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SMALL GROUP APPLICATION/CHANGE FORM (2-50 eligible employees)

Thank you for choosing Empire. Please fill out **all** items below and **print clearly in black or blue ink** in order for us to quickly and accurately process your group's application. Once you've completed this form, please sign in the space provided in **Section 11**.

Current Group Number (if applicable)

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1. REASON FOR APPLICATION/CHANGE

(fill in one only)

New

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Change Existing Benefits

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Requested Effective Date (MMDDYY)

Revision or Renewal Date (MMDDYY)

Sales Representative Last Name

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First Name

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2. GROUP INFORMATION

Group Name (as it appears on documents attached)

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Doing Business As

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Group Mailing Address

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City

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State

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ZIP (5+4)

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County

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Phone

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Fax

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Authorized Group Contacts

Primary Group Contact Last Name

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Primary Group Contact First Name

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Title

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E-mail Address (Benefit Administrator) — mandatory

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Secondary Group Contact Last Name

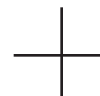
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Secondary Group Contact First Name

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Title

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6. MEDICAL BENEFITS SECTION

Please select all of the coverage options you wish to use, and then fill out the details under the coverage sections.

- HMO*
 Direct HMO*
 Direct POS*
 DirectShareSM POS
 PPO
 EPO
 Value EPO
 Comprehensive Hospital/Medical
 Empire Total BlueSM with HSA
 Empire Prism EPO
 Other _____

*HMO benefits provided by Empire HealthChoice HMO, Inc.

HMO / DIRECT HMO

Please select only one product: HMO Direct HMO

Co-payment Options (fill in one only)

Co-payment Options	Inpatient Co-pay	PCP/Primary Home/Office Co-pay	Specialist Home/Office Co-pay	ER Co-pay	Ambulatory/OP Surgery Co-pay
<input type="radio"/> Opt 2	\$0	\$10	\$10	\$35	\$0
<input type="radio"/> Opt 3	\$250/\$625*	\$10	\$10	\$35	\$0
<input type="radio"/> Opt 4	\$500/\$1,250*	\$15	\$15	\$35	\$0
<input type="radio"/> Opt 5	\$0	\$20	\$20	\$35	\$0
<input type="radio"/> Opt 6	\$500/\$1,250*	\$20	\$20	\$35	\$0
<input type="radio"/> Opt 7	\$0	\$25	\$25	\$75	\$0
<input type="radio"/> Opt 8	\$0	\$25	\$40	\$75	\$0
<input type="radio"/> Opt 9	\$500/\$1,250*	\$25	\$40	\$75	\$75
<input type="radio"/> Opt 10	\$0	\$30	\$50	\$100	\$0
<input type="radio"/> Opt 11	\$500	\$30	\$50	\$100	\$100
<input type="radio"/> Opt 12	\$1,000	\$30	\$50	\$150	\$150

*per admission/family maximum per calendar year

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$5	\$20	\$40
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$25	\$50
<input type="radio"/>	\$10	\$35	\$70
<input type="radio"/>	\$10	50%	N/A [†]
<input type="radio"/>	\$15	N/A	N/A [†]

Deductible** (fill in one only)

- \$0 \$50 \$100 \$150
 \$250*** \$500***
 No prescription drug coverage

*Groups exempt from purchasing contraceptives must attach a signed affidavit.

**Not applicable to mail-order program.

***Available with 10/35/70 co-pay only

[†] Mandatory \$0 deductible

Rating Structure (fill in one only)

- 2-Tier 3-Tier 4-Tier

Vision Option (fill in one only)

Co-payment (fill in one)

- \$5 \$10

Benefit cycle (fill in one)

- 12-month 24-month

Plan choice (fill in one)

- Low (exam plus discounts)
 High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
 No vision coverage

Miscellaneous Options (fill in all of the following options you wish to purchase)

