Blue Cross and Blue Shield of Oklahoma

BlueLincs HMO is a Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma, a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

REP NUMBER:

GROUP APPLICATION FOR CHANGE TO EXISTING GROUP MASTER AGREEMENT

It is intended that this application be completed by the Group's Producer of Record or Account Consultant and be verified by an officer of the Company. Except as amended below, the Group Master Agreement and Group Application remain unchanged.

GROUP NUMBER	EFFECTIVE DATE OF CHANGE	GROUP NAME

MAILING ADDRESS	CITY	STATE

ZIP CODE	PHONE NO.	GROUP LEADER

PRODUCER	PRODUCER NUMBER

BLUELINCS BENEFIT OPTIONS TO BE ADDED OR MODIFIED:

☐ **PLAN A**	☐ **PLAN B**	☐ **PLAN D**	☐ **PLAN E**	☐ **PLAN G**
☐ **PLAN H**	☐ **PLAN H $200**	☐ **PLAN H $300**	☐ **PLAN H $500**	☐ **PLAN H $1,000**
☐ **PLAN OP**	☐ **PLAN OP $200**	☐ **PLAN OP $300**	☐ **PLAN OP $500**	☐ **PLAN OP $1,000**
☐ **PLAN SP**	☐ **PLAN SP $200**	☐ **PLAN SP $300**	☐ **PLAN SP $500**	☐ **PLAN SP $1,000**

VISION CARE: ☐ **YES** ☐ **NO**

RX BENEFITS WE ARE APPLYING FOR:
☐ STANDARD PRESCRIPTION CARD ☐ PRESCRIPTION CARD WITH DEDUCTIBLE
☐ CHAMBER CHOICE PRESCRIPTION PLAN

WAITING PERIOD:
ELIGIBILITY DATE (Days following date of Employment) ☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 1 Month ☐ 2 Month ☐ 3 Month ☐ 6 Month

EFFECTIVE DATE ☐ **Date of Employment** ☐ **Date of Eligibility** ☐ **First Billing Cycle Following or Coinciding Date of Eligibility**

DENTAL AND VISION BENEFITS:
☐ Remove Dental ☐ VGD Option Ia ☐ VGD Option II ☐ VGD Option III ☐ VGD Option IV ☐ Blue Cross Vision

As a Company Officer or Owner of the above group, I am requesting these changes be made to our existing Group Contract. By signing this form I am agreeing that the requested changes will be made, subject to approval by Blue Cross and Blue Shield of Oklahoma. If this application is accepted, the contract and any endorsements thereto will contain all of the terms and conditions. I have reviewed the changes we are requesting with my Producer of Record or assigned Account Consultant and understand the changes we are requesting.

SIGNATURE DATE	COMPANY OFFICER OR OWNER	ACCOUNT CONSULTANT OR PRODUCER

FOR OFFICE USE ONLY

PREMIUM TAX	PRIOR TIER CODE	TIER CODE	SM B PKG #	BLNCS	PL/PN	COPAY $	RENEWAL DATE	RATE CALL	RATE NOTICE	COV. OPT.	WAITING PERIOD

TERM DATE LOB 09	TERM DATE LOB 10	TERM DATE LOB 16	TERM DATE LOB 17	TERM DATE LOB	TERM DATE LOB	TERM DATE LOB	TERM DATE LOB	TERM DATE LOB

EFFECTIVE DATE	LOB	ID CARD CODE	ELIG CERT	TYPE OF BUSINESS	SUB CODE	RATE CLASS	MKT. SEG	BENEFIT TABLE NO.	ADS	PRC	MHP DEF.	DPF

REPRESENTATIVE		UNDERWRITING		MEMBERSHIP SVCS.
		DATE RECEIVED	DATE RELEASED	
DATE RECEIVED	DATE RELEASED	STOP DATE	REASON	ID MAILED
		RESTART DATE		

☐ ENS. ☐ BILL. ☐ I.A. ☐ M.I. ☐ M.S.E. ☐ M.S.W. ☐ ENS. RPT.

Changes made with this document may result in a new agreement being issued to your group, please review the summary information on the back of this form.

This is only a summary of available Group Benefits; this is not a contract, if this application is accepted the details of the terms and conditions will be listed in the Group Master Agreement.

Voluntary Dental Benefits:

Option II is subject to a 12-month waiting period for Prosthetic and Complex Restorative Services.

Options II and III are subject to a $1,000 Maximum Amount per Benefit Period per Subscriber.

Option IV is subject to a $1,250 Maximum Amount per Benefit Period per Subscriber.

Option III must enroll and maintain a minimum of 10 Eligible Persons or 50% of total Eligible Persons, whichever is greater.

Option IV must enroll and maintain a minimum of 10 Eligible Persons or 75% of total Eligible Persons, whichever is greater.

Coverage for Dependent children must be in place for 24 consecutive months before Orthodontic Service Benefits are available.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.