BlueCross BlueShield of Texas

DocuSign Reference Guide:

Obtain Paperwork via DocuSign and Import Data into the ACA Enrollment Tool

July 2019

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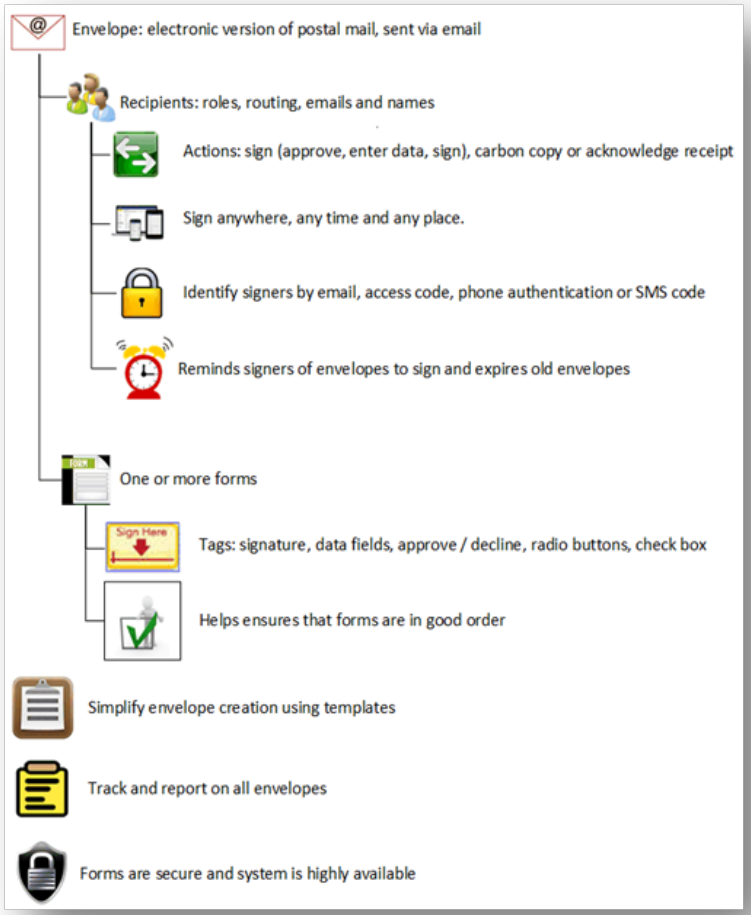
Before You Start

- Chrome is the preferred browser for DocuSign.
  - Internet Explorer 11 and higher can be used.
    - Internet Explorer10 and prior versions are not supported by DocuSign.
- For DocuSign Import to be successful:
  - The Enrollment Package, with the **Sign Now** link on Blue Access for Producers℠ should be used.
  - Entire Producer ID Number, including leading zeros, should be entered on the BPA
  - DocuSign Envelopes will need to be reviewed, completed and signed by all parties.
  - Import will fail if Print & Sign option is used in DocuSign by any one of the parties/signers.

DocuSign Concepts and Terminologies



- **Envelope** - A DocuSign envelope is a container, used in sending one or more documents to recipient(s) for signature using the DocuSign system. Each document has multiple pages.
- **Tag** - A DocuSign tag is an interactive field. Tags can be placed on a document to indicate required fields or actions; a tag can prompt a signer to enter specific information, or initial in a particular location. Placing tags on a document guides the signer through the signing experience.
- **Reminder** – A reminder is an email notification sent to signer(s) automatically by the system. When reminders are enabled, you specify when and how often to send email notifications.
- **Expirations** - By default, all envelopes that are in process will expire if the recipient(s) does not complete the envelope. Expiration is configured by HCSC. When a document expires, the status changes to Voided and it can no longer be viewed or signed by recipients.
- **Template** – A DocuSign Template is a standard document, with set recipient roles, signing tabs and information fields. Templates can also contain the signing instructions for the document and any signature attachments. Templates help streamline the sending process when you frequently send the same or similar documents.
- **PowerForm** – Referred to as Web PowerForm, utilizes DocuSign Template and can be distributed via email or the web with a unique, secure URL automatically generated by the DocuSign system.

Overview of the DocuSign (DS) Paperwork and Importing into the ACA Enrollment Tool Process

Agent/Producer

- From BAP the GA or the Producer, clicks “sign now” link for the Enrollment Package.
- Completes the PowerForm .
- Fills out information on the DS paperwork.
- Clicks Finish to send the DS paperwork to the Group to sign.

Group Contact

- Group contact receives DS email.
- Verifies/fills out the DS paperwork.
- Attaches any artifacts if applicable.
- Completes signing.

Producer

- Producer receives DocuSign paperwork after the Group contact signs.
- Verifies the filled out paperwork.
- Completes required Producer statement.
- Completes signing.
- DS Envelope will be “completed” at this point (if not working with a GA).

GA (Optional)

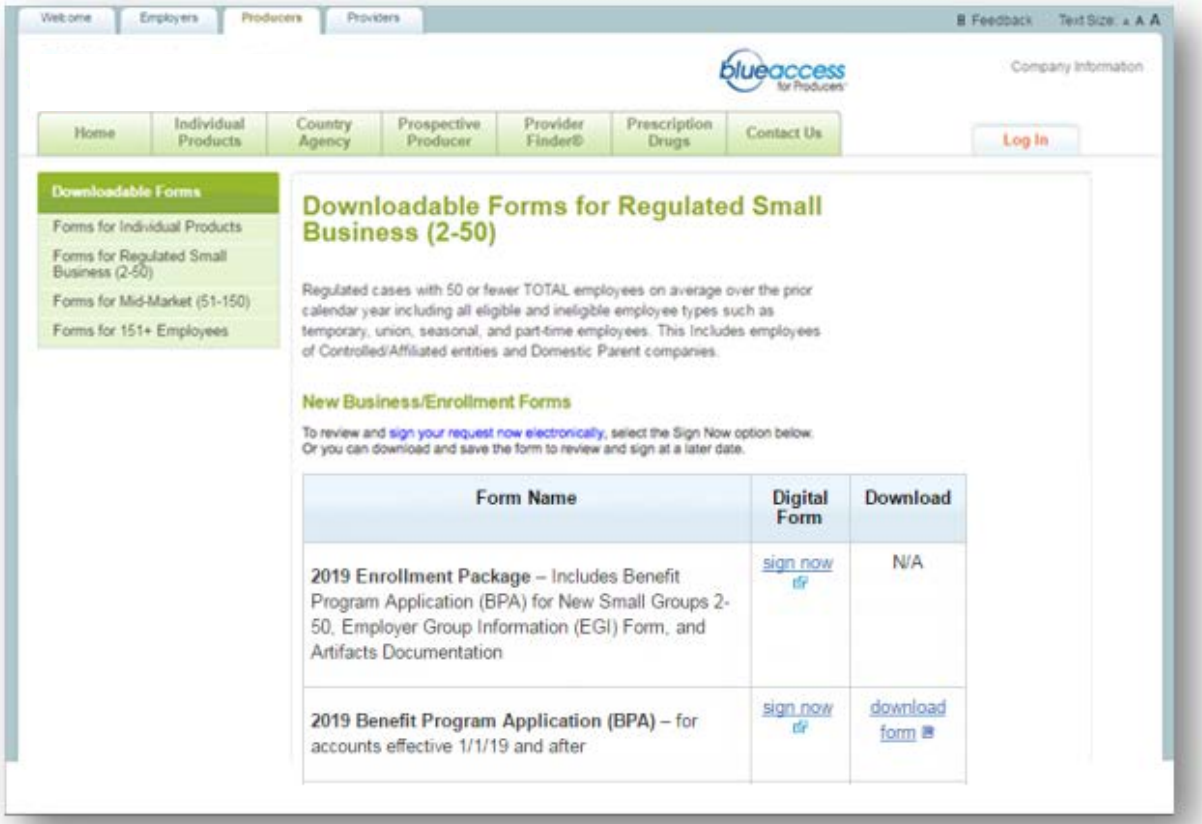
- GA receives DS paperwork after the Producer signs .
- Verifies the DS paperwork.
- Clicks Finish to complete the DS Envelope.
- DS Envelope will be “completed” at this point

Import DS Data Into ACA Enrollment Tool

- Once DS Envelope is completed, DS Envelope ID can be used to import data into the ACA Enrollment Tool.
- DS Data will automatically transfer into ACA Enrollment Tool per mapping.
- DS PDFs will need to be manually attached in ACA Enrollment Tool as these will not be transferred automatically during import.

Accessing and Completing the DocuSign Paperwork

Accessing the PowerForms

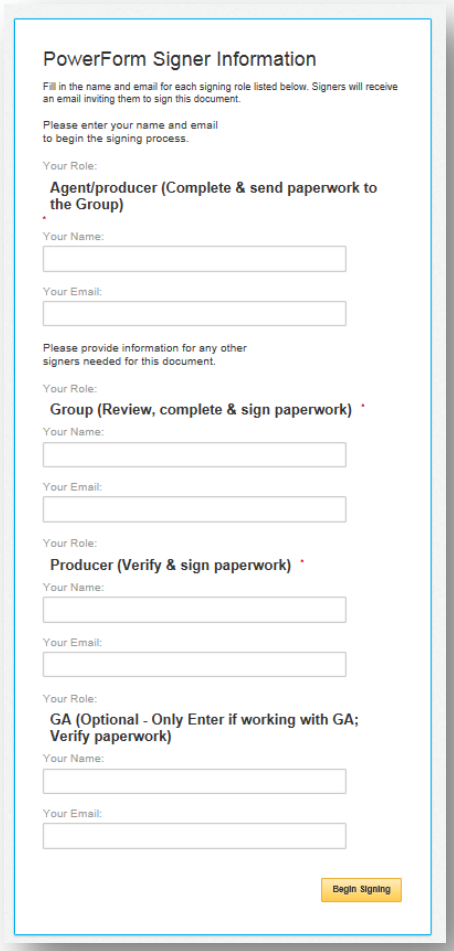


Accessing the PowerForm

Within the Downloadable Forms on Blue Access for Producers Portal, locate the Enrollment Package.

To electronically complete and sign the form, select **Sign Now** digital link.

Accessing the PowerForms


PowerForm Signer Information

Fill in the name and email for each signing role listed below. Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Your Role:

Agent/producer (Complete & send paperwork to the Group) *

Your Name:

Your Email:

Please provide information for any other signers needed for this document.