- Inpatient mental and behavioral health care increases from 30 to 45 days
 Skilled nursing facility increases from 60 to 120 days
 Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
 Outpatient mental and behavioral health care increases from 20 to 40 visits
 Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
 Waive waiting period for pre-existing conditions
 No additional options

HMO / DIRECT HMO

Please select only one product: HMO Direct HMO

Co-payment Options (fill in one only)

Co-payment Options	Inpatient Co-pay	PCP/Primary Home/Office Co-pay	Specialist Home/Office Co-pay	ER Co-pay	Ambulatory/OP Surgery Co-pay
<input type="radio"/> Opt 2	\$0	\$10	\$10	\$35	\$0
<input type="radio"/> Opt 3	\$250/\$625*	\$10	\$10	\$35	\$0
<input type="radio"/> Opt 4	\$500/\$1,250*	\$15	\$15	\$35	\$0
<input type="radio"/> Opt 5	\$0	\$20	\$20	\$35	\$0
<input type="radio"/> Opt 6	\$500/\$1,250*	\$20	\$20	\$35	\$0
<input type="radio"/> Opt 7	\$0	\$25	\$25	\$75	\$0
<input type="radio"/> Opt 8	\$0	\$25	\$40	\$75	\$0
<input type="radio"/> Opt 9	\$500/\$1,250*	\$25	\$40	\$75	\$75
<input type="radio"/> Opt 10	\$0	\$30	\$50	\$100	\$0
<input type="radio"/> Opt 11	\$500	\$30	\$50	\$100	\$100
<input type="radio"/> Opt 12	\$1,000	\$30	\$50	\$150	\$150

*per admission/family maximum per calendar year

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$5	\$20	\$40
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$25	\$50
<input type="radio"/>	\$10	\$35	\$70
<input type="radio"/>	\$10	50%	N/A [†]
<input type="radio"/>	\$15	N/A	N/A [†]

Deductible** (fill in one only)

- \$0 \$50 \$100 \$150
 \$250*** \$500***
 No prescription drug coverage

*Groups exempt from purchasing contraceptives must attach a signed affidavit.

**Not applicable to mail-order program.

***Available with 10/35/70 co-pay only

[†] Mandatory \$0 deductible

Rating Structure (fill in one only)

- 2-Tier 3-Tier 4-Tier

Vision Option (fill in one only)

Co-payment (fill in one)

- \$5 \$10

Benefit cycle (fill in one)

- 12-month 24-month

Plan choice (fill in one)

- Low (exam plus discounts)
 High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
 No vision coverage

Miscellaneous Options (fill in all of the following options you wish to purchase)

- Inpatient mental and behavioral health care increases from 30 to 45 days
 Skilled nursing facility increases from 60 to 120 days
 Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
 Outpatient mental and behavioral health care increases from 20 to 40 visits
 Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
 Waive waiting period for pre-existing conditions
 No additional options

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6. MEDICAL BENEFITS SECTION (continued)

