Group Enrollment Checklist

It's as easy as 1-2-3…

1. Please complete all information in Section 1 prior to submitting group member applications.

2. Verify that your employees have completed all other sections of their application, especially the following fields:
   - Name
   - Address
   - Date of birth
   - Social Security number
   - Marital status (If you provide domestic partner coverage, employee should have indicated this in "Other.")
   - Primary Care Physician (PCP) if choosing BlueCHiP
   - Health plan options
   - Applicant signature and date

3. For existing business, please submit completed information to:

For new business, please forward information to your BCBSRI representative or broker.

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

08/10 VBB-7720 • 8459

SALES AGREEMENT
(50 ELIGIBLE EMPLOYEES OR FEWER)

The Agreement (the "Agreement") between Blue Cross & Blue Shield of Rhode Island (hereinafter referred to as "BCBSRI") and the Group indicated below (hereinafter referred to as "GROUP") is effective on the first date of the Initial Term, as set forth in Section III of the Agreement.

SECTION I. GENERAL GROUP INFORMATION

(GROUP: Please complete Sections I and II and sign page 10.)

GROUP Name: ______________________________	Will GROUP use Electronic Enrollment? YES NO
DBA (if applicable)__________________________	ERISA 5500 Filing Month (list month) _____________
Federal Tax ID# ____________________________	If employees are represented by a Union please provide:
Mailing address	Union Name and Number: ______________________
Street ___________________________________	Contact Information:__________________________
City ________________ State ___ Zip _______	Does the GROUP offer a Pension Plan? YES NO
Phone_____________ Fax _________________	If GROUP offers any of the following, please provide:
Billing address (if different from above)	FSA Vendor Name ____________________________
Street ___________________________________	HRA Vendor Name ___________________________
City __________________State ___ Zip ______	HSA Vendor Name___________________________
Phone _____________Fax _________________	Business SIC#_____________
Contact Person (Administrator)________________	Requested Effective Date: _____/_____/_______
Administrator's Email Address________________	Total # of Employees (Full and Part time)____________
Business Type: Partnership Corporation	Total # of Eligible Employees _____________________
Association Sole Proprietorship Other______	Estimated # Employees Enrolling __________________

GROUP Subsidiary: If a subsidiary is included, please attach a list and include the following information for each subsidiary: Subsidiary's Name, Federal Tax ID #, Address, Date Business/ subsidiary started, Total # of employees (Full and Part time), Total # of Eligible Employees, and an estimated # of Eligible Employees enrolling. If GROUP adds a subsidiary during the term of the Agreement, GROUP agrees to submit written notification to BCBSRI, via telefax, electronic, or other reliable means. Subsidiary coverage will be effective on the effective date mutually agreed upon.

SECTION II. ELIGIBILITY AND CONTRIBUTION INFORMATION

1. Are Retirees eligible for coverage? YES NO If yes, how many? __________

2. Specify percentage or dollar amount of the Monthly Premium paid by the GROUP :
   Enrollee__________ Enrollee& Spouse____________ Enrollee & Children_______
   Enrollee, Spouse, and Children__________

3a. Employee Probationary Period (New Hires) *Coverage begins the first of the month following the completion of such probationary period.*
   Medical: Date of Hire 1 month 2 months Other ______________
   Dental: Date of Hire 1 month 2 months Other_______________

3b. If GROUP has an alternative probationary period please indicate the affected Eligible Employees:
   Management Other, describe: ____
   Describe the terms of the probationary period (select from pre-defined periods in 4a)____________________

4. Name of Worker's Compensation Carrier: ____
If any employees are not covered by Worker's Compensation, please attach a list of employees and job classification(s).

5. If any employees or dependents are currently covered by Medicare, please attach a list of employees/dependents.

6. If GROUP offers any other medical or dental plans, list insurance company or administrator name:
   Medical: ______________________________ *Dental*: ________________________________

7. If GROUP is replacing existing health insurance, indicate type of health care coverage, insurance company's name, and termination date for the plan being replaced:
   Medical: ______________________________ Termination date _____/_____/_______
   Dental: _______________________________ Termination date _____/_____/_______

SECTION III. BENEFITS AND FINANCIAL TERMS

For benefit details refer to Subscriber Agreement(s), incorporated herein by reference.

