

## (1) GROUP SUBMISSION STATUS: (MANDATORY FIELD)

- New to Blue**
 **Add new Vision Product to existing Group**  
 **Add New Medical Group Option**  
 Total Transfer (with Supplemental if applicable) - please cancel old Group refer to Prior Group #  
 Partial Transfer (with Supplemental if applicable)

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

### Open Access

- PPOBlue (100/80)
- PPOBlue Split Copayment 100/80
- PPOBlue Split Copayment Low Cost 90/70
- PPOBlue High-Deductible Value
- PPOBlue Value Plus
- PPOBlue (HDHP 100/80 \$2,600 Deductible)
- PPOBlue (HDHP 80/60 Value Option)
- PPOBlue (HDHP 90/70 \$2,600 Deductible)
- PPOBlue (HDHP 90/70 \$3,500 Deductible)
- DirectBlue
- DirectBlue Basic
- DirectBlue Value

## (2) TYPE OF PROGRAM SOLD: (MANDATORY FIELD)

### Managed Care

- SelectBlue High Option
- SelectBlue Basic
- SelectBlue 90/70
- KeystoneBlue HMO

### Out-of-Area

- Out-of-Area Comprehensive
- Out-of-Area PPO

### Supplemental

- OptiChoice
- Annual OptiChoice
- OptiChoice Gold
- Annual OptiChoice Gold
- Other Vision \_\_\_\_\_

### Traditional

- ClassicBlue Traditional
- ClassicBlue Comprehensive 750/1000
- Over 65 Program (Select Associations Only)

(3) QUOTE ID: (MANDATORY FIELD)

(4) EFFECTIVE DATE	DISTRICT	TERRITORY	REPRESENTATIVE
(5) BUSINESS NAME: (MANDATORY FIELD)		(6) E.I.N. (MANDATORY FIELD)	NEW GROUP NUMBER CLIENT NUMBER
(7) ASSOCIATION / POOL: (MANDATORY FIELD)		(8) PRIOR GROUP NUMBER:	(9) COMMERCIAL CARRIER:
(10) BUSINESS ADDRESS (PHYSICAL LOCATION):			(11) CITY:
(12) STATE:	(13) ZIP+4:	(14) COUNTY:	(15) PHONE:
(16) E-MAIL ADDRESS:		(17) INDUSTRY TYPE:	(18) SIC (MANDATORY FIELD):
(19) SEND CONTRACTS TO:			
(20) HIGHMARK AGENCY NAME & TELEPHONE NUMBER			(21) HIGHMARK AGENCY NUMBER:
1. _____			
2. _____			
(22) PRODUCER NAME & TELEPHONE NUMBER:			(23) PRODUCER NUMBER:
1. _____			
2. _____			
(24) OWNERSHIP TYPE: <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> PROPRIETORSHIP <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> OTHER (SPECIFY): (MANDATORY FIELD) IF INCORPORATED, STATE OF CORPORATION: _____ IF A PARTNERSHIP OR PROPRIETORSHIP, LIST THE NAMES OF EACH PARTNER OR OWNER:			
1. _____		3. _____	
2. _____		5. _____	
4. _____		6. _____	
(25) PLAN SPONSORSHIP: (MANDATORY FIELD) <input type="checkbox"/> PRIVATE ENTITY (ERISA) <input type="checkbox"/> GOVERNMENT ENTITIES (NON-ERISA) <input type="checkbox"/> PUBLIC SCHOOLS (NON-ERISA) <input type="checkbox"/> CHURCH ENTITY (NON-ERISA)			
(26) GROUP ADMINISTRATOR:			(27) TITLE:
(28) EMPLOYER PAYS (MANDATORY FIELD) _____ % OF THE <input type="checkbox"/> INDIVIDUAL COST \$ _____ TOWARD THE <input type="checkbox"/> TOTAL COST _____ % OF THE <input type="checkbox"/> FAMILY COST \$ _____ TOWARD THE <input type="checkbox"/> FAMILY COST		(29) PLEASE LIST BILLING CONTACT NAME: _____ PLEASE LIST BILLING ADDRESS: _____	

**COMPANY SIZE (MANDATORY FIELD)**

\_\_\_\_\_ (30) CURRENT NUMBER OF FULL-TIME EMPLOYEES      \_\_\_\_\_ (31) CURRENT NUMBER OF PART-TIME EMPLOYEES  
\_\_\_\_\_ (32) TOTAL NUMBER OF SEASONAL/INTERMITTENT EMPLOYEES FOR CURRENT CALENDAR YEAR  
\_\_\_\_\_ (33) TOTAL NUMBER OF FULL-TIME EMPLOYEES ENROLLING IN COVERAGE

**(34) AVERAGE AGE:**

NEW TO HIGHMARK CLIENT . . . . . AVERAGE AGE OF THE FULL-TIME EMPLOYEE  
ENROLLING AS OF THE EFFECTIVE DATE \_\_\_\_\_

(35) DOES THE COMPANY HAVE A PROBATIONARY PERIOD FOR NEW EMPLOYEES?    YES     NO

(36) IF YES, COVERAGE BEGINS THE FIRST OF THE MONTH FOLLOWING \_\_\_\_\_ DAYS    \_\_\_\_\_ MONTHS

(37) DOES THE COMPANY WISH TO INCLUDE ELIGIBILITY COVERAGE FOR DOMESTIC PARTNERS?    YES     NO

(38) ARE ANY EMPLOYEES ELIGIBLE FOR MEDICARE?    YES     NO

**PRODUCT MIX (MANDATORY FIELD)**

(39) Other Carrier Offered?    NO     YES

If YES, Carrier Offered: \_\_\_\_\_

Product Offered: \_\_\_\_\_

<p><b>(40) RATING INFORMATION</b></p> <p><input type="checkbox"/> GROUP SIZE 2 - 50 EMPLOYEES (DEMOGRAPHIC RATES)</p>	<p><b>(41) COMPANY LOCATION:</b></p> <p><input type="checkbox"/> AREA A  <input type="checkbox"/> AREA B  <input type="checkbox"/> AREA C</p>	<p><b>(42) INDUSTRY TYPE:</b></p> <p><input type="checkbox"/> BAND 1  <input type="checkbox"/> BAND 2  <input type="checkbox"/> BAND 3</p>
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**(43) REMARKS:**

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\_\_\_\_\_

**(44) EMPLOYER AUTHORIZED SIGNATURE (MANDATORY FIELD)**

I, the undersigned, have the authority to represent this business and recognized the agency (or agencies) listed in "box 20" 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.

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

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