EMPIRE TOTAL BLUESM COVERAGE W/ HSA OPTIONS

Option	In-Network				Out-of-Network			
	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Maximum	Out-of-Pocket Maximum Individual/Family	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Out-of-Pocket Maximum Individual/Family
<input type="radio"/> 1	\$1,250/ \$2,500	80/20%	\$10,000/ \$20,000	\$2,000/ \$4,000	\$5,000/ \$10,000	60/40%	\$25,000/ \$50,000	\$10,000/ \$20,000
<input type="radio"/> 2	\$1,500/ \$3,000	80/20%	\$17,500/ \$35,000	\$3,500/ \$7,000	\$3,000/ \$6,000	60/40%	\$17,500/ \$35,000	\$7,000/ \$14,000
<input type="radio"/> 3	\$2,000/ \$4,000	80/20%	\$15,000/ \$30,000	\$3,000/ \$6,000	\$3,500/ \$7,000	60/40%	\$17,500/ \$35,000	\$7,000/ \$14,000
<input type="radio"/> 4	\$2,000/ \$4,000	80/20%	\$15,000/ \$30,000	\$3,000/ \$6,000	\$10,000/ \$20,000	50/50%	\$40,000/ \$80,000	\$20,000/ \$40,000
<input type="radio"/> 5	\$2,500/ \$5,000	80/20%	\$12,500/ \$25,000	\$2,500/ \$5,000	\$4,500/ \$9,000	60/40%	\$20,000/ \$40,000	\$8,000/ \$16,000
<input type="radio"/> 6	\$3,000/ \$6,000	80/20%	\$10,000/ \$20,000	\$2,000/ \$4,000	\$10,000/ \$20,000	50/50%	\$40,000/ \$80,000	\$20,000/ \$40,000
<input type="radio"/> 7	\$5,000/ \$10,000	100%	N/A	N/A	\$10,000/ \$20,000	70/30%	\$66,667/ \$133,334	\$20,000/ \$40,000
<input type="radio"/> 8	\$3,000/ \$6,000	100%	N/A	N/A	\$6,000/ \$12,000	60/40%	\$30,000/ \$60,000	\$12,000/ \$24,000

Prescription Drug Option

- Drug Coverage (Generic \$10, Brand \$30, Non-Formulary \$50 after deductible* and includes contraceptives**) No Drug Coverage at all

*Rx Co-pays do not apply to Options 7 and 8 but drug option must be selected to receive coverage

**Eligible groups exempt from purchasing contraceptives must submit a signed affidavit for consideration.

Vision Option (fill in one only)

- Co-payment** (fill in one) \$5 \$10

- Benefit cycle** (fill in one) 12-month 24-month

Plan choice (fill in one)

- Low (exam plus discounts)
 High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
 No vision coverage

Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year) Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network Group will establish HSA, but DOES NOT want Empire to facilitate No additional options

DIRECT POS COVERAGE OPTIONS

	In-Network			Out-of-Network			
	PCP/Primary Home/Office Co-payment	Specialist Home/Office Co-payment	Inpatient Co-payment	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
<input type="radio"/> Option 1	\$15	\$15	\$0	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 2	\$15	\$15	\$250/\$625*	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 3	\$20	\$20	\$0	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 4	\$20	\$20	\$250/\$625*	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 5	\$20	\$20	\$500/\$1,250*	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 6	\$20	\$20	\$0	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 7	\$20	\$20	\$250/\$625*	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 8	\$20	\$20	\$500/\$1,250*	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 9	\$15	\$15	\$0	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
<input type="radio"/> Option 10	\$15	\$15	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
<input type="radio"/> Option 11	\$20	\$20	\$0	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
<input type="radio"/> Option 12	\$20	\$20	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
<input type="radio"/> Option 13	\$25	\$40	\$0	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 14	\$25	\$40	\$0	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 15	\$25	\$40	\$0	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
<input type="radio"/> Option 16	\$25	\$40	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000

- Out of Network UCR Option (Usual, Customary and Reasonable Fee Reimbursement) 70% 80%

Note: ER co-pay: Options 1–12 — \$50 Options 13–16 — \$75 Ambulatory/OP Surgery co-pay: Option 16 — \$75 *per admission/family maximum per calendar year

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6. MEDICAL BENEFITS SECTION (continued)

Vision Option (fill in one only)

Co-payment (fill in one) \$5 \$10

Benefit cycle (fill in one)

12-month 24-month

Plan choice (fill in one)

- Low (exam plus discounts)
- High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
- No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$5	\$20	\$40
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$25	\$50
<input type="radio"/>	\$10	\$35	\$70
<input type="radio"/>	\$10	50%	N/A†
<input type="radio"/>	\$15	N/A	N/A†

Deductible** (fill in one only)

- \$0 \$50 \$100
- \$150 \$250 \$500
- No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

** Not applicable to mail-order program.

† Mandatory \$0 deductible

Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network
- Waiver for pre-existing conditions
- No additional options

DIRECTSHARESM POS OPTIONS

Co-payment Options (fill in one only)

