



An Independent Licensee of the Blue Cross and Blue Shield Association

REQUESTED EFFECTIVE DATE (MM/DD/YYYY)

(NO RETROACTIVE CHANGES)

2-99 EMPLOYER APPLICATION Exhibit B

CHECK SECTIONS TO BE CHANGED: I II III

PLEASE FULLY COMPLETE ALL SECTIONS OF THIS APPLICATION EVEN WHERE SPECIFIC PROVISIONS REMAIN UNCHANGED.

NEW Change to existing group: GROUP #

SECTION I - EMPLOYER GROUP INFORMATION

LEGAL COMPANY NAME, DBA, ARIZONA LOCATION STREET ADDRESS, ARIZONA BILLING ADDRESS, COUNTY, FEDERAL TAX ID NUMBER, ARIZONA STATE TAX ID NUMBER, SUBSIDIARY OR AFFILIATE INFORMATION, HEADQUARTERS LOCATION - STREET ADDRESS, TYPE OF BUSINESS, EXECUTIVE NAME, GROUP ADMINISTRATOR

LEGAL ENTITY

SECTION II - PLAN INFORMATION - INDICATE HEALTH / DENTAL PLAN SELECTED

PPO OPTION(S), PPO HSA QUALIFIED OPTION(S), HMO OPTION(S), OTHER OPTION(S), BluePreferred Dental, Waived 12 month waiting period for Type III benefits?

SECTION III - UNDERWRITING, ENROLLMENT, ELIGIBILITY, MANAGEMENT CONTINUATION AND PARTICIPATION

DOES THE EMPLOYER OFFER AN ENROLLMENT PERIOD OF AT LEAST 31 DAYS?, 1) EMPLOYER AGREES TO CONTRIBUTE TO PREMIUM COST..., CLASS 1 DEFINITION, CLASS 2 DEFINITION, 2) EMPLOYEES ARE ELIGIBLE UPON COMPLETION..., 3) NEW GROUP ENROLLMENT REGULATIONS, 4) EMPLOYEE EFFECTIVE / TERMINATION DATE, 5) DOMESTIC PARTNERS TO BE COVERED?, 6) ELIGIBLE EMPLOYEES ARE DEFINED AS THOSE WORKING..., 7) TOTAL NUMBER OF EMPLOYEES, 8) BANKRUPTCY, 9) WORKER'S COMPENSATION, 10) HOW MANY PREVIOUS GROUP HEALTH CARRIERS HAS THE GROUP HAD IN THE LAST FIVE YEARS?, 11) LIST OTHER CO-EXISTING CARRIERS

1) NAME OF PERSON NOT COVERED: REASON NOT COVERED: 2) NAME OF PERSON NOT COVERED: REASON NOT COVERED:

SECTION IV - BROKER INFORMATION

LAST NAME, FIRST NAME, MI, AGENCY NAME, SUITE NO., STREET ADDRESS, CITY, STATE, ZIP + FOUR, PHONE NUMBER, FAX NUMBER, E-MAIL, BROKER TAX ID NUMBER, BCBS BROKER NUMBER, ARIZONA DEPARTMENT OF INSURANCE LICENSE NUMBER

SECTION V - THIS SECTION APPLIES ONLY TO GROUPS OF 26 OR MORE ELIGIBLE EMPLOYEES

PLEASE COMPLETE THE FOLLOWING QUESTIONS WHEN APPLYING FOR NEW GROUP COVERAGE TO THE BEST OF YOUR KNOWLEDGE. THIS INFORMATION IS NECESSARY TO EVALUATE YOUR GROUP'S APPLICATION BY BLUE CROSS BLUE SHIELD OF ARIZONA. IN ORDER TO PROTECT THE INDIVIDUALS INVOLVED, DO NOT DISCLOSE THE NAME OF ANY EMPLOYEE OR DEPENDENT.