Your Role:

Group (Review, complete & sign paperwork) *

Your Name:

Your Email:

Your Role:

Producer (Verify & sign paperwork) *

Your Name:

Your Email:

Your Role:

GA (Optional - Only Enter if working with GA; Verify paperwork)

Your Name:

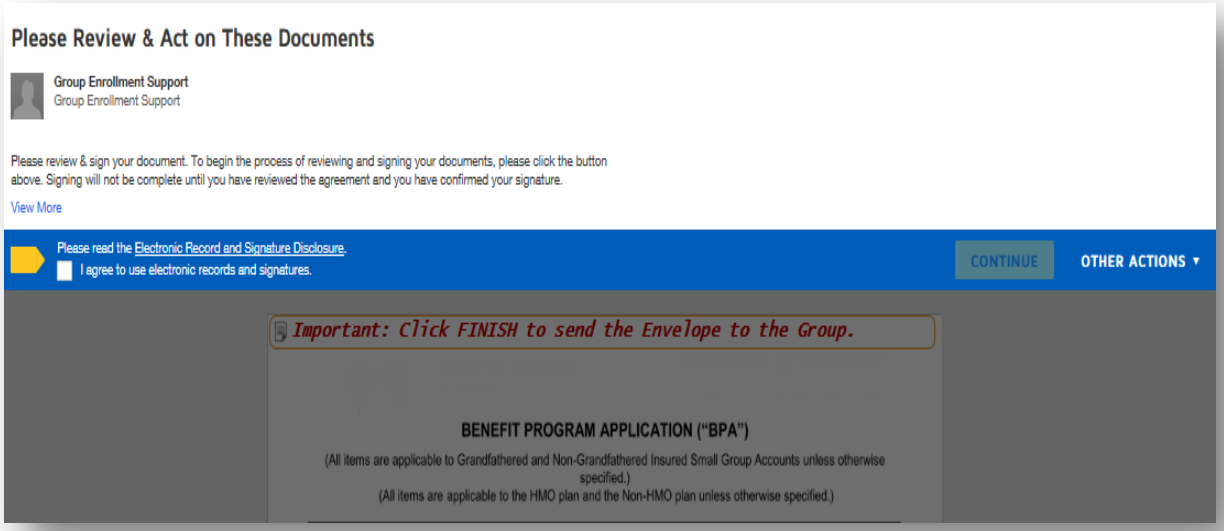
Your Email:

Begin Signing

➢ Entering Recipient's Information

- Enter the full name and e-mail address of the recipient(s) of the envelope.
  - Verify that the typed in e-mail addresses are correct before proceeding.
- Click **Begin Signing** to access the DocuSign Paperwork.

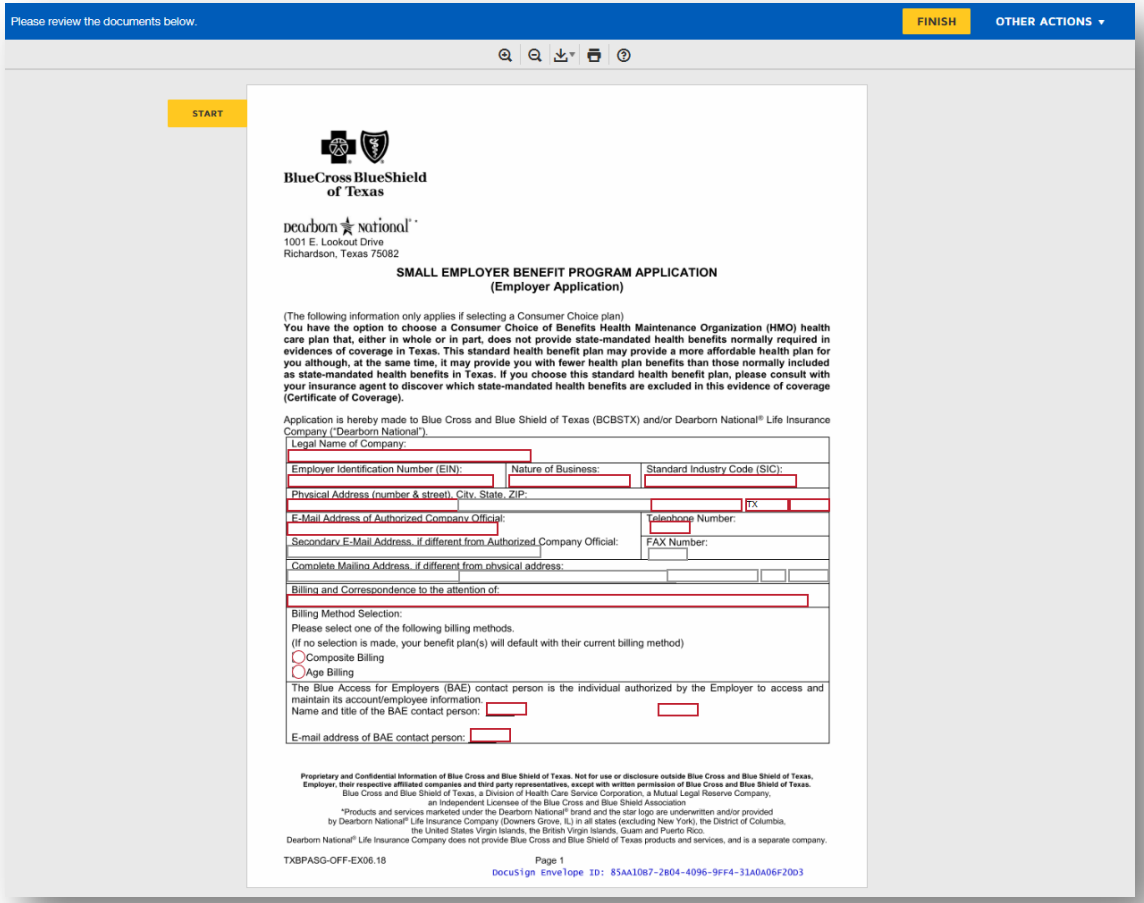
Accessing the PowerForms



➢ Agree to Electronically Sign

- Review and agree to the **Electronic Records and Signature Disclosure.**
- Select **CONTINUE** to start the signing process.

Completing the PowerForm – Agent/Producer

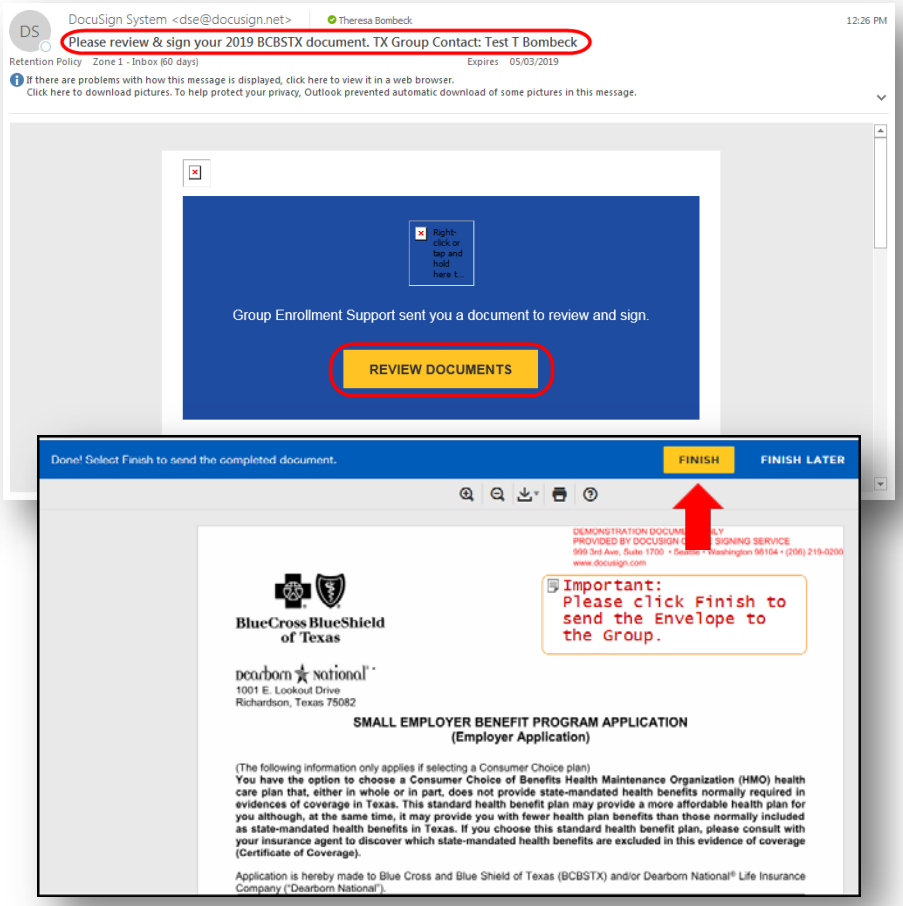


➢ PowerForm Completion

- The Agent/Producer has the ability to fill out as much of the paperwork as they wish or they can send the DocuSign Envelope to the Group for completion.
- Select **FINISH** to complete the form and send the DocuSign paperwork to the Group.

Note: If **FINISH** button is not clicked and "X" is clicked to close then the DocuSign paperwork will not move forward to the Group and a new PowerForm will need to be submitted again.

Complete and Sign DocuSign Envelope - Group



➢ Complete & Sign DocuSign Paperwork

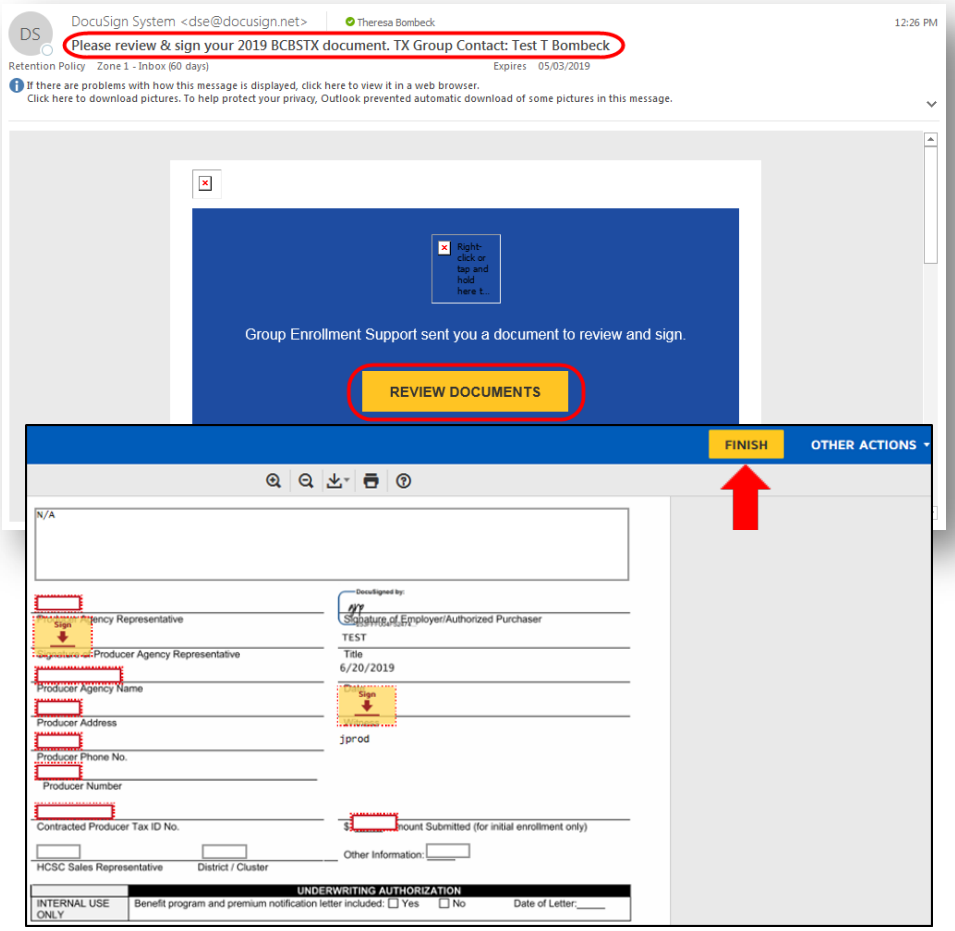
- When DocuSign e-mail is received from DocuSign, click on **REVIEW DOCUMENTS** to display DocuSign Documents.
- Complete filling out information.
  - Note: Required fields are bordered in RED.
- Click **FINISH** to complete signing and to send the paperwork onto the Producer.

