



**BlueCross BlueShield  
of Texas**



**FORT DEARBORN LIFE  
Insurance Company**

Health No. \_\_\_\_\_

Life No. \_\_\_\_\_

**SMALL GROUP EMPLOYER APPLICATION FOR AMENDMENT**

**You have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage (Certificate of Coverage).**

(See page 3, Consumer Choice Plans, for available plan options and page 7 for the Disclosure Statement that applies to these plans.)

Application is hereby made to Blue Cross and Blue Shield of Texas (BCBSTX) and/or Fort Dearborn Life Insurance Company (FDL) to replace benefit and/or eligibility specifications previously in effect with the following:

Coverage changed by this form is replacement coverage, not substitution.

Legal Name of Company: <input type="checkbox"/> No change <input type="checkbox"/> Change: If changed, new name of Company: _____		Nature of Business: <input type="checkbox"/> No change <input type="checkbox"/> Change	SIC/NAICS Code: <input type="checkbox"/> No change <input type="checkbox"/> Change
Physical Address (number & street), City, State, ZIP: <input type="checkbox"/> No change <input type="checkbox"/> Change		Telephone Number: <input type="checkbox"/> No change <input type="checkbox"/> Change	
E-Mail Address of Authorized Company Official: <input type="checkbox"/> No change <input type="checkbox"/> Change		FAX Number: <input type="checkbox"/> No change <input type="checkbox"/> Change	
Secondary E-Mail Address, if different from Authorized Company Official: <input type="checkbox"/> No change <input type="checkbox"/> Change			
Complete Mailing Address, if different from physical address: <input type="checkbox"/> No change <input type="checkbox"/> Change		Billing and Correspondence to the attention of: <input type="checkbox"/> No change <input type="checkbox"/> Change	
Requested Contract(s)/Policy(ies) Effective Date (1 <sup>st</sup> or 15 <sup>th</sup> ): _____ / _____ / _____ Month      Day      Year		Request to change Anniversary Date (AD): Note: Approval required _____ / _____ / _____ Month      Day      Year	
Note: Products with a Health Maintenance Organization (HMO) component must be effective on the first day of the month. Contract(s)/Policy(ies) Anniversary Dates will be 12 months from the Effective Date. <input type="checkbox"/> No change <input type="checkbox"/> Change			

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
 an Independent Licensee of the Blue Cross and Blue Shield Association  
 Fort Dearborn Life Insurance Company, a Member of the Preferred Financial Group

Health No. \_\_\_\_\_

Life No. \_\_\_\_\_

**Eligibility Changes:**  No change  Change (only complete items changing)

1. Waiting Period for eligibility:  0 days  30 days  60 days  90 days  
Number of employees serving Waiting Period: \_\_\_\_\_  
Employee and dependent Health and/or Dental Benefit Plans will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period, if any.
2. Total number of applications submitted: \_\_\_\_\_ Total number of declinations submitted: \_\_\_\_\_
3. Do all employees reside in Texas?  Yes  No
4. Are you adding any affiliates and/or subsidiaries?  Yes  No  
If "yes", list name(s), SIC/NAICS code, and number of employees\*: \_\_\_\_\_  
Are you being added as an affiliate or subsidiary?  Yes  No  
If "yes", list name, SIC/NAICS code, and number of employees\*: \_\_\_\_\_
5. Are you a public entity group?  Yes  No  
A public entity is a State, any of its counties, departments, agencies, independent school districts, or other political subdivisions.
6. Are you an independent school district that is a large employer electing to participate as a small employer?  Yes  No
7. Are any employees currently receiving Workers' Compensation benefits?  Yes  No  
If "yes", list names and conditions\*: \_\_\_\_\_
8. **TEFRA. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** is a Medicare secondary payer requirement that mandates employers that employ 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. **(See page 8 for more Medicare Secondary Payer Rules information)**

Are you subject to the Tax Equity and Fiscal Responsibility Act (TEFRA)?  Yes  No