Are you aware of any employee, dependent, or COBRA employee who:

- a) is currently disabled? _____ YES NO
- b) incurred expenses of \$5,000 or more in the last 18 months? _____ YES NO
- c) has been advised that necessary surgery or hospitalization is required (including pregnancy)? _____ YES NO
- d) has had an organ transplant such as kidney, liver, heart or lung? _____ YES NO
- e) is currently being treated or diagnosed as having cancer, heart/lung disease, high blood pressure, diabetes, muscular skeletal condition? _____ YES NO
- f) is currently taking medication? _____ YES NO
- g) has been diagnosed or is being treated for any other known medical condition? _____ YES NO
- h) has any other known medical conditions? _____ YES NO

If yes to any of the questions above, please explain: _____

SECTION VI - RETIREE COVERAGE IS ONLY AVAILABLE AS SPECIFIED IN THE BCBSAZ UNDERWRITING GUIDELINES.

| | | | | |
|----------------------------|--|---|---|---|
| RETIREE ELIGIBILITY | RETIREES TO BE COVERED? <input type="radio"/> YES <input type="radio"/> NO | IF YES: <input type="radio"/> UNDER 65 <input type="radio"/> 65 AND OLDER | RETIREES DEPENDENTS TO BE COVERED? <input type="radio"/> YES <input type="radio"/> NO | OTHER THAN NEWBORNS, ETC. FOR WHICH COVERAGE MAY BE MANDATED UNDER APPLICABLE ARIZONA LAW |
|----------------------------|--|---|---|---|

RETIREE PARTICIPATION REQUIREMENTS

A) RETIREE MUST COMPLETE _____ YEARS OF SERVICE PRIOR TO RETIREMENT | B) RETIREE IS ELIGIBLE FOR COVERAGE ONLY THROUGH END OF BILLING PERIOD IN WHICH RETIREE REACHES AGE

C) OTHER: _____

SECTION VII - IMPORTANT - READ CAREFULLY

As the authorized representative of Company, I certify that the Company is the sole employer of the employees to be enrolled under this proposed contract for health insurance. I also certify that the information provided on this 2-99 Employer Application and all other applicable documents submitted in connection with this Application, is complete and accurate. I agree that Company shall promptly notify Blue Cross Blue Shield of Arizona (BCBSAZ) of any changes in this information that may affect the eligibility of employees or their dependents, including the hire date of any new eligible employees, addition of dependents, and the termination date of any enrolled employee or dependent. I understand and agree that BCBSAZ may, in its sole discretion, verify Health/Medical and all other information with or through outside sources, including third party investigative firms, as BCBSAZ deems necessary or appropriate for finalizing its decision on this Application. I agree that if the information (including medical information) contained in this Application or other supporting documentation is incomplete, inaccurate, materially misleading, false, or fraudulent, that BCBSAZ has the right to (a) retroactively adjust the Company's rates if such information would have affected the rate calculation; and (b) invalidate, or withdraw any rate proposal or terminate any group, to the extent permitted by law.

I understand and agree that this Application is not accepted until approved by BCBSAZ and that BCBSAZ's acceptance shall be based on information supplied by the group, the requested benefits, and any other information obtained from outside sources which BCBSAZ deems appropriate. BCBSAZ's acceptance shall be evidenced by the execution of this Application by an authorized representative of BCBSAZ, at which time this Application shall become binding upon BCBSAZ and the group. Upon acceptance, this Application shall be attached to and shall become a part of the Group Master Contract (the "Contract"). To the extent permitted by applicable law, BCBSAZ may terminate the Contract in accordance with the Contract terms, including the Group's failure to meet certain obligations under the Contract, such as failure to pay premium; failure to maintain Group contribution rates and percentages; and failure to maintain employee and/or dependent participation levels.

The Company agrees that it is solely responsible for ensuring that its classifications of employees for purposes of defining eligibility for benefits and the specific benefits available comply with applicable laws, including those which prohibit discrimination based upon salary. Company understands and agrees that federal law requires Company to provide dependent coverage for children under age 26, and prohibits Company from imposing pre-existing condition waiting periods for children under age 19.

By including my e-mail address on the reverse side, I authorize BCBSAZ to send me information via e-mail. I also understand I may change my e-mail address or rescind this permission at any time by contacting BCBSAZ through azblue.com.

Company Authorized Officer / Owner / Partner

X _____
SIGNATURE DATE

_____ TITLE LOCATION (CITY, STATE)

X _____
BCBSAZ Authorized Signature: DATE TITLE

To be completed by BCBSAZ
Team Code _____
GROUP # _____