Important:

- Within the **OTHER ACTIONS** button, the Group can select **Finish Later** to save entered information and return at a later time.
- Additionally, if the DocuSign envelope is no longer needed, the Group can **Decline to Sign**.

Note: The **REVIEW DOCUMENTS** link will expire within 48 hours or five clicks and a new DocuSign email with a new link will be systematically sent by DocuSign.

Complete and Sign DocuSign Envelope - Producer

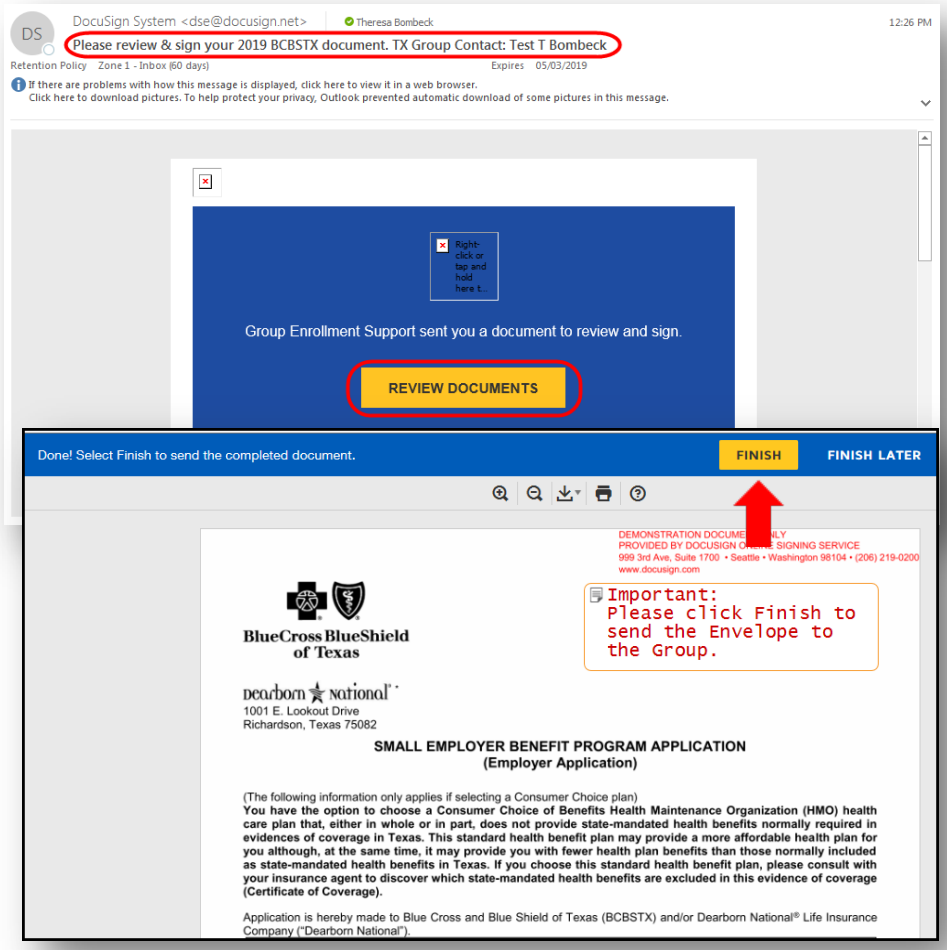


➢ Complete & Sign DocuSign Paperwork

- After the Group contact completes and signs the DocuSign paperwork, the Producer receives the DocuSign Envelope for review, via e-mail.
- Clicks **Review Documents** to access documents.
  - Verifies and completes the Producer Statement.

    Important: When entering the Producer Number please confirm that it is identical to the Producer Number used to login to the ACA Enrollment Tool, including any leading zeros.
  - The Producer has the option to **Finish Later** by clicking the **OTHER ACTIONS** dropdown.
    - To return to the documents to complete, the Producer will open the DocuSign e-mail and click **REVIEW DOCUMENTS.**
- Producer clicks **FINISH** when they have completed reviewing and signing.
- If the Producer is working with a General Agent (GA), the DocuSign Envelope will go to the GA. If there is no GA, the DocuSign Envelope will be completed at this time.

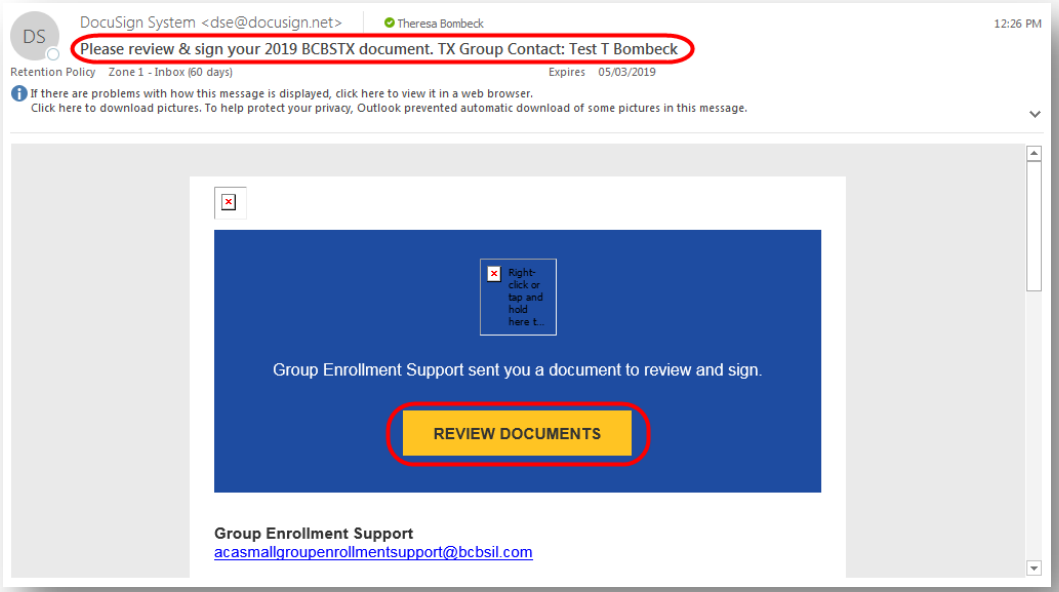
Complete and Sign DocuSign Envelope – General Agent

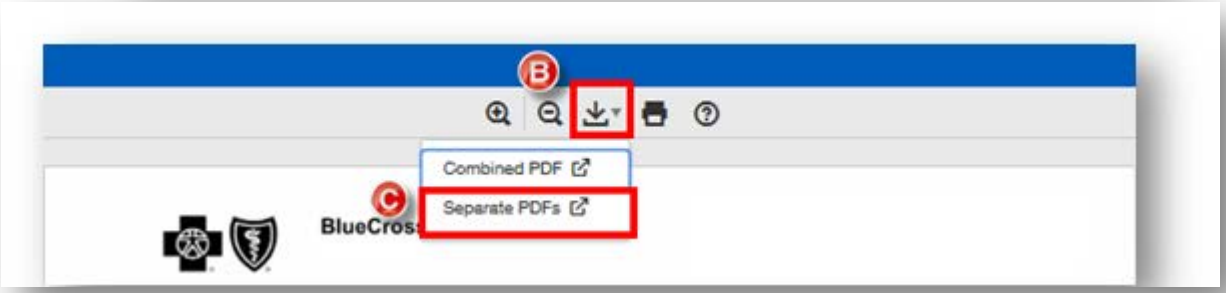


➢ Complete & Sign DocuSign Paperwork

- If there is a GA involved, they will receive the DocuSign Envelope after the Producer has reviewed and signed.
- Clicks **REVIEW DOCUMENTS** in the DocuSign e-mail to access documents.
- Verifies and completes the DocuSign Envelope by clicking **FINISH**.
- The DocuSign Envelope is completed at this point. The DocuSign data is locked in and cannot be edited.
    - The DocuSign system sends "Completed" e-mail to all signers.

Downloading the DocuSign Documents

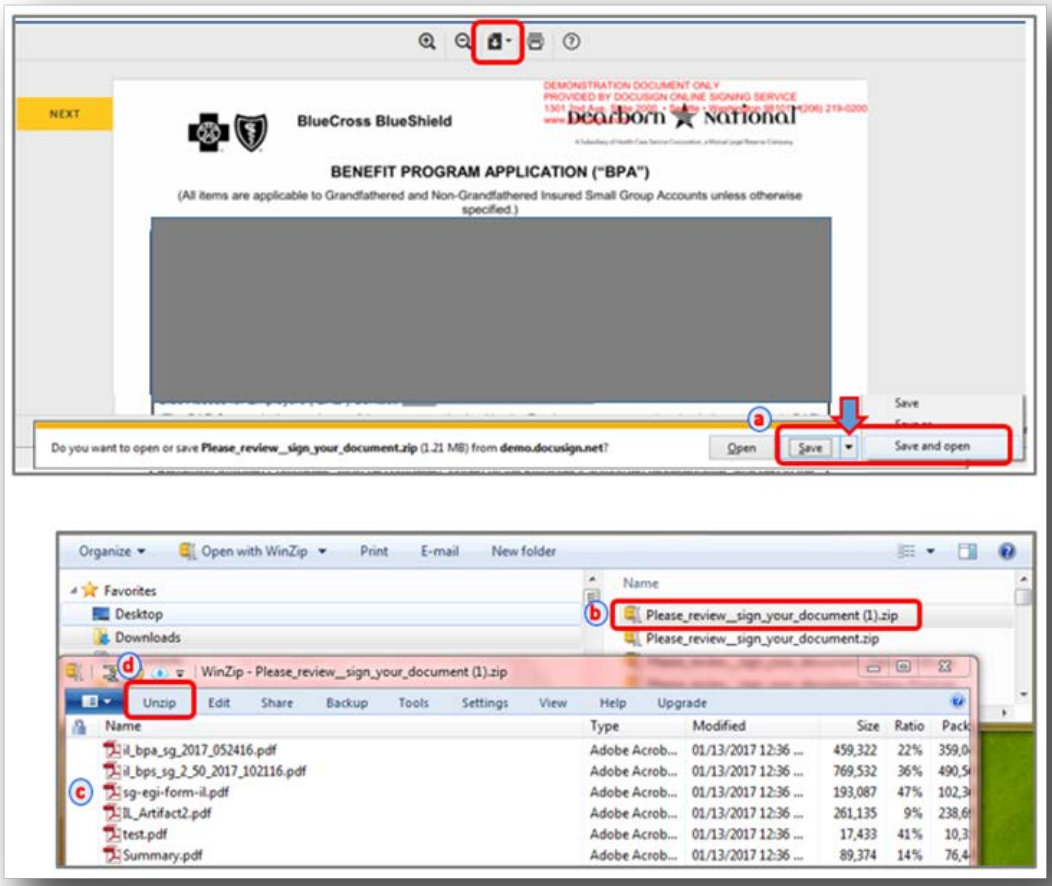




➢ Download Completed and Signed DocuSign Document

- When completed e-mail is received from DocuSign, click on **REVIEW DOCUMENTS** to display DocuSign Documents.
- From the DocuSign Document click the down arrow icon ( ), to download PDFs.
- Select 'Separate PDFs' so that each individual PDF can be attached in the Enrollment Tool.