9. **COBRA.** a. Did your company employ 20 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year?  Yes  No  
b. Are you subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA)?  Yes  No  
If "yes," list names and number of individuals (qualified beneficiaries) currently on COBRA continuation\*: \_\_\_\_\_ **(See page 8 for more COBRA information)**
10. **State Continuation Privilege on Termination of Coverage.** All employees, members, or dependents are entitled to state continuation of group coverage under certain conditions. List names and number of continued persons currently on state (6-months) continuation coverage\*: \_\_\_\_\_  
**State Continuation of Group Coverage for Certain Dependents.** A dependent of an insured is entitled to state dependent continuation under certain conditions. List names and number of continued dependents on state (3 years) dependent continuation coverage\*: \_\_\_\_\_
11. If you currently have group health care coverage with another carrier, attach a copy of the most current billing statement and complete the following:
  - a. Present health carrier's name (if not on billing statement): \_\_\_\_\_
  - b. Paid-to-date with current carrier: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year
  - c. Calendar year medical deductible amount with current carrier: Individual: \_\_\_\_\_ Family: \_\_\_\_\_

**Benefits Changes:**  No change  Change (only complete items changing)

**Maternity Care** coverage: Please check the **one** election that applies to your company.

- We are changing to a MOP, HMO (only), or Consumer Choice HMO (only) plan. We understand maternity care is automatically included in the coverage for these small group employer plans.
- We are changing to a PPO or Consumer Choice PPO plan and have 15 or more full or part-time employees. We understand maternity care is automatically included in the coverage as required by federal law.
- We are changing to a PPO or Consumer Choice PPO plan and have less than 15 full or part-time employees. We have indicated below whether we would like to accept or decline maternity coverage.
  - Accept Maternity Coverage
  - Decline Maternity Coverage

\* If needed, additional space for required information is available on page 6 of this form.

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**Benefit Changes (Continued):**  No change  Change (only complete items changing)

Note: If changing from a PPO or BlueEdge Plan to an HMO Plan or vice versa, you MUST indicate your elections of Texas mandated benefit offers for the new Plan. If benefit changes are not needed, omit this section and proceed to signature line at the end of this form.

<p><b>BESTCHOICE® PREFERRED PROVIDER (PPO):</b>  <i>BlueChoice® Network - BlueChoice Solutions Network</i>          PPO plan selected: _____          Dual PPO plans selected: _____          BlueEdge® HSA/HDHP* plan selected: _____          If BlueEdge HSA/HDHP is selected, provide name of HSA administrator/trustee: _____          BlueEdge Wellness Rewards HCA plan selected: _____</p>	<p><b>HMO:</b> (100% of eligible employees must reside or work in the service area. The HMO Blue Texas service area does not include all counties in Texas.)           HMO Blue plan selected: _____          (HMO plans 9 and 11-19 are available)</p>
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<b>MULTIPLE OPTION PLAN (MOP)</b>	
BestChoice PPO plan selected: _____ BlueEdge® HSA/HDHP plan selected: _____ If BlueEdge HSA/HDHP is selected, provide name of HSA administrator/trustee: _____ BlueEdge HCA plan selected: _____	HMO Blue plan selected: _____ (HMO plans 9 and 11-19 are available)
Serious Mental Illness, Speech and Hearing Therapy, and In Vitro elections must be the same for PPO or BlueEdge Plans and HMO Plans.	

<b>TRIPLE OPTION PLAN</b>		
Plan #1 _____	Plan #2 _____	Plan #3 _____
Only one HMO plan is allowed. At least one plan must be BlueEdge HSA/HCA HDHP. Serious Mental Illness, Speech and Hearing Therapy, and In Vitro elections must be the same for PPO or BlueEdge Plans and HMO Plans.		

PPO or BlueEdge Plans	HMO
The following mandated benefit offers are made by BCBSTX in compliance with Texas regulations. Please mark your acceptance or declination. Acceptance may result in a rate adjustment. <b>Home Health Care – (must choose one)</b> <input type="checkbox"/> Accept - Maximum of 60 visits each Calendar Year <input type="checkbox"/> Decline - If declined, the standard benefit of \$10,000 each Calendar Year will apply	<b>Additional Benefit Options:</b>  Inpatient Mental Health (IPMH): <input type="checkbox"/> IM1 <input type="checkbox"/> IM2  Vision: <input type="checkbox"/> IC <input type="checkbox"/> O2  Durable Medical Equipment (DME): <input type="checkbox"/> DM1 <input type="checkbox"/> DM2
<b>Serious Mental Illness (SMI) – (must choose one)</b> <input type="checkbox"/> Accept - Inpatient days limited to 45 <input type="checkbox"/> Decline – If declined, benefits for SMI are included in the benefits for Mental Health Care <input type="checkbox"/> Public entities must cover SMI same as any other illness	<b>Serious Mental Illness (SMI) – (must choose one)</b> <input type="checkbox"/> Accept - Inpatient days limited to 45 <input type="checkbox"/> Decline – If declined, benefits for SMI are included in the benefits for Mental Health Care <input type="checkbox"/> Public entities must cover SMI same as any other illness (SM2)
<b>In Vitro Fertilization Services – (must choose one)</b> <input type="checkbox"/> Accept – Benefits are paid same as any other medical-surgical expense <input type="checkbox"/> Decline – If declined, no benefits are available	<b>In Vitro Fertilization Services – (must choose one)</b>  <input type="checkbox"/> Accept – Limited Benefits <input type="checkbox"/> Decline – If declined, no benefits are available
<b>Speech and Hearing Therapy – (must choose one)</b> <input type="checkbox"/> Accept – Benefits are paid same as any other illness <input type="checkbox"/> Decline – If declined, therapy is covered same as any other illness; hearing aid benefit is limited to \$1,000 max every 36 months	<b>Speech and Hearing Therapy – (must choose one)</b> <input type="checkbox"/> Accept – Benefits are paid same as any other illness <input type="checkbox"/> Decline – If declined, medically necessary speech therapy is covered on an outpatient basis only; limited hearing. Hearing aids are covered under a DME additional benefit option only