THE INITIAL TERM, HEALTH CARE COVERAGE PURCHASED, AND MONTHLY PREMIUM PER SUBSCRIBER SHALL BE:

Medical: _ _ / _ _ / _ _ _ _ through _ _ / _ _ / _ _ _ _ ("Initial Term")
Dental: _ _ / _ _ / _ _ _ _ through _ _ / _ _ / _ _ _ _ ("Initial Term")

Health Care Coverage Purchased			**Monthly Premium per Subscriber***			
Group Number(s):	*Product Name and SA Form#:*	*Description:*	*Enrollee Only*	*Enrollee & Spouse*	*Enrollee & Children*	*Enrollee, Spouse & Children*
			$	**$**	**$**	**$**
			$	**$**	**$**	**$**
			$	**$**	**$**	**$**
			$	**$**	**$**	**$**
			$	**$**	**$**	**$**
			$	**$**	**$**	**$**

*Final rates to be determined by BCBSRI. BCBSRI may require that certain other documents, such as current financial statements and detailed claims experience, be provided before coverage may be initiated.

REQUIRED DOCUMENTATION:
1. State of Rhode Island Employer's Quarterly Tax and Wage Report or current payroll statement
2. Current Financial Statement (where applicable)
3. Applicable Business Forms: Sole Proprietorship – copy of first page of 1040 and copy of Schedule C;
4. S Corporation – 1120S and all K-1s; Partnership – All K-1s
5. Group Risk Appraisal (where applicable)
6. Certificate of Employer Size and accompanying documentation
7. Detailed Claims experience (where applicable)

GROUP hereby verifies the above information is correct and can be confirmed through payroll and tax records.

BROKER DESIGNATION (if applicable): GROUP shall submit a broker designation notice ("Broker of Record") to BCBSRI; such notice shall identify the GROUP's designated broker(s). Upon receipt of the Broker of Record notice, BCBSRI shall be authorized to release to broker de-identified information, summary health information, and enrollment information on GROUP's behalf. The Broker of Record remains in effect for GROUP, including all subsidiaries of GROUP, until revoked or amended in writing by GROUP.

SECTION IV. TERMS AND CONDITIONS

1. DEFINITIONS.

The first letters of the defined terms used in the Agreement are capitalized. When used in the Agreement, the following terms shall have the meanings set forth below, unless otherwise expressly provided herein:

1.1. "Cause" means an alleged breach or the failure of the other Party to comply with any material term or condition of the Agreement.

1.2. "Eligible Employee" means:

a. an active employee of GROUP who works on a full-time basis with a normal work week of thirty or more hours. At GROUP's sole discretion, an Eligible Employee can also include all full-time employees

who work a normal work week anywhere between seventeen and one-half and thirty hours, as long as the GROUP applies the same eligibility criteria to all employees without regard to any health status related factor and GROUP pays for or provides:

- fringe benefits;
- wages and salaries; and
- contributes to the Monthly Premium charge for the Health Care Coverage selected.

b.an active or former employee for whom GROUP is obligated to provide coverage under Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA'), as amended from time to time.

To enroll in a BlueCHiP Health Plan ("BlueCHiP") an Eligible Employee must also live or work in the BlueCHiP service area, which includes the entire State of Rhode Island.

1.3. "Eligible Dependent" means a person who is eligible for coverage under the Agreement according to the terms of the applicable Subscriber Agreement(s), including coverage under COBRA.

1.4. "Eligible Retiree" means a retired employee of the GROUP who is receiving retirement benefits from GROUP and is entitled to Medicare part A and enrolled in Medicare part B. If this Agreement includes Group Plan 65, an Eligible Retiree who selects Group Plan 65 shall be eligible as an individual. Such Eligible Retiree shall not be deemed to have any dependents who can select Group Plan 65.

1.5. "Enrolled Member" means an Eligible Employee, Eligible Retiree, or Eligible Dependent identified to BCBSRI by GROUP as a person who shall receive Health Care Coverage under the Agreement.

1.6. "Health Care Coverage", if GROUP has selected medical and dental coverage, means both medical and dental coverage, unless otherwise specified.

1.7. "Monthly Premium" means the monthly per Subscriber fee due from GROUP for the benefits selected in Section III of the Agreement. The Monthly Premium fee includes: (i) rates for a given Rating Period, as determined by BCBSRI in accordance with the related approved rating formula on file with the Office of the Health Insurance Commissioner of the State of Rhode Island ("OHIC") and (ii) premium tax as calculated by BCBSRI in accordance with Rhode Island General Law ("RIGL") §44-17-1(a)(1).

1.8. "Party" or "Parties" means BCBSRI and/or GROUP.

1.9. "Rating Period" means the period of time that a rate is effective. Rates applicable to the Initial Term are set forth in Section III. Each successive Rating Period shall be a twelve month period, unless other arrangements are agreed upon by Parties.