Downloading the DocuSign Documents

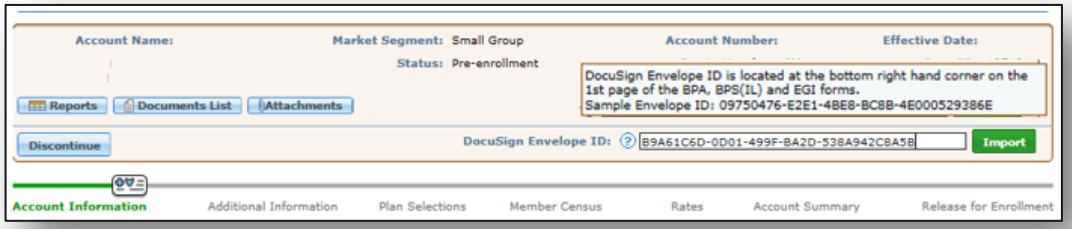


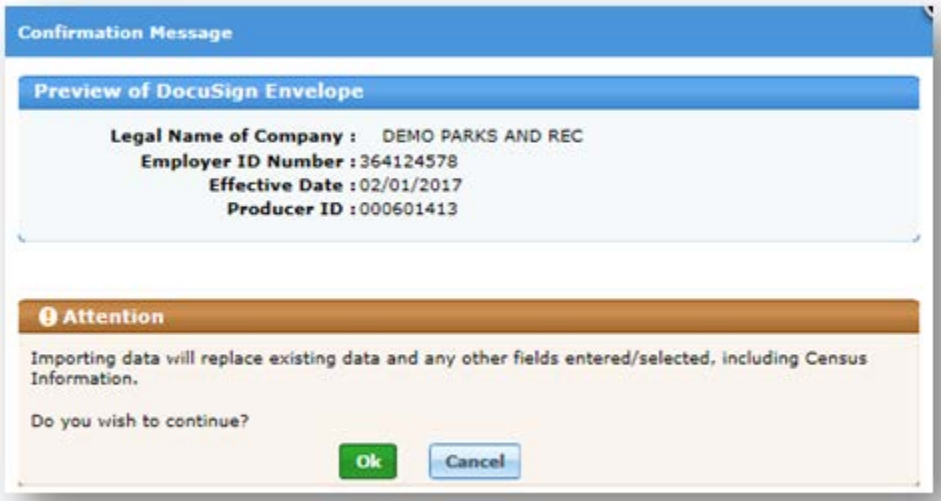
➢ Download Completed and Signed DocuSign Document

- Click on the down arrow, by the **Save** button and select **Save and Open** from the dropdown list.
- The DocuSign Documents download as a zip file.
- The File Manager displays the PDFs within the downloaded zip file.
- Unzip the downloaded zip file and save in an existing folder or create a new folder and then save the document.

Importing DocuSign Data into the ACA Enrollment Tool

Importing Data into the ACA Enrollment Tool



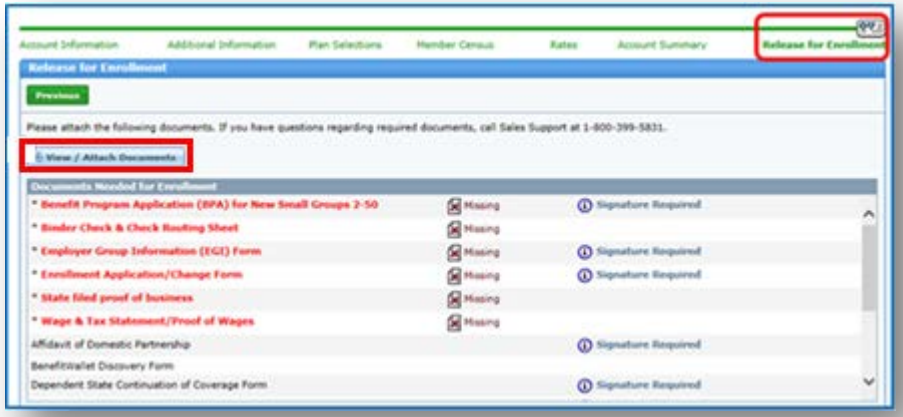


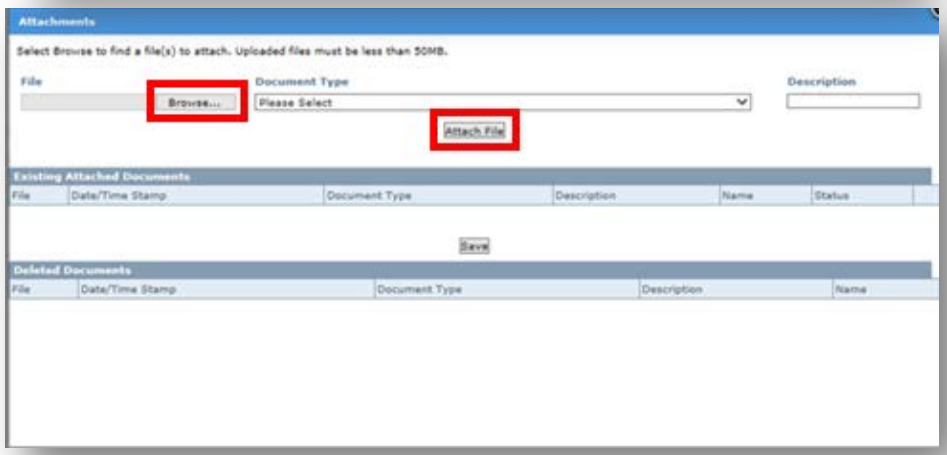
In the ACA Enrollment Tool use the **completed and signed** DocuSign Envelope to import the DocuSign data.

- In the ACA Enrollment Tool, on the **Account Information** page, the DocuSign Envelope ID should be placed within the **DocuSign Envelope ID** field.
  - DocuSign Envelope ID can be located on the bottom right hand corner of the BPA.
- Once the DocuSign Envelope has been copied and pasted into this field, proceed by clicking the **Import** button.
- A confirmation message will display, with *Preview of DocuSign Envelope*.
- Click the **Ok** button to proceed with importing the DocuSign data.
- DocuSign data auto populates into the appropriate fields.
- Verify the imported data.
- Complete fields that do not auto populate.

Attaching the DocuSign PDFs into the ACA Enrollment Tool

Attaching DocuSign Documents into the ACA Enrollment Tool





- Within the *Release for Enrollment* activity of the ACA Enrollment Tool, click the **View/Attach** Documents button.
- The **Attachments** popup box displays. Proceed by clicking the **Browse…** button to locate and select the DocuSign PDFs to be attached.
- Once a document has been selected, select the appropriate **Document Type** from the dropdown and click **Attach File**.

Submitting Changes After the DocuSign Data has been Imported

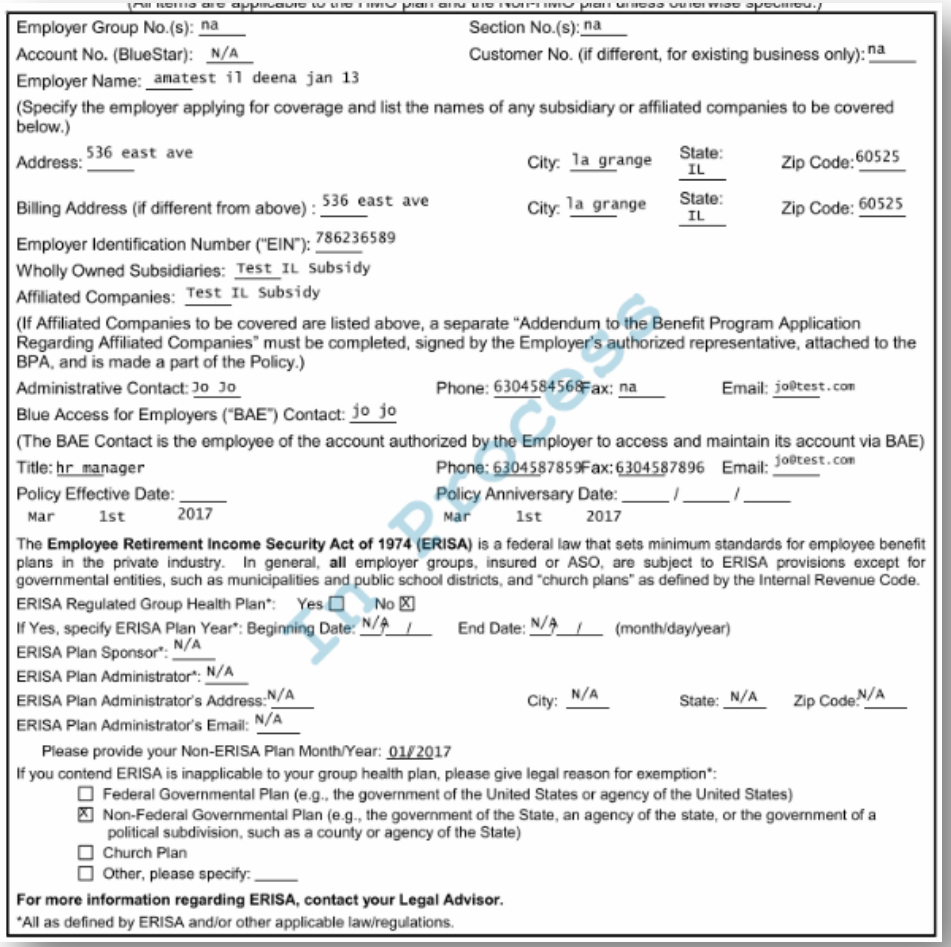
Submitting Changes after the DocuSign Data has been Imported into the ACA Enrollment Tool

Important:

- DocuSign Import feature *should not be used for importing data a second time*, doing so will **wipe out** all existing data, including the following:
  - DocuSign Data that was imported the first time.
  - Any information that was manually entered or selected.
  - Census Information
- Minor changes can be made manually within the ACA Enrollment Tool, as needed. In addition, any revised completed and signed DocuSign documents can be attached within the ACA Enrollment Tool.
- For any major changes a new DocuSign Envelope can be initiated, however this will require all DocuSign steps and signing to be completed again.

DocuSign Features

“In Process” DocuSign Document



(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Group No.(s): na Section No.(s): na

Account No. (BlueStar): N/A Customer No. (if different, for existing business only): na

Employer Name: amatest il deena jan 13

(Specify the employer applying for coverage and list the names of any subsidiary or affiliated companies to be covered below.)

Address: 536 east ave City: la grange State: IL Zip Code: 60525

Billing Address (if different from above): 536 east ave City: la grange State: IL Zip Code: 60525

Employer Identification Number (“EIN”): 786236589

Wholly Owned Subsidiaries: Test IL Subsidy

Affiliated Companies: Test IL Subsidy

(If Affiliated Companies to be covered are listed above, a separate “Addendum to the Benefit Program Application Regarding Affiliated Companies” must be completed, signed by the Employer’s authorized representative, attached to the BPA, and is made a part of the Policy.)