<b>CONSUMER CHOICE PLANS</b>	
(These options are offered in place of PPO-only, HMO-only, MOP, or Triple Option Plan)	
<input type="checkbox"/> Consumer Choice PPO coverage	<input type="checkbox"/> Consumer Choice HMO coverage <input type="checkbox"/> Prescription Drug Option 99 (20/35/50)
<i>If a Consumer Choice Plan is accepted, please sign <b>Disclosure Statement</b> on page 7.</i>	

<b>DENTAL BENEFIT PLANS</b>	
Dental Benefit Plan selected: _____	Dual Option Dental Benefit Plans selected: Plan #1 _____ Plan #2 _____

\* Health Savings Account (HSA) - High Deductible Health Plan (HDHP) - Health Care Account (HCA)

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**The Employer understands and agrees to the following regarding the Health Benefit Plan (Plan), inclusive of the Dental Benefit Plan, when Dental coverage is elected:**

- Applications/declinations are attached for all full-time employees as well as any COBRA or state participant continuations.
- **Minimum Participation Requirement:** A small employer must maintain enrollment of at least 75% participation of eligible employees under this Health Benefit Plan and 75% participation under the Dental Benefit Plan, when Dental coverage is elected.
- **Employer Contribution:** A small employer must contribute a minimum of 50% of the employee only premium for the Health Benefit Plan selected for all enrolled employees and 50% of the employee only premium for the Dental Benefit Plan for all enrolled employees, when Dental coverage is elected.
- The Employer must provide eligibility and enrollment information, effective dates of employment, and all other data necessary for the efficient administration of the Health Benefit Plan and Dental Benefit Plan, when Dental coverage is elected, according to the terms and requests of BCBSTX.
- The Employer, while not an agent of BCBSTX, will be responsible for collection of premiums from employees, will notify employees of the termination of their coverages and will forward to employees notices and/or amendments sent by BCBSTX to the Employer. The Employer will be bound by the terms of the Contract(s)/Policy(ies) already in effect and any changes pursuant to this Employer's Application for Amendment and such shall serve as the basis to resolve any conflict.
- The Employer's Application for Amendment must pre-date the requested effective date specified on page 1 and be received by BCBSTX at its Home Office no less than 30 days prior to the requested effective date. If enrollment material is not received at the Home Office 30 days prior to the effective date requested, changes, if any will be made effective on the first mutually agreeable date.
- Retirees are not eligible for coverage under this Health Benefit Plan or under the Dental Benefit Plan, when Dental coverage is elected.
- Under state law, **eligible employee** means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. The term does not include an Employee who: (1) works on a part-time, temporary, seasonal, or substitute basis, or (2) is covered under (a) another Health Benefit Plan, or (b) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974, or (3) elects not to be covered under the small Employer's health benefit plan and is covered under (a) the Medicaid program; (b) another federal program, including the TRICARE program or Medicare program; or (c) a benefit plan established in another country.
- ERISA Plan Year \_\_\_\_\_ / \_\_\_\_\_  
Month Year

If you contend ERISA is inapplicable to your health plan, please state the basis \_\_\_\_\_

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**(See page 8 for more ERISA information or your Legal Advisor)**

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**Application is hereby made to Fort Dearborn Life Insurance Company® (herein called FDL).  
 For a Life Insurance Plan (including Term Life Insurance, Accidental Death and Dismemberment (AD&D), Dependents' Life, and/or Short Term Disability (STD)).**

