

ALL NON-SHADED FIELDS ARE MANDATORY AND MUST BE COMPLETED

(1) GROUP SUBMISSION STATUS: New to Blue Add new Vision Product to existing Group Add New Medical Group Option

Federal COBRA (20 or more employees) Total Transfer (with Supplemental if applicable) - please cancel old Group (refer to (10) PRIOR GROUP NUMBER)

State Mini-COBRA (2 – 19 employees) Partial Transfer (with Supplemental if applicable) Act 4 (dependent to age 30)

Note: If current Group has Supplemental Coverage and is transferring, complete Type of Program Sold including Supplemental Lines of Business.

(2) TYPE OF PROGRAM SOLD:

<p>Open Access</p> <input type="checkbox"/> PPOBlue High Option I <input type="checkbox"/> PPOBlue High Option II <input type="checkbox"/> PPOBlue Enhanced <input type="checkbox"/> PPOBlue Standard <input type="checkbox"/> PPOBlue 90/70 <input type="checkbox"/> PPOBlue Split Copayment 100/80 <input type="checkbox"/> PPOBlue \$500 Deductible <input type="checkbox"/> PPOBlue 80/60 <input type="checkbox"/> PPOBlue Split Copayment Low Cost 90/70 <input type="checkbox"/> PPOBlue \$750 Deductible Value <input type="checkbox"/> PPOBlue Value Plus 250 <input type="checkbox"/> PPOBlue \$1,000 High-Deductible Value Plan <input type="checkbox"/> PPOBlue 70/50 <input type="checkbox"/> PPOBlue \$1,250 High-Deductible Value Plan <input type="checkbox"/> PPOBlue HDHP 100/80 \$1,250 Deductible Value <input type="checkbox"/> PPOBlue \$1,500 High-Deductible Value	<input type="checkbox"/> PPOBlue HDHP 100/80 \$1,500 Deductible Value <input type="checkbox"/> PPOBlue Value Plus 500 <input type="checkbox"/> PPOBlue \$2,500 High-Deductible Value Plan <input type="checkbox"/> PPOBlue HDHP 80/60 Value <input type="checkbox"/> PPOBlue HDHP 100/80 \$2,000 Deductible Value <input type="checkbox"/> PPOBlue HDHP 100/80 \$2,600 Deductible <input type="checkbox"/> PPOBlue HDHP 90/70 \$2,600 Deductible <input type="checkbox"/> PPOBlue HDHP 90/70 \$3,500 Deductible	<p>Managed Care</p> <input type="checkbox"/> KeystoneBlue HMO <p>Traditional</p> <input type="checkbox"/> ClassicBlue Traditional <input type="checkbox"/> ClassicBlue Comprehensive 750/1000 <input type="checkbox"/> Signature65 (Select Associations Only) <p>Supplemental</p> <input type="checkbox"/> Fashion Advantage Option I <input type="checkbox"/> Fashion Advantage Option V <input type="checkbox"/> Fashion Advantage Gold Option I <input type="checkbox"/> Fashion Advantage Gold Option V <input type="checkbox"/> Other Vision _____
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Open Access Out-of-Area

 Out-of-Area PPO High Option II
 Out-of-Area PPO Standard
 Out-of-Area PPO 1250 High-Deductible Value
 Out-of-Area PPO Value Plus 500
 Out-of-Area PPO (HDHP 100/80 \$2,600 Deductible)
 Out-of-Area PPO 500
 Out-of-Area PPO 1500 High Deductible Value

(3) TAX I.D. / E.I.N. _____

(4) HRA Yes No
NOTE: If YES, then Small Group HRA form must be attached

(5) LIFESTYLE RETURNS Yes No
NOTE: Lifestyle Returns can only be added to Open Access Plans and KeystoneBlue HMO.

(6) QUOTE ID: _____

(7) EFFECTIVE DATE	DISTRICT	TERRITORY	REPRESENTATIVE
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(8) BUSINESS NAME:	NEW GROUP NUMBER	CLIENT NUMBER
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(9) ASSOCIATION / POOL: _____ (10) PRIOR GROUP NUMBER: _____