	In-Network								Out-of-Network			
	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	In-patient Co-Pay*	Deductible*	Coinsurance*	Coinsurance Stop Loss*	Out-of-Pocket Coinsurance Max*	Deductible*	Coinsurance	Coinsurance Stop Loss*	Out-of-pocket Coinsurance Max	
<input type="radio"/> Option 1	\$25	\$40	Ded + Coins	\$ 250	90%/10%	\$10,000	\$1,000	\$1,500	70%/30%	\$10,000	\$3,000	
<input type="radio"/> Option 2	\$30	\$50	Ded + Coins	\$ 500	90%/10%	\$10,000	\$1,000	\$1,000	70%/30%	\$10,000	\$3,000	
<input type="radio"/> Option 3	\$30	\$50	Ded + Coins	\$ 500	80%/20%	\$10,000	\$2,000	\$1,000	60%/40%	\$10,000	\$4,000	
<input type="radio"/> Option 4	\$30	\$50	Ded + Coins	\$ 750	80%/20%	\$12,500	\$2,500	\$1,500	60%/40%	\$12,500	\$5,000	
<input type="radio"/> Option 5	\$30	\$50	Ded + Coins	\$1,000	80%/20%	\$15,000	\$3,000	\$2,000	60%/40%	\$15,000	\$6,000	

Out of Network UCR Option (Usual, Customary and Reasonable Fee Reimbursement) 70% 80%

Note: ER co-pay \$75 *Family coverage is 2.5 times the individual coverage amount.

Vision Option (fill in one only)

Co-payment (fill in one) \$5 \$10

Benefit cycle (fill in one)

12-month 24-month

Plan choice (fill in one)

- Low (exam plus discounts)
- High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
- No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$30	\$50
<input type="radio"/>	\$10	\$35	\$70
<input type="radio"/>	\$10	50%	N/A†
<input type="radio"/>	\$15	N/A	N/A†

Deductible** (fill in one only)

- \$0 \$50 \$100
- \$150 \$250 \$500
- No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

** Not applicable to mail-order program.

† Mandatory \$0 deductible

Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network
- Waiver for pre-existing conditions
- No additional options

ENR6000BPB06

6. MEDICAL BENEFITS SECTION (continued)

EPO COVERAGE OPTIONS

In-Network Options (fill in one only) **Office Visit Co-payment** \$12 \$20 \$30

Vision Co-payment (fill in one only)

- Low \$5 Co-payment (1 exam every 24 months)
 High \$5 Co-payment (1 exam every 24 months)
 \$10 Co-payment for frames
 \$25 Co-payment for contact lenses
 \$35 Allowance for non-plan frames

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$25	\$50

Deductible** (fill in one only)

- \$0 \$50 \$100
 \$150 No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

** Not applicable to mail-order program.

Miscellaneous Options

(fill in all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year) Inpatient rehabilitation for alcohol/substance abuse — 30 days combined in-network No additional options

VALUE EPO OPTIONS Co-payment Options (fill in one only)

In-Network

	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	In-patient Co-Pay*	Deductible*	Coinsurance*	Coinsurance Stop Loss*	Out-of-Pocket Coinsurance Max*
<input type="radio"/> Option 1	\$30	\$30	Ded + Coins	\$1,000	90%/10%	\$10,000	\$1,000
<input type="radio"/> Option 2	\$30	\$30	Ded + Coins	\$1,500	90%/10%	\$10,000	\$1,000
<input type="radio"/> Option 3	\$30	\$30	Ded + Coins	\$2,000	80%/20%	\$10,000	\$2,000
<input type="radio"/> Option 4	\$30	\$30	Ded + Coins	\$500	80%/20%	\$20,000	\$4,000
<input type="radio"/> Option 5	\$30	\$30	Ded + Coins	\$3,000	80%/20%	\$10,000	\$2,000

Note: ER co-pay \$100 *Family coverage is 2.5 times the individual coverage amount.