**I. Group Life Administration Information**

No change  New Coverage Applied For  Upgrade  Other (explain)

Eligibility:  All active employees  All active employees enrolled for health insurance  
 who work a minimum of 30 hours per week excluding seasonal, temporary, or retired employees

Benefit: All employees according to the following schedule:

Class	Job Title, as shown on the enrollment form	Life & AD&D Benefit Amount	STD Amount (if elected)
1			
2			
3			
		<b>Term Life/AD&amp;D</b>	<b>Dependents' Life</b>
Total eligible employees:			
Total enrolling:			

First Contract Anniversary Date:  12 months from Contract Effective Date  Other \_\_\_\_\_

**II. Term Life Insurance and AD&D:**

No change  New Coverage Applied For  Upgrade  Other (explain)

Complete Life and AD&D Benefit Amount in Section I	Guarantee Issue Maximum: \$
Rates: <input type="checkbox"/> Step-Rated <input type="checkbox"/> Composite Rated	(Include a copy of the rating exhibit if rated in the field)
Employer Contribution: <input type="checkbox"/> 100% <input type="checkbox"/> Other %	(Minimum 25% Employer contribution required)
Life/AD&D Reductions due to Attained Age (All benefits terminate at retirement):	
<input type="checkbox"/>	Reduces by 35% at age 65, to 50% of the original benefit at age 70, to 25% of the original benefit at age 75, and to 15% of the original benefit at age 80. (Standard under 10 eligible lives)
<input type="checkbox"/>	Reduces by 35% at age 65 and to 50% of the original benefit at age 70. (Unavailable under 10 eligible lives)
<input type="checkbox"/>	Reduces to 50% at age 70. (Unavailable under 10 eligible lives)
Term Life is <input type="checkbox"/> in addition to, or <input type="checkbox"/> replacement of current term life coverage <input type="checkbox"/> no current carrier	
If replacement, give current carrier: _____ Termination date of prior plan: _____	

**III. Dependents' Term Life Insurance:**

No change  New Coverage Applied For  Upgrade  Other (explain)

Benefits:	Spouse: \$
Rate: \$	Child(ren) age 15 days up to 6 mos: \$
Employer Contribution: %	Child(ren) age 6 mos. up to age 25 & Students: \$

**IV. Short Term Disability (STD) Insurance:**

No change  New Coverage Applied For  Upgrade  Other (explain)

Wage-Based Benefit: <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% of Basic Weekly Wages to a Benefit Maximum of \$	
Flat Benefit: <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250 not to exceed 66 2/3% of Basic Weekly Wages	
Class Defined Plan: Complete STD amount in Section I	
Benefits Begin:	Due to an Accident: (select one)
	Due to Sickness: (select one)
	<input type="checkbox"/> 1 <sup>st</sup> day <input type="checkbox"/> 8 <sup>th</sup> day <input type="checkbox"/> 15 <sup>th</sup> day <input type="checkbox"/> 31 <sup>st</sup> day
	<input type="checkbox"/> 8 <sup>th</sup> day <input type="checkbox"/> 15 <sup>th</sup> day <input type="checkbox"/> 31 <sup>st</sup> day
Maximum Weekly Benefit Duration: <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks	
Rates: <input type="checkbox"/> Step-Rated <input type="checkbox"/> Composite Rated (Include a copy of the rating exhibit if rated in the field)	
Employer Contribution: <input type="checkbox"/> 100% <input type="checkbox"/> Other % (Minimum 25% Employer contribution required)	
STD is <input type="checkbox"/> in addition to, or <input type="checkbox"/> replacement of current STD coverage <input type="checkbox"/> no current STD carrier	
If replacement, give current carrier: _____ Termination date of prior plan: _____	
STD benefits are payable for non-occupational disabilities only.	STD benefits terminate at retirement.

