PLAN SPONSOR USE ONLY: BLUE KC GROUP NO. _____ CLASS NO. _____ SUBGROUP NO. _____

Group Application

FOR LEVEL FUNDING ADMINISTRATIVE SERVICES ONLY

Please Complete All Boxes LEGIBLY (Print) IN BLUE OR BLACK INK and Sign.

I Group Information

1. COMPANY NAME (FULL LEGAL NAME)			2. REQUESTED EFFECTIVE DATE
3. STREET ADDRESS			4. P.O. BOX
5. CITY	6. STATE	7. ZIP	8. COUNTY
9. CONTACT NAME	10. TITLE		11. FEDERAL TAX ID NUMBER
12. PHONE NUMBER	13. FAX NUMBER	14. E-MAIL ADDRESS	
15. NAME OF PREVIOUS HEALTH INSURANCE CARRIER			
16. DATE BUSINESS ESTABLISHED	17. NATURE OF BUSINESS, INCLUDING SUBSIDIARIES		18. SIC CODE (IF KNOWN)

20. DOES BLUE KC CURRENTLY PROVIDE OR ADMINISTER YOUR COMPANY'S HEALTH INSURANCE COVERAGE? ☐ YES ■ NO

If "Yes," please provide your group number: _____

II Type of Coverage to be Administered

21. APPLICATION FOR Medical Coverage to be Administered

Preferred-Care Blue

Preferred-Care Blue (PPO)

☐ $500 (OOPM $1,500) ☐ $500 (OOPM $3,500)
☐ $1,000 (OOPM $2,500) ☐ $1,000 (OOPM $4,000)
☐ $1,500 (OOPM $4,500) ☐ $1,500 (OOPM $6,000)
☐ $2,000 ☐ $2,700 ☐ $3,000 (OOPM $3,000)
☐ $3,000 (OOPM $5,000) ☐ $4,000 ☐ $5,000

AffordaBlue (PPO)

☐ $5,500

BlueSaver (For use with an HSA)*

☐ $2,800 ☐ $4,000 ☐ $5,000

Personal Blue PPO HRA

☐ $3,000

BlueSelect Plus†

BlueSelect Plus (PPO)†

☐ $1,000 ☐ $2,000
☐ $3,000 (OOPM $3,000) ☐ $3,000 (OOPM $5,000)
☐ $4,000 ☐ $4,000 (EPO)

BlueSelect Plus BlueSaver (For use with an HSA)*†

☐ $3,000 (PPO) ☐ $5,000 (PPO) ☐ $5,000 (EPO)

Spira Care with BlueSelect Plus†

☐ $1,500 (EPO) ☐ $3,500 (EPO) ☐ $7,000 (EPO)

Spira Care with BlueSelect Plus BlueSaver (For use with an HSA)*†

☐ $3,000 (EPO)

* Do you plan to establish a relationship with a Blue KC preferred bank if electing an HSA offering?
☐ YES ☐ NO

† Must meet county requirements to select this plan option.

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III Eligibility/Participation/Contribution

22. Are you aware of any disabled dependents? ☐ YES (Give details on a separate page) ■ NO

23. Are any individuals not actively at work (excluding scheduled vacation)? ☐ YES (Give details on a separate page) ■ NO

24. Are there any owners/partners to be excluded from Worker's Compensation? ☐ YES ■ NO If yes, please list names:

25. Effective date for new employees and their dependent(s) is: ☐ Date of hire ☐ First of the month following date of hire
☐ First of the month following the completion of 30 days ■ First of the month following the completion of 60 days

26. Total number of full-time employees: _____ Total number of part-time employees: _____
Full-time is defined as working at least 30 hours per week.

27. Total number of eligible full-time employees applying: _____

28. Are there any eligible employees in their new hire waiting period? ☐ YES ■ NO If yes, please list names and submit applications:

29. Are there any employees/dependents on Continuation of Coverage/COBRA? ☐ YES ■ NO If yes, please list names:

30. ARE ANY EMPLOYEES OF ANY SUBSIDIARY OR AFFILIATED COMPANIES TO BE COVERED UNDER THIS PLAN?
☐ YES ■ NO (If yes, complete information) Company Name(s) _____
_____ Federal Tax ID Numbers of Each Subsidiary _____
No. of Employees _____ Address _____
City _____ State _____ Zip _____ County _____

31. Will coverage be offered to employees of one or more non-affiliated companies? ☐ YES ■ NO

IV IMPORTANT - Please Read Carefully

The Company represents that the information provided above is complete and accurate and can be substantiated by business records maintained by the Company. The Company understands that the information provided herein shall be the basis of any coverage administered and that this application will be attached to and incorporated into any agreement that may be entered into hereunder by Blue Cross and Blue Shield of Kansas City ("Blue KC"). The Company agrees to provide the documentation requested by Blue KC, which establishes that, all eligibility, underwriting and participation requirements of the service agreement are met.

The Company agrees that providing incomplete, inaccurate, or untimely information may affect the administration of the individual's or group's coverage. The Company shall notify Blue KC promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Blue KC shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage.

During and after termination of the service agreement, the Company grants Blue KC permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in Blue KC's possession. The parties shall maintain the confidentiality of any information relating to Covered Persons in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without the prior written consent of that party. The Company's canceled check is a receipt for the deposit. The deposit will be applied to the first contribution due if the application is approved. The deposit is not refundable after the service agreement has been approved and issued.

DO NOT CANCEL EXISTING MEDICAL COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Employer Signature _____ Date _____

Title _____

Agent Information		Blue KC Office Use Only	
AGENT NAME (PLEASE PRINT) Jason Powers	AGENT NUMBER	COMMISSION ARRANGEMENT HEALTH	COMMISSION ARRANGEMENT DENTAL
PHONE NUMBER (913) 631-0102		COMMISSION ARRANGEMENT LIFE	COMMISSION ARRANGEMENT VISION
AGENCY NAME Legacy Brokers LLC		BLUE KC GROUP NUMBER	BLUE KC PARENT NUMBER
AGENT OFFICE CONTACT E-MAIL		SALES REP NUMBER	RISK CLASS

AGENT SIGNATURE _____ DATE _____