1.10. "Subscriber" means an Eligible Employee or Eligible Retiree who also is an Enrolled Member.

1.11. "Subscriber Agreement(s)"and "SA" means the booklet that describes the Health Care Coverage provided to Enrolled Members. The Subscriber Agreement(s) applicable to the Initial Term are listed in Section III.

2. TERM AND TERMINATION.

2.1. Term.

2.1.1. Initial Term.

The Initial Term and the applicable Monthly Premium rates are set forth in Section III.

2.1.2. Extension of Agreement.

Following the Initial Term of the Agreement, the Agreement shall automatically renew for a successive Rating Period(s), unless terminated in accordance with the terms of the Agreement.

The Financial Terms, as set forth in Section III, shall change at the start of each Rating Period. BCBSRI shall send Financial Terms changes to GROUP in a writing signed by BCBSRI. Such writing shall constitute an amendment to the Agreement. The amendment shall be deemed accepted by GROUP upon payment of the applicable Monthly Premium for such Rating Period.

Any change to the terms and conditions of this Agreement, other than a change in the financial terms as described above or in Section IV (3.1), shall be communicated to GROUP in a writing approved by an officer of BCBSRI and signed by the Parties hereto, which writing shall constitute an amendment to the Agreement.

During any extension, the Agreement and all of its terms and conditions shall remain in full force and effect, except as otherwise amended or modified in writing.

2.2. Termination.

2.2.1. By GROUP.

GROUP may end all or part of the Agreement by providing BCBSRI with no less than thirty days prior written notice ("Notice Period") of its intent to terminate. The termination effective date shall be no earlier than the first day of the month following the end of the Notice Period.

GROUP shall have the right to end all or part of this Agreement effective as of the last date of the Initial Term, or the last date of any Rating Period subsequent to the Initial Term by providing BCBSRI with no less than thirty days prior written notice of its plan not to renew.

2.2.2. By BCBSRI.

2.2.2.1. Medical Coverage.

BCBSRI may end or refuse to renew the medical coverage as permitted by RIGL §27-50-6(a), or any other applicable law.

2.2.2.2. Dental Coverage.

BCBSRI may end the dental coverage upon sixty (60) days prior written notice for Cause ("Notice Period"). Such notice shall identify the Cause. GROUP shall have the right to cure the Cause within thirty days following receipt of such notice. The termination date for the dental coverage shall be no earlier than the first day of the month following the end of the Notice Period.

BCBSRI shall have the right to end the dental coverage effective as of the last date of the Initial Term, or the last date of any Rating Period subsequent to the Initial Term by providing GROUP with no less than thirty days prior written notice of its plan not to renew.

2.2.2.3. Health Care Coverage.

In the event GROUP shall materially fail to comply with Section IV(3.1) titled "Financial Terms of GROUP" with respect to either the medical or dental coverage, BCBSRI shall have the right to cancel the Agreement upon thirty-one days written notice. GROUP shall have the right to cure such non-compliance within said thirty-one days ("grace period'), as defined in Section 3.1 of the Agreement.

2.2.3. By GROUP or BCBSRI.

2.2.3.1. Medical Coverage.

Upon termination by either Party, each type of medical benefits furnished under the Agreement and identified in the applicable Subscriber Agreement(s) shall end.

2.2.3.2. Dental Coverage.

Upon termination by either Party, each type of dental benefits furnished under the Agreement and identified in the applicable Subscriber Agreement(s) shall end.

3. OBLIGATIONS OF GROUP

3.1. Financial Terms of GROUP.

The Monthly Premium per Subscriber rates for the Initial Term are set forth in Section III. BCBSRI shall send a Monthly Premium bill to GROUP. The payment is due on the first day of each month, unless another payment arrangement is agreed upon by both Parties.

BCBSRI may change the Monthly Premium rates at any time during the term of the Agreement if:

- benefits change at the request of GROUP.
- there is a significant change in enrollment.
- family composition changes.
- a change occurs that is required by law, such as a benefit change or increase in premium tax.

Any changes to the financial terms, as described in this section, shall be sent to GROUP in a writing signed by BCBSRI. Such writing shall constitute an amendment to the Agreement. The amendment shall be deemed accepted by GROUP upon payment of the applicable Monthly Premium for such Rating Period.