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**The undersigned represents he/she is an Employer engaged in (groups with 2 to 9 employees must check ✓ one):**

Wholesale, Retail, or Distribution Business; or  Service Business; or  Manufacturing Business

**The Employer agrees to comply with all terms and provisions of the Group Life and/or Disability Contracts(s) issued, and trust agreements, if applicable, and also accepts enrollment under the FDL trust policy(ies), if applicable. The Employer further agrees to comply with the following requirements:**

1. For Life and STD, if coverage is contributory, a minimum of 75% of the eligible employees must enroll. If coverage is non-contributory, 100% of the eligible employees must enroll.
2. Group term life, for groups with less than ten (10) eligible employees, may be sold on a contributory basis, however, in no event may the contribution by the insured employee exceed forty cents (\$0.40) per thousand dollars of coverage per month.
3. STD may be sold on a contributory basis, however, the Employer must contribute a minimum of 25%. STD is available only if group term life and AD&D is selected.
4. Coverage for employees who are not actively at work, as defined in the policy, on the date their coverage would otherwise become effective will be deferred until the date they return to active work.
5. If life and AD&D benefits are selected by occupational class, there must be at least one eligible employee in each class, and no class may have a benefit greater than 2½ times the amount for the next lower class.
6. The Employer shall remit all required premium payments to FDL no later than the first day of each billing period. If the premium payments are not received by FDL, insurance for the Employer and all covered employees shall cease in accordance with the terms of the Policy.
7. The Employer shall provide eligibility and enrollment information, dates of employment, and all other data necessary for the efficient administration of the FDL Life and/or Disability Insurance Plan.
8. Coverage for the Employer may be amended from time to time, and the Employer's participation may be terminated with 31 days written notice by FDL in accordance with the terms of the Policy. FDL reserves the right to change premium rates for reasons including, but not limited to, change in benefit design or Policy terms, change of industry, utilization within the industry, or other factors bearing on the assumed risk.
9. FDL reserves the right to terminate the Employer's participation in the Life Insurance Plan if the Employer fails to maintain compliance with the requirements set forth herein.
10. Benefit amounts in excess of the guarantee issue and all late applications for contributory coverage are subject to satisfactory evidence of insurability. The Employer agrees not to collect any premium from employees on amounts for which satisfactory evidence of insurability is required until notified by FDL of the approval of the employee's application for coverage.

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**Employer: Do Not Cancel Current Coverage Until Notified By BCBSTX and/or FDL  
That This Application Has Been Approved.**

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**\*Additional Information:** Include list of affiliates, name of parent company(ies), COBRA and/or state continuation participants or state dependent continuation participants, anyone currently receiving Workers' Compensation benefits, and the names of any full-time employees NOT submitting an application/declination (give reason).

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**ELECTRONIC RECEIPT OF CERTIFICATE-BOOKLETS**

The Employer consents to receive an electronic file (E-file) version of the  medical,  prescription drug, and  dental certificate-booklets provided by BCBSTX for covered employees. In providing this consent, the Employer agrees to and/or understands that:

- (1) the E-file provided by BCBSTX is a certificate-booklet and is not intended to satisfy all ERISA compliance regulations as a summary plan description (SPD);
- (2) the Employer is aware of the basic requirements established by Department of Labor regulations governing electronic distribution of coverage documents to employees;
- (3) the Employer is solely responsible for providing each insured employee access to the most current version of any E-file certificate-booklet, amendment, or other revised form provided by BCBSTX, or to provide a paper copy of the same to an employee upon request or to an HMO subscriber who has not agreed to accept the certificate of coverage electronically;
- (4) the Employer will receive hard copy versions (paper copies) of all documents that, together, constitute the contract between the Employer and BCBSTX. This hard copy version and an exact copy held by BCBSTX are the legal documents used to administer the BCBSTX group benefits and provisions and will prevail in the event of any conflict between the paper copy and the electronic copy;
- (5) as modifications are made to existing forms or when new, revised forms are necessary, they will be received via an E-file and all provisions above will apply. The Employer will rely on BCBSTX instructions to determine if the file is a replacement or addition to existing documents and will provide the information to employees accordingly; and
- (6) the Employer is solely responsible and holds BCBSTX harmless from any misuse of the E-file provided by BCBSTX; and
- (7) the electronic transmission shall be in the format specified by BCBSTX, and if transmission errors occur, the Employer will contact BCBSTX immediately to request redirection of the information.

**Decline** – Employer does not consent to receive electronic versions of certificate-booklets for covered Employees and desires BCBSTX to print and distribute hard copy versions.

**Group Executive Initials:**

**DISCLOSURE STATEMENT**

(Only sign and complete this section if a Consumer Choice Plan was selected)

I acknowledge this Consumer Choice of Benefit Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization Health Care Plan (Plan), either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage (Certificate of Coverage) in Texas.

I am aware this Plan may provide more affordable health benefits, although, it may provide fewer health benefits than those normally included in policies or evidences of coverage (Certificate of Coverage) with state mandated health benefits in Texas.