Vision Option (fill in one only)

Co-payment (fill in one) \$5 \$10

Benefit cycle (fill in one)

- 12-month 24-month

Plan choice (fill in one)

- Low (exam plus discounts)
 High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
 No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$10	\$25	\$50
<input type="radio"/>	\$10	\$35	\$70
<input type="radio"/>	\$10	50%	N/A†
<input type="radio"/>	\$10	N/A	N/A†

Deductible** (fill in one only)

- \$0 \$50 \$100
 \$150 \$250 \$500
 No prescription drug coverage

*Groups exempt from purchasing contraceptives must attach a signed affidavit.

† Mandatory \$0 deductible

** Not applicable to mail-order program.

Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year) Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network
 4th Quarter Deductible Carry Over No additional options

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6. MEDICAL BENEFITS SECTION (continued)

PPO COVERAGE OPTIONS

In-Network Options (fill in one only) **Office Visit Co-payment** \$12 \$20 \$30

Out-of-Network Options (fill in one only)

	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
<input type="radio"/> 1	\$500/\$1,250	70%/30%	\$5,000/\$12,500	\$1,500/\$3,750
<input type="radio"/> 2	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> 3	\$750/\$1,875	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> 4	\$1,000/\$2,500	70%/30%	\$25,000/\$62,500	\$7,500/\$18,750

Vision Co-payment (fill in one only)

- Low \$5 Co-payment (1 exam every 24 months)
- High \$5 Co-payment (1 exam every 24 months)
\$10 Co-payment for frames
\$25 Co-payment for contact lenses
\$35 Allowance for non-plan frames

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$25	\$50

Deductible** (fill in one only)

- \$0 \$50 \$100
- \$150 No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.
** Not applicable to mail-order program.

Miscellaneous Options

(fill in all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network
- No additional options

COMPREHENSIVE HOSPITAL AND EXTENDED MEDICAL OPTIONS

Deductible and Coinsurance Applies to Hospital and Extended Medical

Deductible, Coinsurance and Stop-Loss Options

Check the deductible you desire in the "Deductible" column below. Then move to the right of your selection and choose the coinsurance and stop-loss level you wish (fill in one only).

Annual Deductible
(Individual/Family)

Options: Coinsurance and Stop Loss
(Individual/Family)

<input type="radio"/> \$200/\$500	<input type="radio"/> 80% Coinsurance to \$2,000/\$5,000 Stop Loss	<input type="radio"/> 80% Coinsurance to \$4,000/\$10,000 Stop Loss	<input type="radio"/> 80% Coinsurance with No Stop Loss
<input type="radio"/> \$500/\$1,000	<input type="radio"/> 80% Coinsurance to \$2,000/\$5,000 Stop Loss	<input type="radio"/> 80% Coinsurance to \$4,000/\$10,000 Stop Loss	
<input type="radio"/> \$1,000/\$2,000	<input type="radio"/> 80% Coinsurance to \$4,000/\$10,000 Stop Loss		

Rating Structure (fill in one only)

- 2-Tier 4-Tier

Miscellaneous Options (fill in all of the following options you wish to purchase)

- Alcohol and substance abuse—7 days detox and 30 days inpatient rehab per calendar year
- Private duty nursing (\$10,000 per year maximum; \$50,000 per lifetime maximum)
- Nonpar hospital paid as par
- Additional outpatient services (7 outpatient visits per person per calendar year for mental and nervous care; 60 additional outpatient visits per person per calendar year for alcohol and substance abuse)
- Dependent college student age increases to 25 end of calendar year
- Speech and occupational therapy—unlimited visits

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6. MEDICAL BENEFITS SECTION (continued)

EMPIRE PRISM EPO OPTIONS

Select the following new Copay Options and prescription drug card choice if applicable.