Any payment not received by BCBSRI within thirty-one days ("grace period") of the due date will be subject to a late payment charge, at the annual rate of twelve percent. The late payment charge will apply to each day after said grace period until payment is received by BCBSRI. GROUP shall also pay all cost incurred by BCBSRI. Incurred costs shall include unpaid premiums, attorneys' fees, and court costs. A one year waiting period shall be imposed on any group cancelled by BCBSRI for non-payment.

In the event GROUP does not agree with the amount of the Monthly Premium billing, GROUP shall pay, when due, the Monthly Premium bill which would have been payable absent the dispute. If the disputed amount is resolved in favor of the GROUP, BCBSRI shall pay the appropriate amount due to GROUP with interest. Interest will be calculated in the same manner as the late payment charges, described above.

3.2. Enrollment and Eligibility.

Only an eligible person, as defined in the Subscriber Agreement, shall be entitled to enroll for Health Care Coverage under the Agreement. The effective date of enrollment for an eligible person shall be on the first day of a calendar month.

GROUP agrees to make enrollment changes based on BCBSRI's enrollment guidelines and:

- enroll only eligible persons without regard to health status factors;
- notify BCBSRI of the name of eligible persons; and
- notify BCBSRI of the names of persons no longer eligible for Health Care Coverage.

Enrolled Members shall continue to be covered until GROUP notifies BCBSRI that such Enrolled Members are no longer eligible for Health Care Coverage. GROUP shall be responsible to pay BCBSRI for all Enrolled Members.

GROUP agrees to send all changes, upon discovery, to BCBSRI via approved method of electronic enrollment notification or fax.

Retroactive enrollment changes will not be honored, except as required by applicable law. The effective date of retroactive enrollment shall be the first of the month in which the request is received. GROUP agrees retroactive enrollment changes:

- will be requested to correct administrative errors;
- in the absence of such administrative error, will be requested to enroll or cancel employees and dependents on the date that they should have been enrolled or cancelled, based on the terms of the applicable Subscriber Agreement(s); and
- shall not request to enroll any person who had previously declined to enroll when first eligible.

Retroactive cancellations will not be permitted by BCBSRI under these terms until it is first confirmed that no claims have been incurred subsequent to the requested retroactive cancellation effective date. This includes all incurred claims not yet received and/or paid by BCBSRI, at the time of notification by GROUP of such requested retroactive cancellations.

GROUP agrees to pay the Monthly Premium owed to BCBSRI when a claim has been incurred after the requested cancellation date. GROUP agrees that BCBSRI shall have no liability to GROUP for health care services rendered to such Enrolled Members incurred before the effective date or after the termination date.

3.3. Coverage under COBRA.

If GROUP has twenty (20) or more employees as defined in the COBRA, GROUP shall notify BCBSRI on a timely basis of any "qualifying events", as defined in COBRA. GROUP shall notify BCBSRI of any election to continue coverage under COBRA. BCBSRI will end coverage upon notice of a qualifying event.

BCBSRI will retroactively reinstate coverage following election to continue coverage under COBRA, unless BCBSRI is specifically notified to the contrary by GROUP.

BCBSRI will continue COBRA coverage for such Enrolled Members until notified by GROUP to cancel. The cancellation date will be based on BCBSRI enrollment guidelines.

3.4. Distribution of Documents.

GROUP shall issue to Subscribers such documents as Subscriber Agreements, participating provider directories, and any other materials required to be distributed to Subscribers.

4. OBLIGATIONS OF BCBSRI.

In consideration of payment of the Monthly Premium, BCBSRI shall provide Health Care Coverage to Enrolled Members for the coverage described in the applicable Subscriber Agreement(s) listed in Section III. Such documents may be replaced, changed, or amended from time to time.

BCBSRI will provide an original copy of each Subscriber Agreement to GROUP. GROUP shall distribute a copy of the applicable Subscriber Agreement to its Subscribers. BCBSRI shall issue Subscriber Agreement(s) directly to the Subscribers when an Eligible Member requests a Subscriber Agreement through BCBSRI's customer service or grievance and appeals departments, or otherwise in response to a request from an Eligible Member or his/her representative.

5. RIGHT TO EXAMINE RECORDS.

BCBSRI and/or its authorized delegate shall be allowed to review all books and accounts of GROUP, which are reasonably necessary to confirm GROUP's performance of its obligations under the Agreement. This includes but is not limited to eligibility and enrollment records. All records shall be available during normal business hours for review.