Administrative Contact: Jo Jo Phone: 6304584568 Fax: na Email: jo@test.com

Blue Access for Employers (“BAE”) Contact: jo jo

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE)

Title: hr manager Phone: 6304587859 Fax: 6304587896 Email: jo@test.com

Policy Effective Date: Mar 1st 2017 Policy Anniversary Date: Mar 1st 2017

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, specify ERISA Plan Year*: Beginning Date: N/A / / End Date: N/A / / (month/day/year)

ERISA Plan Sponsor*: N/A

ERISA Plan Administrator*: N/A

ERISA Plan Administrator’s Address: N/A City: N/A State: N/A Zip Code: N/A

ERISA Plan Administrator’s Email: N/A

Please provide your Non-ERISA Plan Month/Year: 01/2017

If you contend ERISA is inapplicable to your group health plan, please give 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: _____

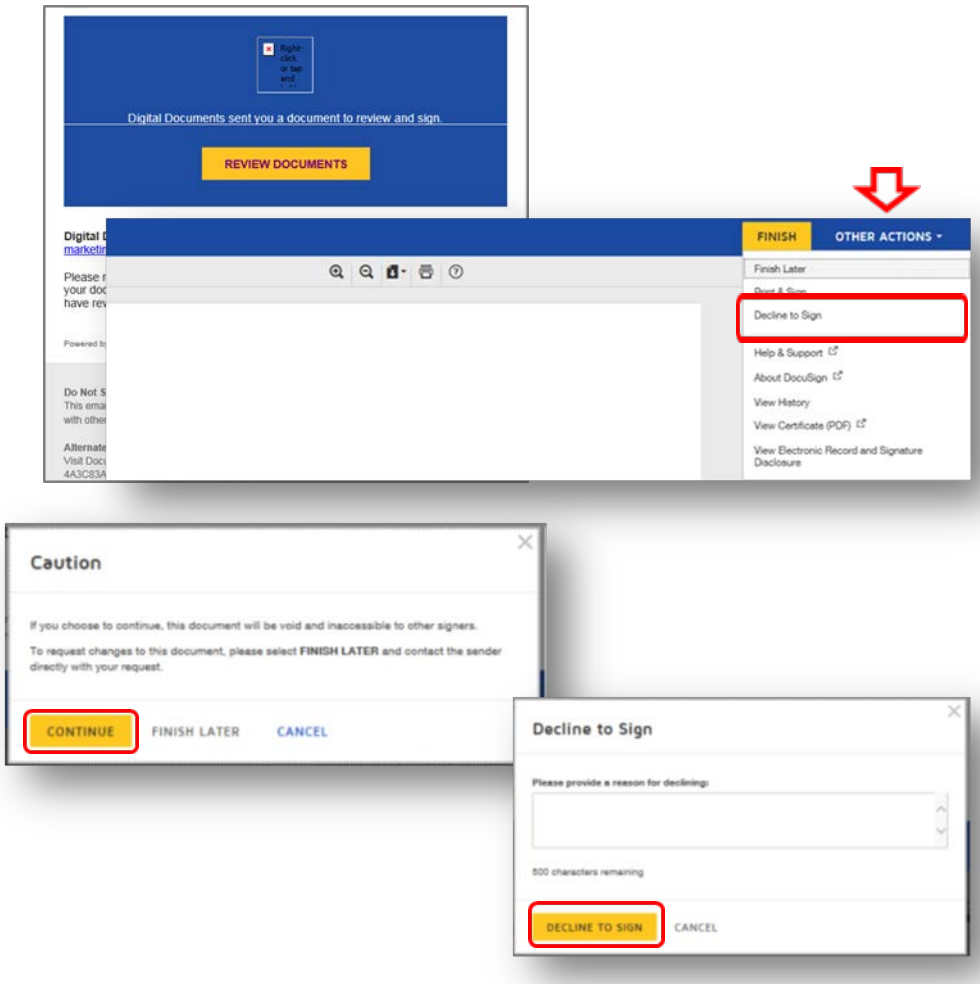
For more information regarding ERISA, contact your Legal Advisor.

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

➢ “In Process” – DocuSign Document

- In case a DocuSign PDF is downloaded, prior to being completed and signed, there will be an “**In Process**” watermark displayed, diagonally on the center of the page.
- “**In Process**” DocuSign PDFs should not be attached in the Enrollment Tool.
- The “**In Process**” watermark will not display on signed and completed DocuSign PDFs.

Signing Option “Decline to Sign”

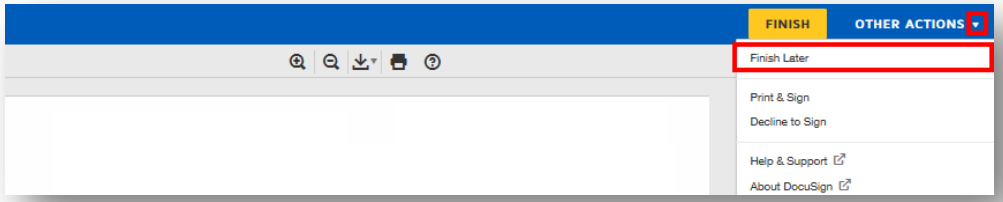


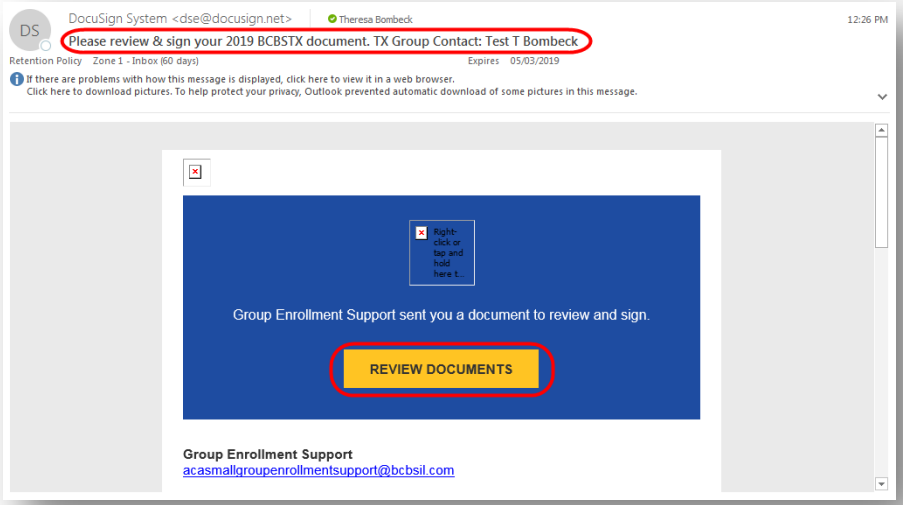
➢ Decline to Sign

If a DocuSign document no longer needs to be completed and signed, user should select the ‘Decline to Sign’ option, from the dropdown.

- Reopen the document from the DocuSign e-mail by clicking on **REVIEW DOCUMENTS.**
- Click the **OTHER ACTTONS** dropdown.
- Select **DECLINE TO SIGN.**
- A ‘Caution’ message will display, proceed by clicking on **CONTINUE.**
- ‘Decline to Sign’ message displays, with text box. User should explain reason for declining to sign the document, in the text box.
- Finally click **DECLINE TO SIGN.**

Signing Option “Finish Later”





➢ Finish Later

- Click on the **OTHER ACTIONS** dropdown.
- Select **Finish Later** to save the document and complete the form, at a later time.
- Reopen the document from the DocuSign e-mail, by clicking on the **REVIEW DOCUMENTS** BUTTON.
- Continue completing and signing the document.

Note: DocuSign system will send a reminder e-mail if the envelope is incomplete. Envelope will be systematically voided if not signed by all parties within 30 days.

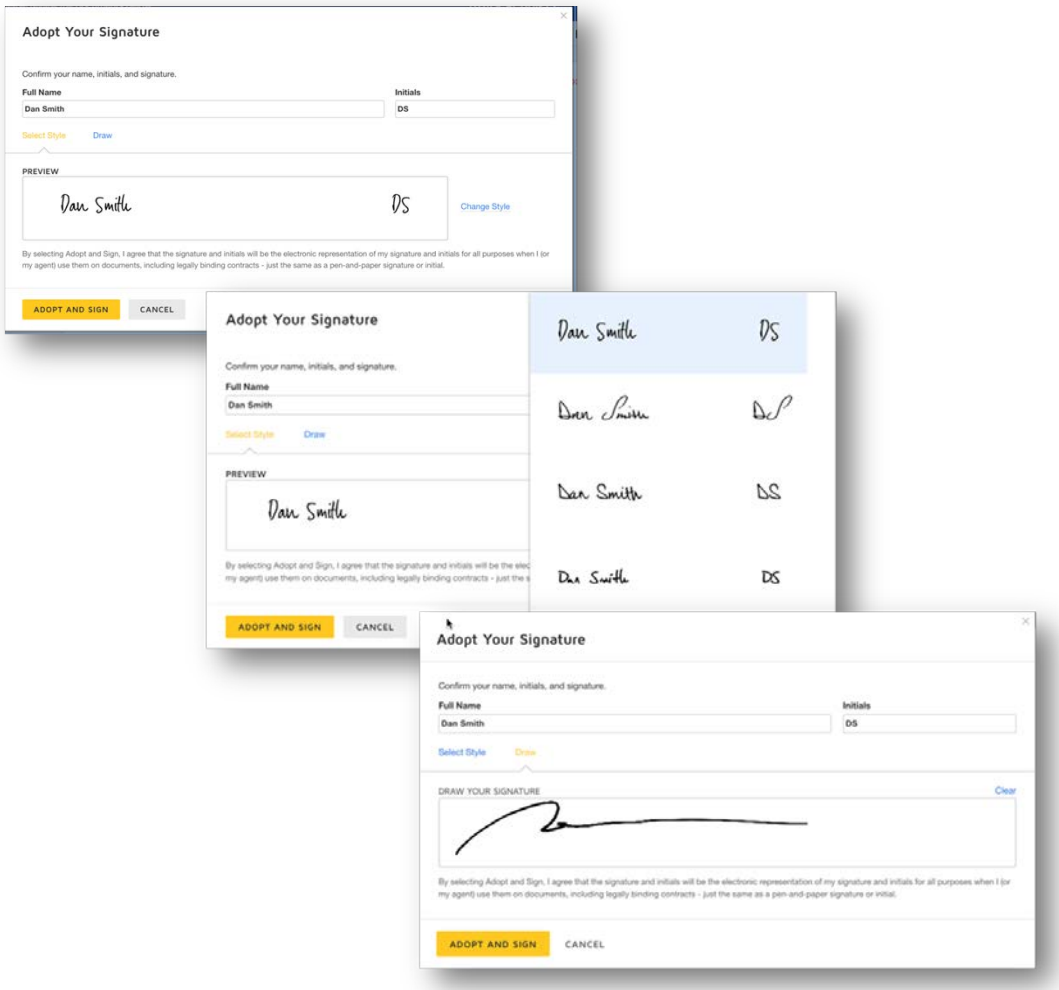
Review Documents Link in DocuSign E-mail Expires

Review Documents URL link in DocuSign email expires after 5 clicks or 48 hours from the time the email is sent. DocuSign system will automatically send a new email with a new link.

- Within the DocuSign e-mail, click **REVIEW DOCUMENTS**.
- If the Review Documents URL link has expired, a message will display.
- To request a new link, click the **SEND NEW LINK** button within the message.
- DocuSign system will generate a new e-mail with a new **REVIEW DOCUMENTS** link.

Note: Always use the most current DocuSign e-mail to access the DocuSign paperwork.