Co-payment Options (fill in one only)

Co-Payment options	Inpatient Co-Pay	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	ER Co-Pay	Ambulatory/ OP Surgery Co-Pay
<input type="radio"/> Option 1	\$200/\$500*	\$25	\$25	\$100	\$150
<input type="radio"/> Option 2	\$500/\$1,250*	\$35	\$35	\$100	\$300

* per admission/family maximum per calendar year

Prescription Drug (includes contraceptives)

Co-pay Options (fill in one only)

Generic	Brand	Non-Formulary
<input type="radio"/> \$10	\$35	\$70*
<input type="radio"/> \$10	\$35	\$70 (\$2,000 max)
<input type="radio"/> \$10	50%	N/A [†]
<input type="radio"/> \$15	N/A	N/A [†]

Deductible (fill in one only)

- \$0 \$50
 \$100 \$250
 \$500

*\$0 Deductible not Allowed

[†]Mandatory \$0 Deductible.

Rating Structure (fill in one only)

- 2-Tier (Upstate & Mid-Hudson regions)
 3-Tier (Upstate & Mid-Hudson regions)
 4-Tier (All rating regions)

Vision Option (fill in one only)

Co-payment (fill in one)

- \$5 \$10

Benefit Cycle (fill in one)

- 12-month 24-month

Plan Choice (fill in one)

- Low (exam plus discounts)
 High (exam plus \$10 co-payment on glasses/contacts and \$35 allowance on non-plan frames)
 No vision coverage

Miscellaneous Options

(fill in all of the following options you wish to purchase)

- Dependent children/student age increase from 19/23 to 23/25 (end of calendar year)
 Inpatient rehabilitation for alcohol/substance abuse 30 days in-network

The Personnel Record and the attached complete copy of my New York State Department of Taxation and Finance "Quarterly Combined Withholding and Wage Reporting return of Wages Paid to each Employee (NYS-4/NYS-45/NYS-45ATT)" as filed, signed by an officer or owner of the group, W-2 forms or any additional documentation validating enrollment of employees, owners or partners (i.e., K-1, notarized statements, payroll records) are a completed statement of the total number of our employees, including the reasons why any individuals are not being covered, for which appropriate documentation is submitted.

For eligible retirees, evidence of past employment and continuing financial arrangements is required.

If the enrollment forms submitted meet Empire's credentialing and eligibility requirements, and are in compliance with New York State law, and we issue coverage, the group agrees to the following:

Remit to Empire the charges payable in accordance with the terms of such contracts, and if employee contributions are required, make necessary payroll deductions; group must also submit payment promptly, not to be received after the expiration of the grace period. (Failure to pay promptly will result in the

termination of the group's coverage.) Empire must be allowed to audit and/or make copies of any records or information that relate to the administration of this coverage.

Ensure compliance with HIPAA (45 CFR Parts 160-164) as it relates to health plans. Ensure compliance with TEFRA / DEFRA / COBRA / OBRA legislation as it relates to any active employee or dependent of an active employee who elects the group's benefits as primary. Ensure prompt conversion to Medicare-related / Carveout coverage of Medicare-eligible actively employed group members and dependents not covered by TEFRA / DEFRA / OBRA legislation. Ensure prompt conversion to Medicare-related/ Carveout coverage for eligible Medicare retirees.

Promptly submit an employee's enrollment form for eligible members only and promptly remove members who are no longer eligible. Failure to report removals promptly could result in the group being responsible for premiums or claims paid subsequent to the employee's removal date. The group must also ensure all employees enroll in accordance with their marital status.

If an acceptable enrollment form is received prior to or within 60 days after the eligibility date, coverage will

begin on the date of eligibility; otherwise, coverage will begin on open enrollment or the next group renewal date.

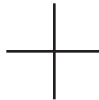
Benefits purchased and established eligibility selected may be changed at renewal only. It is understood that this agreement may be terminated by the group giving 30 days' prior written notice. In the event of termination by the group, the group will be required to pay premiums to a date not less than 60 days subsequent to the written notification by the group to Empire. Empire may terminate this agreement for any of the reasons set forth in the group contract. This group application is a part of the agreement between Empire and the group for health insurance benefits.