**Excluded PPO State Mandates**

- 1. Chemical Dependency
- 2. Prescription Contraceptive Drugs and Devices and Related Drugs (Oral Contraceptives not excluded)
- 3. In-Vitro Fertilization
- 4. Serious Mental Illness (non-public entities only)
- 5. Speech and Hearing (limited benefit)
- 6. Home Health (limited benefit)

**Excluded HMO State Mandates**

- 1. Chemical Dependency
- 2. Prescription Contraceptive Drugs and Devices and Related Drugs (Oral Contraceptives not excluded)
- 3. In-Vitro Fertilization
- 4. Serious Mental Illness (non-public entities only)
- 5. Speech and Hearing

**Group Executive Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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Under the **Medicare Secondary Payer Rules**, it is your responsibility to annually inform BCBSTX of proper employee counts for the purpose of determining payment priority between Medicare and BCBSTX. **To satisfy this responsibility, BCBSTX will provide you with an Annual Medicare Secondary Payer Employer Acknowledgement Form. Upon receipt of this document, complete, sign, date, and return to BCBSTX.**

It is your responsibility to annually inform BCBSTX of whether **COBRA** is applicable to you based upon your full and part-time employee count in the prior calendar year. Failure to advise BCBSTX of a change of status could subject you to governmental sanctions.

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;
- Public school districts, and "church plans" as defined by the Internal Revenue Code.

I have read and understand this Employer's Application for Amendment and the agent, if any, named below is authorized to represent the Employer for any revisions made to the Health Benefit Plan and/or the Dental Benefit Plan and/or Group Life Insurance Plan.

The undersigned representative acknowledges that if any agent is acting on behalf of the Employer for purposes of purchasing Employer insurance, and that if BCBSTX/FDL accept this Small Group Employer Application for Amendment and issues a Group Contract/Policy to the Employer, BCBSTX/FDL may pay the agent a commission and/or other compensation in connection with the issuance of such Group Contract/Policy. The undersigned further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the agent by BCBSTX/FDL in connection with the issuance of a Group Contract/Policy, they should contact the agent.

All statements contained in the Employer's Application for Amendment and all information required to be furnished to BCBSTX/FDL are complete and true to the best of my knowledge and belief. I understand that BCBSTX/FDL will rely on the statements made and information furnished, as the basis in determining the appropriate rate level and/or approval of this Employer's Application for Amendment. I understand that no insurance or changes will become effective without approval of BCBSTX/FDL. The requested Contract(s)/ Policy(ies) effective date (as listed on page 1) is subject to change by BCBSTX/FDL if all required documents are not completed and received by the date requested.

\_\_\_\_\_  
**Signature of Authorized Company Official**

\_\_\_\_\_  
**City and State of Signing Official**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

Health No. \_\_\_\_\_  
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**TO BE COMPLETED BY AGENT(S) - PLEASE PRINT**

**Agent's Statement**

I have advised the Employer of its rights as a small group employer to purchase one of the Consumer Choice of Benefits Plans. I have also advised the Employer that I have no authority to bind these coverages, to alter the terms of the Contract(s)/Policy(ies), this Application for Amendment, or enrollment material in any manner or to adjust any claims for benefits under the Contract(s)/Policy(ies).

1. Agent or Agency Name\* (to whom commissions are to be paid): \_\_\_\_\_  
Percentage of Commission\*\* : \_\_\_\_\_  
Street, City, ZIP: \_\_\_\_\_  
Tax ID/SSN/Agent #: \_\_\_\_\_  
E-Mail address: \_\_\_\_\_  
FAX number: \_\_\_\_\_
  
2. Agent or Agency Name\* (to whom commissions are to be paid): \_\_\_\_\_  
Percentage of Commission\*\* : \_\_\_\_\_  
Street, City, ZIP: \_\_\_\_\_  
Tax ID/SSN/Agent #: \_\_\_\_\_  
E-Mail address: \_\_\_\_\_  
FAX number: \_\_\_\_\_

If a multiple location agency and the servicing agency is not the location listed in Item 1 or item 2, above, include location here: \_\_\_\_\_

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Agent's signature	Business Phone	Date	Appointed with BCBSTX/FDL
			<input type="checkbox"/> Yes <input type="checkbox"/> No

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BCBSTX or FDL Sales Representative	Title	Date
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**NOTE:**

\* The agent 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 to be split, please provide the information requested above on both agents or agencies. BOTH must be appointed to do business with BCBSTX and/or FDL.