Adopt a Signature



➢ Adopting Your Signature

- After Selecting the **SIGN** tag, signer will be presented with an "Adopt Your Signature" pop-up window, to adopt a signature.
- Select the **ADOPT AND SIGN** button, to adopt and save your signature information

➢ Selecting Signature Style

- Select **Style Type** to select from pre-defined signature layouts.
- Select **ADOPT AND SIGN** to adopt the signature style.

➢ Drawing Your Signature

- Select **Draw** to draw your desired signature in the box.
- Select **ADOPT AND SIGN** to adopt the drawn signature.

Reporting Issues

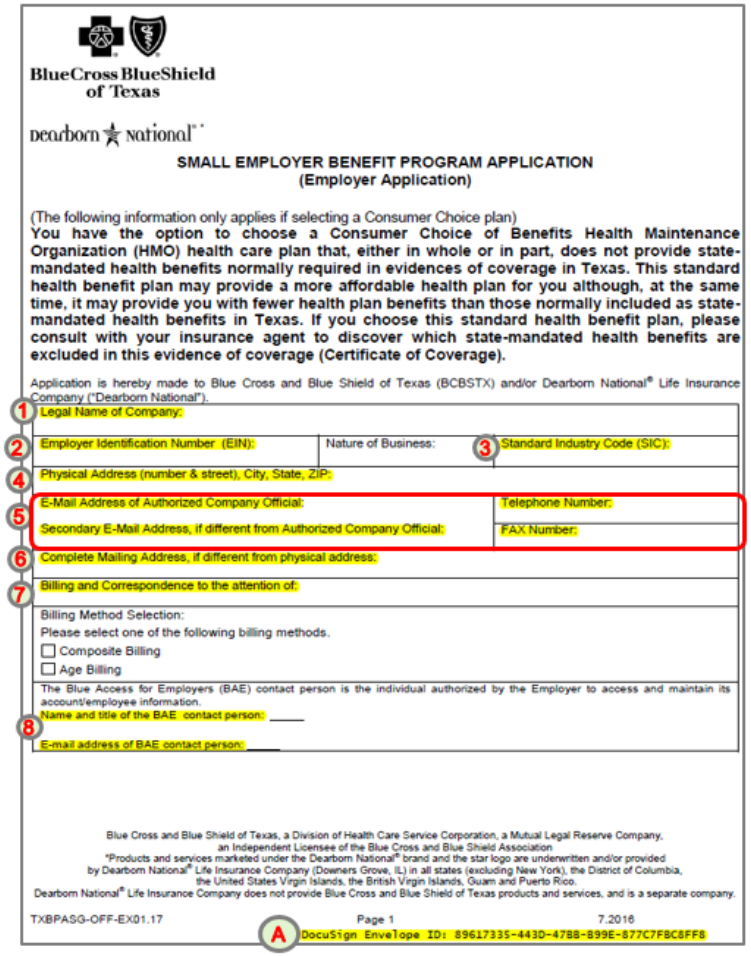
Reporting Issues

- For technical issues with the ACA Enrollment Tool, please contact our ITG Service Center at 888-706-0583

- If there are any questions regarding any of the information within the User Manual or the DocuSign Data Import process, Please feel free to email us at ACASmallGroupEnrollmentSupport@bcbsil.com.
  - Within the e-mail please include the following:
    - **DocuSign Data Import** on the subject line.
    - **DocuSign Envelope ID** in the body of the e-mail.
    - **Screenshot** (If possible and applicable)

Appendix

TX BPA Page 1



BlueCross BlueShield of Texas

dearborn national

SMALL EMPLOYER BENEFIT PROGRAM APPLICATION
(Employer Application)

(The following information only applies if selecting a Consumer Choice plan)
You have the option to choose a Consumer Choice of Benefits Health Maintenance Organization (HMO) health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits 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 evidence of coverage (Certificate of Coverage).

Application is hereby made to Blue Cross and Blue Shield of Texas (BCBSTX) and/or Dearborn National® Life Insurance Company ("Dearborn National").

1 Legal Name of Company:

2 Employer Identification Number (EIN): | Nature of Business: | 3 Standard Industry Code (SIC):

4 Physical Address (number & street), City, State, ZIP:

5 E-Mail Address of Authorized Company Official: | Telephone Number:
Secondary E-Mail Address, if different from Authorized Company Official: | FAX Number:

6 Complete Mailing Address, if different from physical address:

7 Billing and Correspondence to the attention of:

Billing Method Selection:
Please select one of the following billing methods.
☐ Composite Billing
☐ Age Billing

The Blue Access for Employers (BAE) contact person is the individual authorized by the Employer to access and maintain its account/employee information.

8 Name and title of the BAE contact person: ____

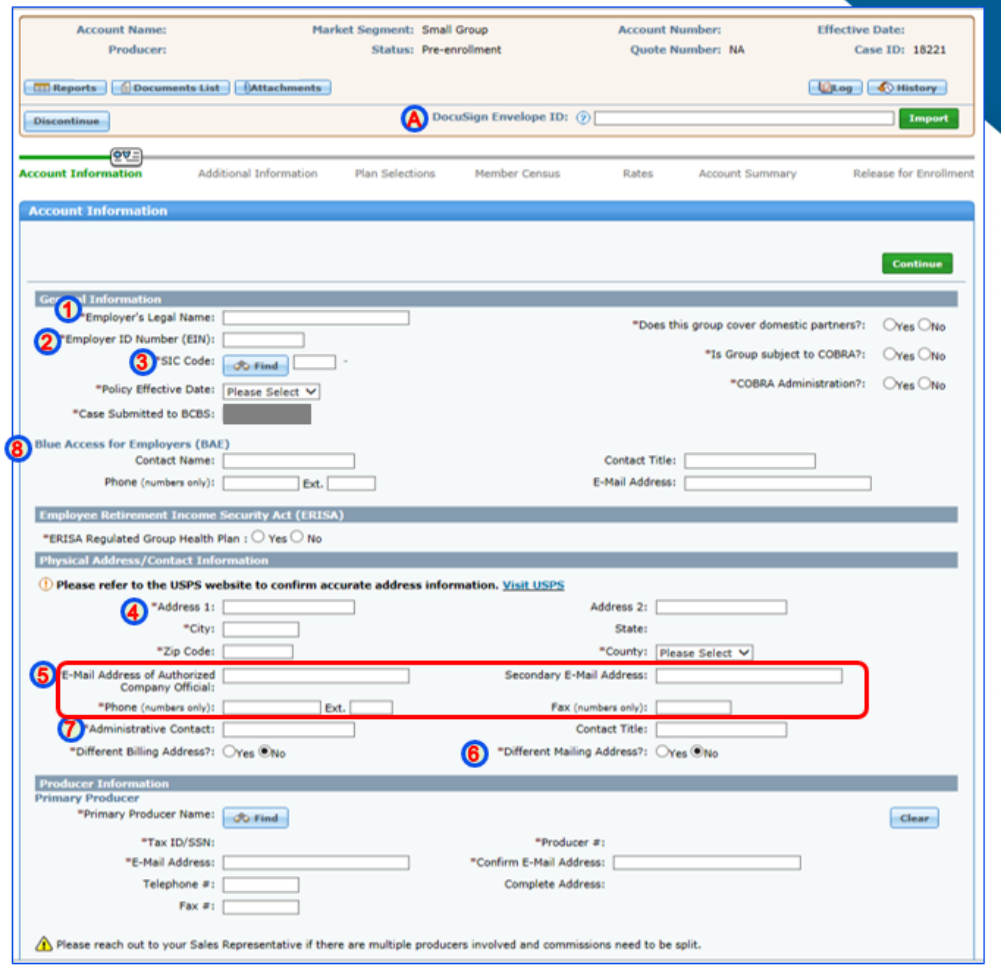
E-mail address of BAE contact person: ____

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
*Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.
Dearborn National® Life Insurance Company does not provide Blue Cross and Blue Shield of Texas products and services, and is a separate company.

TXBPASG-OFF-EX01.17 Page 1 7.2016

A DocuSign Envelope ID: 89617335-443D-478B-B99E-877C7FBC8FF8

Small Group ACA Enrollment Tool



Account Name: | Market Segment: Small Group | Account Number: | Effective Date:
Producer: | Status: Pre-enrollment | Quote Number: NA | Case ID: 18221

Reports | Documents List | Attachments | Log | History

Discontinue | A DocuSign Envelope ID: | Import

Account Information | Additional Information | Plan Selections | Member Census | Rates | Account Summary | Release for Enrollment

Account Information

Continue

General Information

1 *Employer's Legal Name:
2 *Employer ID Number (EIN):
3 *SIC Code: Find
*Policy Effective Date: Please Select
*Case Submitted to BCBS:
*Does this group cover domestic partners? Yes No
*Is Group subject to COBRA? Yes No
*COBRA Administration? Yes No

8 **Blue Access for Employers (BAE)**
Contact Name:
Phone (numbers only): Ext.
Contact Title:
E-Mail Address:

Employee Retirement Income Security Act (ERISA)
*ERISA Regulated Group Health Plan : Yes No

Physical Address/Contact Information
Please refer to the USPS website to confirm accurate address information. Visit USPS

4 *Address 1:
*City:
*Zip Code:
Address 2:
State:
*County: Please Select
5 E-Mail Address of Authorized Company Official:
*Phone (numbers only): Ext.
Secondary E-Mail Address:
Fax (numbers only):
7 *Administrative Contact:
Contact Title:
*Different Billing Address? Yes No
6 *Different Mailing Address? Yes No

Producer Information
Primary Producer
*Primary Producer Name: Find
Clear
*Tax ID/SSN:
*E-Mail Address:
Telephone #:
Fax #:
*Producer #:
*Confirm E-Mail Address:
Complete Address:

Please reach out to your Sales Representative if there are multiple producers involved and commissions need to be split.

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9 Requested Contract(s)/Policy(ies) Effective Date (1st or 15th): ____/____/____ Month Day Year

A copy of your most recent Texas Workforce Commission (TWC) Report(s) or other supporting documentation must be submitted with this Employer Application (please identify part-time employees and terminations). W4s, 1099s, or a Texas Supplemental Employment Verification form must be submitted for any applicants not included on the TWC Report.

1. Select a Waiting Period:
   If a person is added to the Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply, based on the Waiting Period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the coverage date for such person.

10 a. Newly eligible individuals will become effective on:

☐ The first day of the contract/participation month following ☐ 0 days ☐ 30 days ☐ 60 days
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 and any substantive eligibility criteria.