6. RIGHTS AND RESPONSIBILITIES UNDER FEDERAL AND STATE PRIVACY LAWS.

6.1. Federal and State Privacy Laws.

Each Party shall comply with the applicable respective obligations under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 CFR Parts 160-164, jointly "HIPAA"), the Gramm-Leach-Bliley Financial Modernization Act (15 U.S.C. 6801-6908), state laws governing the privacy of medical records. This includes but is not limited to the Rhode Island Confidentiality of Health Care Communications and Information Act (RIGL 5-37.3 et seq.) and any other state and federal privacy laws in effect. BCBSRI shall protect the personal information pertaining to an Enrolled Member as required by Massachusetts Regulation 201.

Upon request, GROUP shall receive the following from BCBSRI, as defined by HIPAA:

- (i) De-Identified Information.
- (ii) Summary Health Information, for purposes of request premium bids or to make changes the GROUP's health plan.
- (iii) Enrollment and eligibility information.

GROUP shall not receive from BCBSRI Protected Health Information ("PHI"), as defined by HIPAA, except as allowed under law.

6.2. Obligations Under ERISA, COBRA, and Other Laws.

For the purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"), COBRA, or any other federal or state law, GROUP and BCBSRI agree that BCBSRI is not the plan administrator of GROUP's health plan and BCBSRI shall not have any reporting or other responsibilities.

7. BLUE CROSS AND BLUE SHIELD ASSOCIATION.

7.1. Blue Cross and Blue Shield Association.

GROUP expressly acknowledges the understanding that the Agreement constitutes an agreement between GROUP and BCBSRI and that BCBSRI is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield plans. The Association permits BCBSRI to use the Blue Cross and Blue Shield service marks in the State of Rhode Island, and BCBSRI is not contracting as the agent of the Association. GROUP further accepts and agrees that it has not entered into the Agreement based upon representations by any person other than BCBSRI, and that no person, entity, or organization other than BCBSRI shall be held responsible or liable to GROUP for any of BCBSRI's obligations to GROUP created under the Agreement.

7.2. Out-of-Area Services

BCBSRI has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Enrolled Members access healthcare services outside the geographic area BCBSRI serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSRI for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Enrolled Members under the Agreement are described generally below.

Typically, Enrolled Members, when accessing care outside the geographic area BCBSRI serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Enrolled Members may obtain care from non-participating healthcare providers. BCBSRI payment practices in both instances are described below.

If the Agreement includes BlueCHiP coverage, BCBSRI covers only limited healthcare services received outside of BCBSRI service area. As used in this section, "Out-of-Area Covered Healthcare Services" include covered health care services obtained outside the geographic area BCBSRI serves that: (a) qualify as emergency care or urgent care, or (b) are provided with a referral from the Enrolled Member's primary care physician ("PCP") and approved by BCBSRI, or (c) are included in the flex plan rider, as described in the BlueCHiP Subscriber Agreement(s). Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

7.2.1. BlueCard® Program

Under the BlueCard® Program, when Enrolled Members access covered healthcare services within the geographic area served by a Host Blue, BCBSRI will remain responsible to GROUP for fulfilling BCBSRI contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers including some managed care services, as applicable. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, BCBSRI's action will be consistent with the spirit of this description. The BlueCard program does not apply to Group Plan 65 and dental coverage.

7.2.1.1. Liability Calculation Method Per Claim

The calculation of the Enrolled Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to BCBSRI by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to BCBSRI by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases; or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Enrolled Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCBSRI is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Enrolled Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCBSRI would then calculate Enrolled Member liability in accordance with applicable law.

7.2.1.2. Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

7.2.2. Non-Participating Healthcare Providers Outside BCBSRI Service Area.

7.2.2.1. Enrolled Member Liability Calculation.

When covered healthcare services are provided outside of BCBSRI service area by non-participating healthcare providers, the amounts an Enrolled Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Enrolled Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSRI will make for the covered services as set forth in this paragraph.

7.2.2.2. Exceptions.

In some exception cases, BCBSRI may pay claims from non-participating healthcare providers outside of BCBSRI service area based on the provider's billed charge, such as in situations where an Enrolled Member did not have reasonable access to a participating provider, as determined by BCBSRI in BCBSRI sole and absolute discretion or by applicable state law. In other exception cases, BCBSRI may pay such claims based on the payment BCBSRI would make if BCBSRI were paying a non-participating provider for the same covered healthcare services inside of BCBSRI service area, as described in the Subscriber Agreements, where the Host Blue's corresponding payment would be more than BCBSRI in-service area non-participating provider payment, or in BCBSRI sole and absolute discretion, BCBSRI may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Enrolled Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSRI will make for the covered services as set forth in this paragraph.