(11) PRIOR MEDICAL COVERAGE:
 UNINSURED: YES NO - IF "NO," COMMERCIAL CARRIER: _____

(12) BUSINESS ADDRESS (PHYSICAL LOCATION): _____ (13) CITY: _____

(14) STATE: _____ (15) ZIP+4: _____ (16) COUNTY: _____ (17) PHONE: _____

(18) E-MAIL ADDRESS: _____ (19) INDUSTRY TYPE: _____ (20) SIC: _____

(21) SEND CONTRACTS TO: _____

(22) HIGHMARK AGENCY NAME & TELEPHONE NUMBER _____ (23) HIGHMARK AGENCY NUMBER: _____

1. _____
 2. _____

(24) PRODUCER NAME & TELEPHONE NUMBER: _____ (25) PRODUCER NUMBER: _____

1. _____
 2. _____

(26) OWNERSHIP TYPE: CORPORATION PARTNERSHIP PROPRIETORSHIP GOVERNMENT COMMON OWNERSHIP
 OTHER (SPECIFY): _____ IF INCORPORATED, STATE OF CORPORATION: _____

IF A PROPRIETORSHIP, PARTNERSHIP OR COMMON OWNERSHIP, LIST THE NAMES OF EACH OWNER, PARTNER AND/OR COMMONLY OWNED COMPANIES:

1. _____ 3. _____ 5. _____
 2. _____ 4. _____ 6. _____

(27) PLAN SPONSORSHIP: PRIVATE ENTITY (ERISA) GOVERNMENT ENTITIES (NON-ERISA) PUBLIC SCHOOLS (NON-ERISA) CHURCH ENTITY (NON-ERISA)

(28) GROUP ADMINISTRATOR: _____ (29) TITLE: _____

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(30) EMPLOYER PAYS _____% OF THE INDIVIDUAL COST
 \$_____ TOWARD THE TOTAL COST
 _____% OF THE FAMILY COST
 \$_____ TOWARD THE FAMILY COST

(31) PLEASE LIST BILLING CONTACT NAME: _____
 PLEASE LIST BILLING ADDRESS: _____

COMPANY SIZE

_____ (32) Current No. of Full-Time Employees _____ (33) Current No. of Part-Time Employees
 _____ (34) Total No. of Seasonal/Intermittent Employees for current calendar year.
 _____ (35) No. of Hours Required for Full-Time _____ (36) Total No. of Full-Time Employees enrolling in coverage.
 (37) In determining who is an employee for this purpose, the Federal government counts all employees who work under a common ownership or corporation and who are subject to FICA taxes. (If you are exempt from FICA taxes, count employees who would be subject to FICA taxes if the exemption did not apply.) This includes individuals employed:

- Locally and out of the area
- Full-time, part-time, intermittently and/or on a seasonal basis

a. In the preceding calendar year, did you have at least 20 or more employees for each working day or 20 or more calendar weeks? YES NO Company did not exist

b. As of today's date in the current calendar year, did you have at least 20 or more employees for each working day of 20 or more calendar weeks? YES NO Unknown, enough time has not expired

c. In the preceding calendar year, did you have at least 100 or more employees during 50% or your regular business days? YES NO Company did not exist

d. As of today's date in the current calendar year, did you have at least 100 or more employees during 50% of your regular business days? YES NO Unknown, enough time has not expired

(38) Does the company have a probationary period for new employees? YES NO

(39) If YES, coverage begins the first day of the month following _____ DAYS _____ MONTHS

(40) Does the company wish to include eligibility coverage for Domestic Partners? YES NO

(41) Does the company wish to include eligibility coverage for Act 4? YES NO

(42) Are there any employees eligible for Medicare? YES NO

PRODUCT MIX

(43) Other Carrier Offered? NO YES If YES, Carrier Offered: _____
 Product Offered: _____

(44) REMARKS: _____

(45) EMPLOYER AUTHORIZED SIGNATURE _____

I, the undersigned, have the authority to represent this business and recognized the agency (or agencies) listed in "box 23" as our exclusive Producer of Record (P.O.R.) for all Highmark Blue Cross Blue Shield products and they will receive any and all commissions included in the rates. I understand that all underwriting and participation guidelines must be met and that rates are **not binding** until approved by Highmark Blue Cross Blue Shield. Any need for additional information could impact the effective date of coverage, the rates quoted, or the ability to offer group insurance coverage. Furthermore, all underwriting and participation guidelines must be met throughout the duration of the insurance contract and Highmark reserves the right to re-confirm compliance with these guidelines at anytime in the future. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I acknowledge and agree that any personally identifiable health information ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office. **I further acknowledge and agree that Highmark may disclose enrollment, disenrollment, summary health and/or premium billing information requested by the P.O.R. for purposes of inputting, updating and/or reviewing the same for the above-identified business.**

Name _____ Title _____

Signature _____ Date _____

Please return form to:
 Highmark Blue Cross Blue Shield • Small Group Submissions • 120 Fifth Avenue, Suite 1025 • Pittsburgh, PA 15222-3099