
V \$2,500 VI \$3,500 VII \$5,000 VIII \$10,000

PPO Select Saver

Deductible Plan: I \$500 II \$1,000 III \$1,500 IV \$2,500
V \$3,500 VI \$5,000 VII \$10,000

PPO Select Choice

Deductible Plan: I \$250 II \$500 III \$1,000 IV \$1,500
V \$2,500 VI \$3,500 VII \$5,000 VIII \$10,000

DENTAL INSURANCE COVERAGE I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage. **I understand this will be my only opportunity to purchase dental insurance.**

SECTION C – PAYOR AND BILLING INFORMATION

Requested Effective Date (mo./day/yr.) 05/03/2008

Premium Mode: Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
 Monthly Direct Bill Two Month Direct Bill Quarterly Direct Bill
 List Bill Monthly (Available for two or more applicants billed at the same address)

A \$30.00 NONREFUNDABLE Application Fee must be submitted with completed application. Please make check payable to Blue Cross and Blue Shield of Texas.

Application Fee	N/C	\$30.00
Premium (if enclosed)		\$84.00
TOTAL enclosed		\$84.00

Payor of premium (if different than applicant)
Will your employer be contributing towards the premium for this policy? Yes No

Name: Jane Jones Address/City/State/ZIP: DOB: 01-01-1960 SSN:

FORM NO. IND-APP/MCF-1 TEST E-APP 000007277 Please complete all pages 1-4. 1 Source: WEBTX00202 41745.0106