SMALL BUSINESS GROUP HEALTH INSURANCE PROGRAM RENEWAL APPLICATION

Instructions: Please complete this form **only if you wish to change your benefit coverage or add optional benefits**. Return it in the enclosed postage-paid envelope or fax it to us at **302.421.3354**.

SECTION A

Please **choose 2 plan options** from the benefit plans listed below.

Standard

☐ IPA Standard $10 with $5 or 25% Rx

Basic

☐ IPA Basic $10 with no Rx

Blue Care® IPA Benefits	**Rx Plan Option No.**
☐ IPA $15/$25 100	________
☐ IPA $20/$40 100	________
☐ IPA $30/$60 100	________
Blue Choice PPO Benefits	
☐ PPO $15 $0 Ded. 90/70	________
☐ PPO $25 $500/$1,500 80/60	________
☐ PPO $30 $3,000/$6,000 80/60	________
Simply Blue EPO Benefits	
☐ EPO 100 $250	________
☐ EPO 100 $500	________
☐ EPO 100 $1,000	________
☐ EPO $15 $0 Ded. 90	________
☐ EPO $25 $500/$1,500 80	________
☐ EPO $15 $1,000/$2,000 80	________
☐ EPO $15 $2,000/$4,000 80	________
☐ EPO $30 $3,000/$6,000 80	________
Simply Blue EPO Value Option Benefits	
☐ EPO $750 80	________
☐ EPO $1,500 80	________

If you are making a change, but keeping an existing health plan, which is not listed above please indicate your renewal plan(s) and Rx option(s) below.

1) Health Plan________________ ☐ Rx Option____________

2) Health Plan________________ ☐ Rx Option____________

Blue Advantage (HSAs and HRAs)

The following are high-deductible health plans that are compatible with a Health Savings Account (HSA) and a Health Reimbursement Arrangement (HRA). Please contact your broker or call one of our Highmark Blue Cross Blue Shield Delaware Marketing representatives at 800.572.4400 for additional details and/or assistance.

HSAs	**Rx Plan Option No. (HRA only)**
☐ HSA PPO $1500/$3000 100/80	________
☐ HSA EPO $1,350/$2,700 100*	________
☐ HSA EPO $1,500/$3,000 100	________
☐ HSA EPO $2,000/$6,000 100*	________
☐ HSA EPO $2,500/$7,500 100	________
☐ HSA EPO $5,000/$10,000 100	________
☐ HSA EPO $1,500/$3,000 ***Hybrid***	________
☐ HSA EPO $3,000/$6,000 ***Hybrid***	________
HRAs	
☐ HRA PPO $1,500/$3,000 100/70	________
☐ HRA PPO $2,000/$6,000 100/70	________
☐ HRA EPO $1,500/$3,000 100	________
☐ HRA EPO $2,000/$6,000 100	________
☐ HRA EPO $2,500/$7,500 100	________
☐ HRA EPO $5,000/$15,000 100	________
☐ HRA EPO $5,000/$15,000 80	________
HRA Alternative Option Benefits	
☐ HRA EPO $25 $2,500/$5,000 80	________

Will you be offering a HSA and/or HRA with your high deductible health plan?

☐ Yes ☐ No

Note: The HSA Plans have the Integrated Drug Card option only. With the HRA Plans, you have the choice of selecting a Prescription Drug (Rx) Plan Option.

Your Prescription Drug Card Option Choice

Please indicate your drug option number in the blank space next to your medical plan selection(s).

Rx Plan Options:

1 $ 0/$20/$60 Rx Plan with no deductible
2 $10/$20/$35 Rx Plan with no deductible
3 $10/$25/$50 Rx Plan with no deductible
4 $15/$30/$60 Rx Plan with no deductible
5 $20/$60/$80 Rx Plan with no deductible
6 $15/$75/$100 Rx Plan with no deductible

*Integrated drug covered at 100% after deductible is met.

SECTION B

Check one box to indicate the Medicare Supplement program your company wishes to offer to retirees who are enrolled in Medicare Parts A and B.

☐ None ☐ Secure 65 ☐ Special Medicfill®° ☐ Special Medicfill®° with $10/$25/$50 Rx

SECTION C

Check the box(es) to indicate the dental and vision benefits you wish to offer. You may offer our **Traditional** or the new dual option **Blue Dental DHMO/PPO** plan. Traditional dental cannot be combined with the dual option Blue Dental DHMO/PPO plan.

Employers adding Traditional dental and vision must complete an **Account Roster**.

Employees adding either Traditional or DHMO/PPO must complete an individual application.

Please call us at **800.572.4400** for information about our dual option Blue Dental DHMO/PPO program.

☐ Traditional dental

☐ Blue Dental DHMO/PPO*

☐ Continue current dental coverage

☐ None

☐ Cancel our current dental program

*The dual option Blue Dental DHMO/PPO plan replaces the Dental Health Plus (DHP) plan.

Vision

☐ BlueVision Premier

SECTION D

I certify I am authorized to represent my company in the purchase and administration of the group insurance program.

Company representative's signature: ____________________

Date (month, day, year):____________________

Print your name and title: ____________________

Federal Employer ID Number:____________________

SIC Number: ____________________

Company Name:____________________

Company Email: ____________________

Account Number:____________________

Please Note: This application must be received by Highmark Blue Cross Blue Shield Delaware 15 days before your requested effective date.

If you have any questions about this application, please call us at **800.572.4400**.

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