11 b. Waive the Waiting Period on initial group enrollment? ☐ Yes ☐ No

c. Number of employees serving Waiting Period: ____

d. 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. In no event can the substantive eligibility criteria result in a delay of coverage for eligible employees, as defined under Texas law, longer than 90 days inclusive of the Waiting Period. If any of these eligibility conditions change, you are required to submit a new BPA to reflect that new information.
Check all that apply:

☐ An Orientation Period that:

1) Does not exceed one month (calculated by adding one calendar month and subtracting one 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 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 day of the following month;
2) Does not exceed 12 months; and
3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

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

2. Total number of enrollment applications submitted: ____ Total number of declinations submitted: ____
3. Do all employees reside in Texas? ☐ Yes ☐ No
   If no, is Texas the state with the greatest number of employees eligible to enroll in this group plan? ☐ Yes ☐ No

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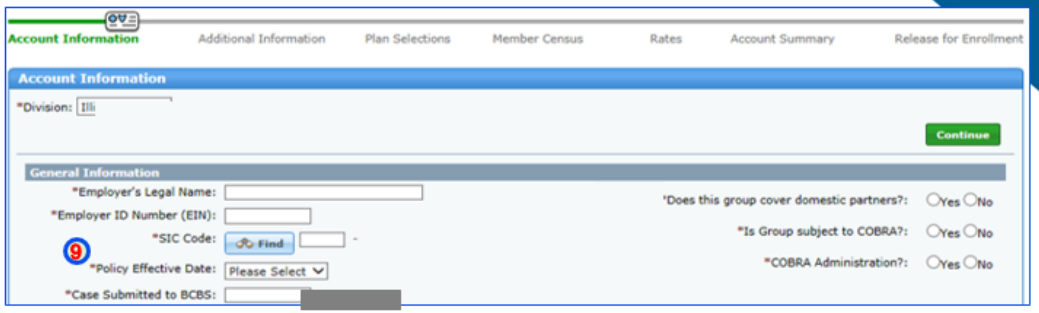
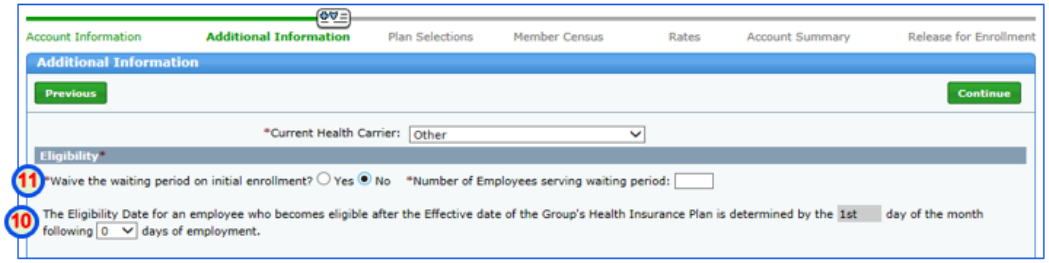
Small Group ACA Enrollment Tool





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12 4. Domestic Partners covered: ☐ Yes ☐ No

If yes: A Domestic Partner, as defined in the Plan, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those covered Employees with Domestic Partners.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but are eligible for continuation coverage similar to that available to spouses under COBRA continuation.

5. Is the company headquarters in Texas? ☐ Yes ☐ No

6. Are you an independent school district that is a large employer electing to participate as a small employer? ☐ Yes ☐ No

7 Will you have been without group coverage (uninsured) for at least two months prior to the requested Contract(s)/Policy(ies) effective date of coverage? ☐ Yes ☐ No

8 If you currently have group health care coverage, complete the following:
a. Present health carrier's name_____
b. Paid-to-date with current carrier: ____/____/____ (mm/dd/yyyy)
c. Calendar year medical deductible amount with current carrier: Individual:____Family: ____

LEGISLATIVE REQUIREMENTS

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.

13 Please provide your ERISA Plan Year*: Beginning Date: ____/____/____ End Date: ____/____/____
Month Day Year Month Day Year

ERISA Plan Sponsor*: _____

If you maintain that ERISA is not applicable to your account, 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: ____

Please provide Non-ERISA Plan Year: ____/____/____
Month Day Year

For more information regarding ERISA, contact your Legal Advisor.

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

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Small Group ACA Enrollment Tool

General Information

*Employer's Legal Name:
*Employer ID Number (EIN):
*SIC Code: Find -
*Policy Effective Date: Please Select
*Case Submitted to BCBS:

12 *Does this group cover domestic partners?: Yes No
*Is Group subject to COBRA?: Yes No
*COBRA Administration?: Yes No

Blue Access for Employers (BAE)

Contact Name:
Phone (numbers only): Ext.
Contact Title:
E-Mail Address:

Employee Retirement Income Security Act (ERISA)

13 ERISA Regulated Group Health Plan : Yes No

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BENEFIT PLAN SELECTIONS

Understanding the Plan # Sample Plan # : B634ADT		
Metallic Level	B	Bronze, Silver, Gold, Platinum
Benefit Design	634	633, 634, etc.
Network/Product Name	ADT	ADT = Blue Advantage HMO CHC = Blue Choice PPO HMH = Blue Premier Access

14 Health Products/Benefit Plan Selection:

The Left hand column lists the benefit designs. Up to three selections from this column are allowed. The corresponding rows to the right of the benefit designs indicate network/product choices for the specified benefit. A maximum of six network/product options may be selected.

If HSA/HDHP is selected, provide name of HSA administrator/trustee:

Benefit Design (select up to 3)		Blue Choice PPO		*Blue Advantage HMO℠ (select up to 6)		*Blue Premier Access℠	
☐	B600	☐	B600CHC				
☐	B633	☐	B633CHC				
☐	B634	☐	B634CHC	☐	B634ADT	☐	B634HMH
☐	B635					☐	B635HMH
☐	B651			☐	B651ADT		
☐	B652	☐	B652CHC	☐	B652ADT		
☐	S606	☐	S606CHC	☐	S606ADT	☐	S606HMH
☐	S607	☐	S607CHC	☐	S607ADT	☐	S607HMH
☐	S608	☐	S608CHC	☐	S608ADT		
☐	S609	☐	S609CHC	☐		☐	S609HMH
☐	S610	☐	S610CHC	☐	S610ADT	☐	S610HMH
☐	S611	☐	S611CHC	☐	S611ADT		
☐	G613	☐	G613CHC				
☐	G617	☐	G617CHC	☐	G617ADT		
☐	G618			☐	G618ADT		
☐	G619	☐	G619CHC				
☐	G620	☐	G620CHC	☐	G620ADT	☐	G620HMH
☐	G622	☐	G622CHC	☐	G622ADT		
☐	G623	☐	G623CHC	☐	G623ADT		
☐	G632			☐	G632ADT		

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Small Group ACA Enrollment Tool

Account Information | Additional Information | **Plan Selections** | Member Census | Rates | Account Summary | Release for Enrollment

Plan Selections

Previous | Continue

14 Health ◉ Yes ○ No

In-Vitro Coverage: ○ Yes ◉ No

Blue Choice PPO Network

Plan #	Ded In/Out	Office Visit/ Specialist	Coins In/Out	OPX In/Out	ER Copay*3/ER Coins	IP In/Out	OP Surg In/Out	Ped Dental In/Out	Rx**
PPO Plans									
Blue Platinum Plans									
P600CHC	$250/$500	$25/$45	80%/60%	$1250/$2500	$300/80%	$150/ $250	$100/$200	70%/70%	$5/$15/$45/$85/$150
P601CHC	$1250/$2500	$25/$45	100%/100%	$1250/$2500	$300/100%	$150/ $250	$100/$200	100%/100%	$5/$15/$45/$85/$150
Blue Gold Plans									
G620CHC	$1000/$2000	$20/$40	80%/60%	$3900/$7800	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$50/$65/$65
G623CHC	$1250/$2500	$20/$60	100%/80%	$4500/$9000	$300/100%	$150/ $250	$100/$200	70%/70%	$5/$15/$60/$110/$150
G622CHC	$1250/$2500	$30/$50	80%/60%	$3500/$7000	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$40/$55/$55
G617CHC	$3000/$6000	$30/$50	100%/100%	$3000/$6000	$400/100%	$200/ $300	$150/$250	100%/100%	$5/$15/$60/$110/$150

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☐	G653			☐	G653ADT		
☐	P600	☐	P600CHC	☐	P600ADT		
☐	P601	☐	P601CHC	☐	P601ADT		

*If a Blue Premier Access or Blue Advantage HMO product/benefit plan (with the exception of G632ADT plan) is selected, please complete, sign and submit a Disclosure Statement with this Application for Amendment.

Additional Information: _____

DENTAL PRODUCTS/BENEFIT PLAN SELECTION:

Plan Pairings (Groups 10+)
True Group
Any one true group high option can be paired with any one true group low option; DTXHM11 can be freely paired with any true group.

High Option	Low Option
DTXHR01	DTXLR06
DTXHR02	DTXLR07
DTXHR03	DTXLM08

Voluntary
Any one voluntary high option can be paired with any one voluntary low option. DTXHM15 can be freely paired with any one voluntary option.

High Option	Low Option
DTXHR12	DTXLM14
DTXHM13	

Participation Requirements
True Group
>75% participation
>50% employer contribution

Voluntary
>25% participation
Employers are not required to contribute to Voluntary Dental plans

15 **DENTAL PLAN SELECTION**

	Plan #	Segment
	High Coverage Allocation	
☐	DTXHR01	True Group
☐	DTXHR02	True Group
☐	DTXHR03	True Group
☐	DTXHR04	True Group
☐	DTXHM09	True Group
☐	DTXHM11	True Group
☐	DTXHR12	Voluntary
☐	DTXHM13	Voluntary
☐	DTXHM15	Voluntary
	Low Coverage Allocation	
☐	DTXLR05	True Group
☐	DTXLR06	True Group
☐	DTXLR07	True Group
☐	DTXLM08	True Group
☐	DTXLM10	True Group
☐	DTXLM14	Voluntary

Small Group ACA Enrollment Tool

15 * Ancillary Products - Dental ◉ Yes ○ No

If Dental is purchased, select from the following Dental plans.

	Plan #	Plan Type	Deductible In/Out*2	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance		Orthodontia Lifetime Max
						In Network	Out Of Network	
	True Group							
	High Allocation							
☐	DTXHR01	Passive	$25/$25	$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000
☐	DTXHR02	Passive	$50/$50	$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000
☐	DTXHR03	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500
☐	DTXHR04	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000
☐	DTXHM09*1	Passive	$50/$50	$1500	MAC	100%/80%/50%/NA	100%/80%/50%/NA	NA
☐	DTXHM11*3	Passive	$25/$25	$750	MAC	100%/80%/NA/NA	100%/80%/NA/NA	NA
	Low Allocation							
☐	DTXLR05	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA
☐	DTXLR06	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA
☐	DTXLR07	Passive	$75/$75	$1000	90th R&C	90%/70%/50%/NA	90%/70%/50%/NA	NA
☐	DTXLM08	Passive	$50/$50	$1500	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000
☐	DTXLM10*1	Passive	$75/$75	$1000	MAC	90%/70%/50%/NA	90%/70%/50%/NA	NA

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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.

THE FOLLOWING MANDATED BENEFIT OFFERS ARE ALREADY INCLUDED IN THE PPO AND HMO PLANS

- Treatment of mental or emotional illness
- Treatment of loss or impairment of speech or hearing
- Treatment of serious mental illness

MANDATED BENEFIT OFFERS

16 **In Vitro Fertilization Services** - (must choose one)
☐ Accept – Outpatient benefits are paid same as any other pregnancy-related expense **(Note: If selected an additional charge will be added to your rates.)**
☐ Decline – If declined, no benefits are available

The Employer understands and agrees to comply with the following requirements regarding the Health Benefit Plan(s) elected:

- Applications/Declinations are attached for all full-time employees as well as any COBRA or state participant continuations.
- **Minimum Participation and Employer Contribution :**

  BCBSTX reserves the right to: 1) restrict new business enrollment in health insurance coverage to open or special enrollment periods unless the 50% minimum employer contribution is met and at least 75% of eligible employees (less valid waivers) have enrolled for coverage; and 2) review participation and contribution on existing business and non-renew or discontinue health coverage if the 50% minimum employer contribution is not met and/or less than 75% of Eligible Persons (less valid waivers) are enrolled for coverage for six consecutive months.