8. GENERAL PROVISIONS.

8.1. Assignment.

The Agreement shall bind and inure to the benefit of and be enforceable by the Parties, their respective successors, and permitted assigns. The Agreement, including all rights or obligations of GROUP, may not be assigned or transferred by GROUP without the prior written consent of BCBSRI. BCBSRI may assign or transfer the Agreement and/or its rights or obligations to an affiliate of BCBSRI by providing written notice to GROUP.

8.2. Waiver.

The failure of any Party to insist upon strict performance of a covenant or representation of any obligation, irrespective of the length of time for which such failure continues, shall not be a waiver of such Party's right to demand strict compliance in the future. No consent or waiver, express or implied, to or of any breach or default in the performance of any obligation, shall constitute a consent or waiver to or of any other breach or default in the performance of the same or any obligation hereunder.

No term of the Agreement may be waived, unless such waiver is in writing and signed by the Party against whom such waiver is sought to be enforced.

8.3. Applicable Law.

The Agreement shall be governed by federal laws and the laws of the State of Rhode Island.

8.4. Entire Agreement; Severability.

If any term of the Agreement is illegal, invalid or not enforceable under any law, present or future, the remainder of the Agreement shall not be affected. The Parties shall work in good faith to replace any such term with a valid, legal, and enforceable term as similar in terms to the original term as is possible.

The Agreement is the entire understanding between the Parties with respect to the transactions contemplated herein. Any changes to the Agreement will be sent in a writing signed by the Parties, except as otherwise permitted in Section III and Section IV(3.1). Such writing shall be an amendment to the Agreement.

8.5. Third Party Beneficiaries.

The Agreement is entered into solely between, and may be enforced only by, BCBSRI and GROUP. The terms of the Agreement shall not be deemed to create any rights in third parties or obligations of BCBSRI or GROUP to any such third parties. This includes employees, third party vendors, and customers of BCBSRI or GROUP. Nothing herein shall limit the rights of an Eligible Member from seeking to enforce his/her rights pursuant to the applicable Subscriber Agreement.

8.6. Notice.

All notices required under the Agreement shall be in writing. Notices shall be delivered by postage-prepaid certified mail or overnight carrier, return receipt requested. Notice shall be sent to the signatory and the address shown in Section 10 of the Agreement or to such other person and address as may be provided in writing by either Party. The date indicated on the return receipt shall be the notice effective date.

9. REGULATORY COMPLIANCE.

The Agreement is intended to comply with Rhode Island Insurance Regulation 23 ("Regulation 23"), as amended from time to time. The following provisions are included in order to be compliant with Regulation 23:

- The validity of the Agreement shall not be contested after it has been in force for two years from its date of issue except for non-payment of premiums and other amounts due.
- A copy of the application and/or Risk Appraisal, if any, made by GROUP to obtain coverage under the Agreement shall be attached to the Agreement. All statements made by GROUP in the Agreement shall be deemed to be representations and not warranties.
- All benefits payable under the Agreement shall be paid not later than sixty days after receipt of proof of loss.
- No statement made by any Eligible Employee, Eligible Retiree, or Eligible Dependent shall be used to avoid insurance or reduce benefits unless:
    - such insurance has been in force for a period of less than two years during such individual's lifetime;

- such statement was contained in a written instrument signed by the individual making the statement; and
- a copy of the written instrument was provided to the individual.

10. SIGNATURE.

GROUP, through its authorized representatives, employees, and/or agents, has read and accepts the terms and conditions of the Agreement.

The Agreement is not binding until signed by the GROUP and by an officer of BCBSRI. A signed copy of the Agreement will be sent to GROUP. The Agreement may be executed and delivered by facsimile or e-mail, and such facsimile or e-mail delivery shall constitute the final agreement of the Parties and conclusive proof of this Agreement.

IN WITNESS WHEREOF, BCBSRI and GROUP have executed the Agreement.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	**GROUP**
By: ______________________ Authorized Signature Print Name: Thomas D. Cauthorn Title: Vice President and Chief Sales Officer Notice Address: Blue Cross & Blue Shield of Rhode Island 500 Exchange Street Providence, RI 02903 Date: ____/______/________	By: ______________________ Authorized Signature Print Name: ______________________ Title: ______________________ Notice Address: ______________________ ______________________ ______________________ Date: ____/______/________

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

AFFIDAVIT FOR OWNER/EMPLOYEE NOT ON PAYROLL

THIS INSTRUMENT HEREBY ACKNOWLEDGES that the undersigned, ___________________, ("affiant"),

[name]

residing at ____, is of legal age, and does hereby swear and affirm that

[address, city, and state]

the following is true and accurate, to the best of [his/her] knowledge, under penalty of perjury:

I am an eligible employee of_______________________, according to the definition of an eligible employee put forth in Rhode Island Small Group Law 27-50(m): "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this eligibility criterion is applied uniformly among all of the employer's employees and without regard to any health status-related factor. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than seventeen and one-half (17.5) hours per week. Any retiree under contract with any independently incorporated fire district is also included in the definition of eligible employee. Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation requirements pursuant to section 27-50-7(d)(9).