New York insurance law requires that your employees who receive health coverage from an HMO, Direct HMO or Direct POS health plan, be given 30 days' prior notice when an increase in the group insurance premium rates results in an increase to their premium contributions. Employers offering other types of health coverage are also encouraged to provide this information to their employees. For more information and to download a sample employee notification letter, visit www.empireblue.com.

10. SIGNATURE OF AUTHORIZED REPRESENTATIVE — I HAVE READ THIS ENTIRE APPLICATION AND THE CERTIFICATION AND FRAUD STATEMENT.

Group hereby designates the broker(s) listed on this application as the broker(s) of record for the Group (the "BOR"), and agrees that notice to the BOR constitutes notice to the Group. Further, that the Group has agreed that the BOR will be paid the commission specified in #9 above in compliance with Empire's applicable commission schedule. Further the Group agrees that the BOR designation and the commission rate will continue until expressly terminated in writing by the Group.

The commission rate or other compensation that may be received by your broker does not change your premium rate. Small group brokers who provide specific additional administrative services may also receive an additional payment from Empire. You can obtain additional information regarding Empire's standard commission scale applicable to your product and any applicable broker compensation programs by visiting www.empireblue.com or by contacting your Empire representative.



Authorized Group Signature

Date (MMDDYY)

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Print Last Name

Print First Name

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Title

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INSURANCE FRAUD STATEMENT

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 material fact thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.



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11. OPTIONAL EMPLOYER ONLINE SERVICES DELEGATION FORM

Empire BlueCross BlueShield is offering Group Benefit Administrators an opportunity to delegate the administration of their accounts to their Broker of Record. The Broker of Record will perform the administrative duties assigned to him or her by the Group Benefits Administrator via Empire's secure Broker Online Services web site at www.empireblue.com.

Please complete this form and the Terms and Conditions Letter Agreement (the "Agreement") if you would like to permit your Broker of Record to administer your account for you. Please be sure to discuss this delegation with your broker prior to submission.

Please mail or fax this form to:

Broker Relations
 15 MetroTech Center, 4th Fl.
 Brooklyn, NY 11201
 Fax: 1-718-312- 6006

Please note: By filling out this form and the Agreement and giving your Broker of Record access to manage your account, you are not giving up your right to access your account through Employer Online Services or to administer your account.

Please check if you would like to:

- Delegate administration of your account to your Broker of Record to
 - Manage only existing sub-groups
 - Manage all existing and future sub-groups
- Delegate to your Broker of Record the ability to add/cancel users
- Change your Broker of Record's access level
- Terminate a Broker of Record's administrative rights to manage your account*

Please check all activities that you would like to delegate to your Broker of Record:

- Basic Group Admin
- View Group Forms
- View Claims
- Enroll Employees and Perform Enrollment Changes
- View Roster (2-500)
- Basic Employee Admin
- View Employee Forms
- View Billing
- Request ID Cards
- Perform Demographic/Dependent Changes

Please complete your contact information:

Print Last Name	Print First Name	
<input type="text"/>	<input type="text"/>	
Company Name	Base Group Number	
<input type="text"/>	<input type="text"/>	
Renewal Date (MMDDYY)	E-mail Address (optional)	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please provide your Broker of Record's contact information:

Print Last Name	Print First Name	
<input type="text"/>	<input type="text"/>	
License Number	E-mail Address (optional)	Date of Birth (MMDDYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>

* You will not be able to assign a new Broker of Record using this form. Please check the box only if you would like to terminate your current Broker of Record's administrative rights.