  If applicable, BCBSTX reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. 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.

  Employer will promptly notify BCBSTX of any change in participation and Employer contribution.
- 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(s) elected, according to the terms and requests of BCBSTX.
- After approval by BCBSTX the Health and/or Dental Benefit Plan(s) applied for, individuals will become effective on the first day of the contract/participation month following satisfaction of the Waiting Period (if any, but not to exceed 90 days). Employees whose applications are received more than 31 days after date-of-hire or received after expiration of the Waiting Period will be considered late enrollees and will be eligible to enroll during the next open enrollment period.
- 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) issued pursuant to this Employer Application and such shall serve as the basis to resolve any conflict. When issued, the Contract(s)/Policy(ies) will include this Employer Application and any Addenda issued pursuant to this Employer Application.
- Premium rates for the coverages applied for are determined by BCBSTX and will become a part of the Contract(s)/Policy(ies) issued by BCBSTX and any amendments thereto.
- This Benefit Program Employer Application must pre-date the requested effective date and be received by BCBSTX at its Home Office no less than thirty (30) days prior to the requested effective date.
- Retirees are not eligible for coverage hereunder.
- Under Texas 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

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Small Group ACA Enrollment Tool

Account Information | Additional Information | **Plan Selections** | Member Census | Rates | Account Summary | Release for Enrollment

Plan Selections

Previous | Continue

View BPCS Request/Response XML

Health ◉ Yes ○ No

16 In-Vitro Coverage: ○ Yes ◉ No

Blue Choice PPO Network

Plan #	Ded In/Out	Office Visit/ Specialist	Coins In/Out	OPX In/Out	ER Copay*?/ER Coins	IP In/Out	OP Surg In/Out	Ped Dental In/Out	Rx**
PPO Plans									
Blue Platinum Plans									
☐ P600CHC	$250/$500	$25/$45	80%/60%	$1250/$2500	$300/80%	$150/ $250	$100/$200	70%/70%	$5/$15/$45/$85/$150
☐ P601CHC	$1250/$2500	$25/$45	100%/100%	$1250/$2500	$300/100%	$150/ $250	$100/$200	100%/100%	$5/$15/$45/$85/$150
Blue Gold Plans									
☐ G620CHC	$1000/$2000	$20/$40	80%/60%	$3900/$7800	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$50/$65/$65
☐ G623CHC	$1250/$2500	$20/$60	100%/80%	$4500/$9000	$300/100%	$150/ $250	$100/$200	70%/70%	$5/$15/$60/$110/$150
☐ G622CHC	$1250/$2500	$30/$50	80%/60%	$3500/$7000	$400/80%	NA/NA	NA/NA	70%/70%	$20/$20/$40/$55/$55
☐ G617CHC	$3000/$6000	$30/$50	100%/100%	$3000/$6000	$400/100%	$200/ $300	$150/$250	100%/100%	$5/$15/$60/$110/$150

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Application is hereby made to Dearborn National® Life Insurance Company (herein called "Dearborn National") 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

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			

	Term Life/AD&D	Dependents' Life	STD
Total eligible employees:			
Total enrolling:			

Contract Anniversary Date: ☐ 12 months from Contract Effective Date ☐ Other ____

17 II. Term Life Insurance and AD&D: ☐ Applied For ☐ Not Applied For

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

18 III. Dependents' Term Life Insurance: ☐ Applied For (offered only with Term Life/AD&D) ☐ Not Applied For

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

19 IV. Short Term Disability (STD) Insurance: ☐ Applied For (offered only with Term Life/AD&D) ☐ Not Applied For

Wage-Based Benefit: ☐ 50% ☐ 60% ☐ 66 2/3% of Basic Weekly Wages to a Benefit Maximum of $		
Flat Benefit: ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 not to exceed 66 2/3% of Basic Weekly Wages		
Class Defined Plan: Complete STD amount in Section I		
20 Benefits Begin:	Due to an Accident: (select one) ☐ 1st day ☐ 8th day ☐ 15th day ☐ 31st day	Due to Sickness: (select one) ☐ 8th day ☐ 15th day ☐ 31st day
Maximum Weekly Benefit Duration: ☐ 13 weeks ☐ 26 weeks		
Rates: ☐ Step-Rated ☐ Composite Rated (Include a copy of the rating exhibit if rated in the field)		
Employer Contribution: ☐ 100% ☐ Other % (Minimum 25% Employer contribution required)		
STD is ☐ in addition to, or ☐ replacement of current STD coverage ☐ 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.	

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

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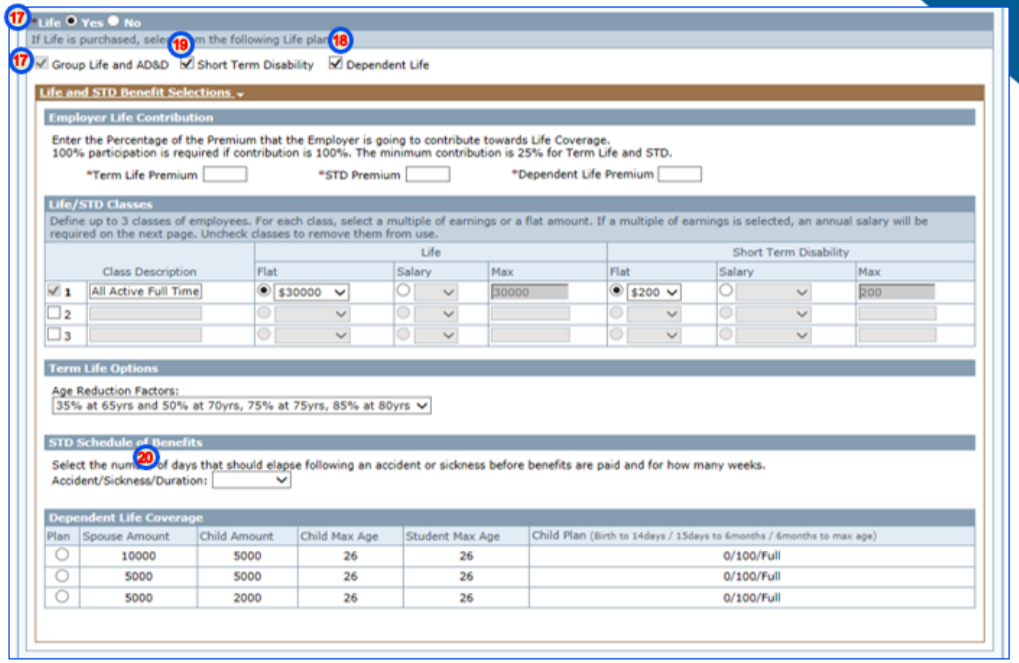
Small Group ACA Enrollment Tool



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PRODUCER'S STATEMENT
TO BE COMPLETED BY PRODUCER(S) - PLEASE PRINT

PRODUCER'S
I certify that I have reviewed all enrollment materials and I have advised the Employer not to terminate any existing coverage(s) until receiving notice that BCBSTX/Dearborn National have accepted and approved this Employer Application. I have advised the Employer of its rights as a small group employer to purchase the **HMO** Blue Advantage 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 Employer Application, or enrollment material in any manner or to adjust any claims for benefits under the Contract(s)/Policy(ies).

Writing **Producer's** name (please print) _____ E-Mail Address _____

_____ _____ _____ _____
Writing **Producer's** signature **Producer #** Date Telephone #

_____ _____
BCBSTX Sales Representative Date

1. Primary **Producer's** or Agency Name* (to whom commissions are to be paid): _____
   (Please also use 2. below, for split commissions)
   Percentage of Split**: _____
   Complete Address: _____
   Tax ID/SSN: _____ 21 **Producer #:** _____ FAX number: _____
   Name and phone # of agent to contact for this case: _____
   Contact's E-mail address (please print clearly): _____
2. **Producer's** or Agency Name* (if commissions are to be split): _____
   Percentage of Split**: _____
   Street, City, ZIP: _____
   Tax ID/SSN: _____ **Producer #:** _____ FAX number: _____
   Contact's E-Mail address (please print clearly): _____
3. General Agent Name (if applicable): _____
   Street, City, ZIP: _____
   22 **Tax ID/SSN:** _____ **Producer #:** _____ FAX number: _____
   Contact name and telephone number for this case: _____
   Contact's E-Mail address (please print clearly): _____
   General Agent's Signature: _____

* 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 to be split, please provide the information requested above on both **Producers or agencies. **Both Producers** or agencies must be appointed to do business with BCBSTX and/or Dearborn National and total commissions paid must equal 100%.

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Small Group ACA Enrollment Tool

Producer Information

Primary Producer

*Primary Producer Name: Find Clear

*Tax ID/SSN: *Producer 21

*E-Mail Address: *Confirm E-Mail Address:

Telephone #: Complete Address:

Fax #:

⚠ Please reach out to your Sales Representative if there are multiple producers involved and commissions need to be split.

General Agent

General Agent Name: Find Clear

Tax ID/SSN 22 Producer #:

E-Mail Address: Confirm E-Mail Address:

Telephone #: Complete Address:

Fax #:

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SECTION C

COBRA IS FEDERALLY MANDATED AND APPLIES TO EMPLOYERS WITH 20 OR MORE FULL-TIME OR PART-TIME EMPLOYEES. EMPLOYER PENALTIES FOR NONCOMPLIANCE MAY APPLY.

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

23 b. Are you subject to the Consolidated Omnibus Reconciliation Act (COBRA)? ☐Yes ☐No
If "yes", list names and number of individuals (qualified beneficiaries) currently on COBRA continuation*:

Name of COBRA Continuee	Coverage Type (Individual or Family)	Projected COBRA Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐Individual ☐Family	____/____/____	☐Health ☐Dental
	☐Individual ☐Family	____/____/____	☐Health ☐Dental
	☐Individual ☐Family	____/____/____	☐Health ☐Dental

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.

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

Workers' Compensation.
Are any employees currently receiving Workers' Compensation benefits? ☐Yes ☐No
If "yes", list names and date last worked:

Employee Name	Date Last Worked
	____/____/____
	____/____/____
	____/____/____

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 continuation coverage:

Name of State Continuee	Coverage Type (Individual or Family)	Projected State Continuation Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐Individual ☐Family	____/____/____	☐Health ☐Dental
	☐Individual ☐Family	____/____/____	☐Health ☐Dental
	☐Individual ☐Family	____/____/____	☐Health ☐Dental

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:

Name of State Dependent Continuee	Coverage Type (Individual or Family)	Projected State Continuation Termination Date (MM/DD/YYYY)	Type of Coverage Extended
	☐Individual ☐Family	____/____/____	☐Health ☐Dental
	☐Individual ☐Family	____/____/____	☐Health ☐Dental
	☐Individual ☐Family	____/____/____	☐Health ☐Dental

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Small Group ACA Enrollment Tool

General Information

*Employer's Legal Name:
*Employer ID Number (EIN):
*SIC Code: Find -
*Policy Effective Date: Please Select

23 *Does this group cover domestic partners?: ○Yes ○No
*Is Group subject to COBRA?: ○Yes ○No
*COBRA Administration?: ○Yes ○No

For additional information please see the Group, Training & Admin section on Blue Access for Producers.

BlueCross BlueShield of Texas