I also certify that I do not currently appear on a formal payroll document, or a RI Quarterly Tax and Wage Report. Upon the end of the tax year, I will be able to justify my wages by submitting the following tax documentation:

- Schedule C – Profit or Loss From Business
- Schedule F – Profit or Loss From Farming
- 1099 – Miscellaneous Income
- 1065K1 – Partners Share of Income
- 1120 – Corporation Income Tax Return

I further understand that misrepresenting myself as an eligible employee of said company for the purposes of obtaining health insurance will be treated as fraud and will give Blue Cross the right to void my insurance contract.

Signed this _______ day of ____________, _________.
[day] [month] [year]

____
Print Name of Affiant

____
Signature of Affiant

____

____
Address

STATE OF _____________________

COUNTY OF ____________________

In _______________, on the _____________ day of ____________, 20___, before me, a Notary Public in and for the above state and county, personally appeared ____ , known to me or proved to be the person named in and who executed the foregoing instrument, and being first duly sworn, such person acknowledged that he or she executed said instrument for the purposes therein contained as his or her free and voluntary act and deed.

Type of ID Produced: _________________________

Affiant __ is __ is not personally known to me.

_______________________________ NOTARY PUBLIC

My Commission

Expires: ________ (SEAL)

Note: If your group is unable to provide a formal payroll document or a RI Quarterly Tax and Wage Report, please also attach ONE of the following:

- Name of Company as filed and viewable in the Secretary of State website
- Copy of license or permit as a RI business
- Copy of RI Sales Tax or Litter Permit
- Copy of RI Business Application and Registration form submitted to RI Division of Taxation
- Copy of a contract that verifies income as a Business
- Rhode Island Bank Account in the Company Name
- Rhode Island Phone Bill/Utility Bill in the Company Name
- And other documentation that verifies that you are a RI business

Prospect Data Profile

Company Name: ___________________________________
Company Address: ___________________________________
Contact Person: ___________________________________
Effective Date: ___________________________________
Business Phone: ___________________________________
Cell Phone: ___________________________________
Fax Number: ___________________________________
E-mail Address: ___________________________________
Current Carrier: ___________________________________

Current Rates:
Individual: ___________________________________
Employee & Spouse: ___________________________________
Employee & Children: ___________________________________
Family: ___________________________________
Broker Name (if applicable): ___________________________
Number of Employees Enrolling: ___________________________
Number of Employees Waiving Coverage: ___________________
Requesting Quote for: ☐ Medical and Dental Coverage ☐ Medical Coverage Only ☐ Dental Coverage Only

Employee Census			
Employee Name	**DOB**	**Gender**	**Coverage Type**
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)
		☐ Male ☐ Female	☐ Individual ☐ Employee & Spouse ☐ Employee & Children ☐ Waiving Coverage ☐ Family (Employee, Spouse, and Children)

If you need more space, attach another copy.

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04/09 SAL-5577

Group Member Application for Health and Dental Insurance

Please be sure ALL information below is complete to avoid delays in processing.
Please **print clearly** using blue or black ink.

Section 1 Employer Information (To be completed by plan administrator.)

Group name		Effective date (mm/dd/yyyy)	Date of hire (mm/dd/yyyy)
Group number	Dept. number		

Choose one:
- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (HIPAA Certificate of Creditable Coverage required)
- ☐ Other ____________________

or

Add dependent(s)
- ☐ Spouse
- ☐ Dependent

Date of event (mm/dd/yyyy) ________________
(Must add within 31 days of marriage, birth, or adoption of dependent.)

Section 2 Employee Information

Last name	Suffix	First name	M.I.
Home address (street/apartment number)	City/town	State	ZIP code

Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Marital status (please check one)
☐ Single ☐ Married ☐ Divorced ☐ Common law ☐ Other ____________________

Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 3 Health Plan Options

Plan type

☐ **Medical:** ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren)
☐ Enrollee, spouse and child(ren)

☐ **Dental:** ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren)
☐ Enrollee, spouse and child(ren)

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

What product(s) are you selecting?