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11. TERMS AND CONDITIONS LETTER AGREEMENT FOR ACCESS TO THE EMPIRE EMPLOYER ONLINE DELEGATION (continued)

This Terms and Conditions Letter Agreement (the "Agreement") sets forth the understandings and agreement between _____ ("the Group") and Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross BlueShield and Empire HealthChoice HMO, Inc., d/b/a Empire BlueCross BlueShield HMO (together referred to as "Empire"), to permit access to Empire's interactive Employer Online Services web site ("web site") for use by the Broker of Record, or an authorized designee of the Broker of Record (together referred to as "brokers"), designated by the Group, to facilitate the administration of the health benefit plan(s) (the "plan(s)") purchased by the Group from Empire pursuant to a separate Contract (the "Contract"). The Group understands and agrees that access to the web site granted by Group to its designated brokers is subject to the following terms and conditions:

- 1. Empire shall provide those brokers designated by the Group access to the Employer Online Services web site in accordance with Empire's registration procedures. The Group understands that all designated brokers must agree to the web site Terms and Conditions.
- 2. The Group understands that the purpose of this web site is to provide an additional medium for the Group, through its designated brokers, to carry out the certain plan administration functions as delegated by the Group, including the ability to: maintain eligibility files, process enrollment and enrollment changes for members and dependents, select and change PCPs on behalf of and at the request of a member, search for participating providers, view certain claims information on behalf of and at the request of a member, request ID cards and print temporary cards, maintain and update COB information, and view statements of account(s), access billing reports, pay and/or adjust bills, and other functions as may be added from time to time by Empire and delegated by the Group.
- 3. The Group is solely responsible for the accuracy and authenticity of the information submitted on the web site.
- 4. This agreement relates solely to access by the brokers designated by the Group to the web site and does not add, diminish or otherwise change the obligations of the parties, which remain subject to the Contract, any other agreements executed by the parties, the contracts of health insurance coverage issued by Empire, and Empire policies and procedures. In the event of a conflict between this agreement and any of the aforementioned, the aforementioned shall control.
- 5. The Group shall advise Empire, in writing, of the names and other information as requested by Empire, of its brokers who shall have web site access, and shall timely notify Empire of brokers who no longer are authorized to access the web site. Notice shall be sent by fax to 1-718-312-6006.
- 6. Any data accessed and/or provided to the Group or to its brokers on the web site shall remain the property of Empire.
- 7. Empire is not responsible for the accuracy and completeness of records supplied to Empire by the Group, the brokers or by health care providers.
- 8. The Group and its representatives shall maintain and preserve the confidential and proprietary nature of all Empire's data to which the Group and its representatives have access. The Group shall not provide either web site access, or other access to Empire's proprietary and confidential information available to the Group on the web site, to any unauthorized party, or in a manner in conflict with this Agreement.
- 9. The Group will hold Empire, its officers, directors and agents, harmless from any loss, expense, liability, claim, lawsuit or judgement (including reasonable attorneys' fees) arising directly or indirectly out of Empire's disclosure of the Group's enrollment and/or claims information or from the Group's provision to Empire of enrollment information, or resulting from the Group's failure to abide by the terms of this Agreement.
- 10. The obligations undertaken herein in Paragraphs 8 and 9 above shall survive the expiration or termination of this Agreement.
- 11. Nothing contained in this Agreement shall be construed as granting or conferring any rights by license, patent, copyright or any other intellectual property right of one party to the other.
- 12. This Agreement shall terminate:
 - a. by Empire or the Group upon five (5) business days written notice by facsimile transmission, or otherwise, or as otherwise agreed to by the parties hereto in writing;
 - b. if prohibited by any law or regulation;
 - c. six (6) months after the termination of the Contract.
- 13. If the Group has more than one health benefits plan under the terms of its Contract, the Group's designated brokers shall have access, if such access is delegated to the brokers, to any of its health benefits plans that may terminate during the term of the Contract, for the earlier of twenty-four (24) months after termination of the specific health benefits plan or six (6) months after the termination of the Contract.

Please sign and date this Agreement in the space provided below to confirm your agreement to these terms and conditions, and return the fully executed original at your earliest convenience.

Sincerely,



Mark Wagar
President

Acknowledged and Agreed to

This _____ day of _____, 200_____

Print Name: _____

Signature: _____

Title: Group Benefits Administrator

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