- ☐ HealthMate Coast-to-Coast ______________
- ☐ HealthMate Coast-to-Coast HDHP ______________
- ☐ BlueSolutions for HRA ______________
- ☐ BlueSolutions for HSA ______________
- ☐ BlueCHiP ______________
- ☐ Classic ______________
- ☐ Dental ______________

Section 4 Spouse Information

Last name	Suffix	First name	M.I.

Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 5 Dependent Information (If necessary, please attach dependent addendum.)

Dependent #1 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter

Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*

Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter

Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*

Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans)			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans)			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

☐ **Check here if Group Dependent Addendum form will be attached.**

Section 6 Other Insurance

Are you or any of your dependents covered by other insurance?
☐ Yes ☐ No

Name of other insurance company and name(s) of covered person(s):

Covered person 1 ______________________
Insurance company ______________________
Member ID #1 ______________________

Covered person 2 ______________________
Insurance company ______________________
Member ID #2 ______________________

What is the name of your prior health insurance carrier?
____
____

What was the date of termination? (mm/dd/yyyy)
____
If loss of coverage, please attach a copy of the Certificate of Creditable Coverage.

Is anyone named in this application eligible for Medicare?
☐ Yes ☐ No

If yes, name of eligible person
____

Is the eligible person ☐ Over 65 ☐ Disabled	Retired date (if applicable) ______________________	Medicare number __ __ __ - __ __ - __ __ __ __ - ____

Effective dates: (mm/dd/yyyy)
Part A (hospital): ______________________ Part B (medical): ______________________

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Section 7 Signature

By signing this form,

1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me and my minor dependents. I permit BCBSRI to use such medical records and reports for purposes of:
- claims payment,
- case management,
- coordination of benefits,
- any other purpose directly related to the administration of BCBSRI, and
- inviting me and my enrolled members to take part in medical, disease, or case management programs.

This approval shall end two (2) years from the issue date of this plan, unless canceled sooner.

2.) I certify the information is true and complete to the best of my knowledge.

____

Signature of applicant Date

Application rec'd date____________________ ID #____

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Blue Cross & Blue Shield of Rhode Island
Small Employer Waiver Form/Certification

EMPLOYER NAME		GROUP ID. NO.	
EMPLOYEE NAME		DATE	

REASON FOR WAIVER *CHECK THE ONE THAT APPLIES*	¨ COVERED UNDER A SPOUSE'S PLAN ¨ COVERED UNDER A PARENT OR GUARDIAN'S PLAN ¨ OTHER (PLEASE SPECIFY):____________________ ____ ____	**OTHER INSURANCE INFORMATION** Name of policy holder with other insurance: ____ Name of other insurance: ____ ____
TYPE OF WAIVER *CHECK ALL THAT APPLY*	Waiver is for: ¨ Employee ¨ Spouse ¨ Child/Children	Waiver is for: ¨ Health only ¨ Dental only ¨ Health & Dental

LIST THE NAMES OF EMPLOYEE'S SPOUSE, AND/OR CHILDREN INCLUDED IN THIS WAIVER	Spouse's Name: ____ Children's Names*: 1. ____ 2. ____ 3. ____ 4. ____ *Note: For children, please list the name of each unmarried child who is included in this waiver and is (a) under age 19; (b) a student between the ages of 19 and 25 that is financially dependent upon the employee; or (c) disabled and financially dependent upon the employee.

I understand that, by waiving coverage under my employer's plan at this time, my request for coverage at a later time may subject me or my dependents to penalties not imposed on other subscribers, including, if applicable, the application of a pre-existing condition exclusion provision.

However, if I am declining enrollment for myself or for my dependents (including my spouse) because of other health insurance coverage, I may be able to enroll myself or my dependents in my employer's plan without any pre-existing condition exclusion if that coverage ends in the future, provided that I request enrollment within thirty (30) days after that coverage ends. In addition, if I get married or have a child (whether by birth, adoption, or placement for adoption) after I decline enrollment, I may be able to enroll myself and my dependents in my employer's plan at that time without any pre-existing condition exclusion, provided that I request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Complete only one of the following sections (Waiver by Employee or Certification of Employer):

WAIVER BY EMPLOYEE		CERTIFICATION OF EMPLOYER The employee was offered coverage and was presented this form, but he or she declined coverage, refused to sign this form, or was unable to sign it.	
______________________________ SIGNATURE	____/_____/_____ DATE	______________________________ SIGNATURE	______/_____/_______ DATE
______________________________ PRINTNAME		______________________________ PRINTNAME	