Benefits Manager, Inc

Enrollment Instructions for Regence Blue Cross Blue Shield of Utah

Here is a checklist of a few things that are commonly overlooked and are mandatory for processing your application.

- ❑ Print all pages of the application including instructions. **Print Form**
- ❑ Complete all questions and sections of the application in blue or black ink.

Don't forget to -

- ❑ You must submit to our office by the 25th of the month in order to qualify for your policy to be effective on the 1st of the following month.
- ❑ Select your preferred billing method.
- ❑ Sign and date the application.
- ❑ If you have requested that your monthly premium be deducted automatically from your checking account, you must sign and date the authorization form and attach a voided check to it.

Or

- ❑ To enclose a check for money order payable to ValueCare based on the payment option selected.

❑ Mail completed, originally signed application and check if applicable to:

Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creek Ln.
Layton, UT 84041

As an example of one of many of our free services to our clients, Benefits Manager, Inc will review your application for completeness and accuracy before we submit it to Regence Blue Cross Blue Shield of Utah for approval. This will greatly reduce the approval time because Regence Blue Cross Blue Shield of Utah does not process unclear or incomplete applications until the missing information has been gathered.

After your application has been reviewed by Benefits Manager it will be submitted to *Regence Blue Cross Blue Shield of Utah* for processing. If errors are found, please make any necessary changes and re-mail the corrected application to Benefits Manager for processing.

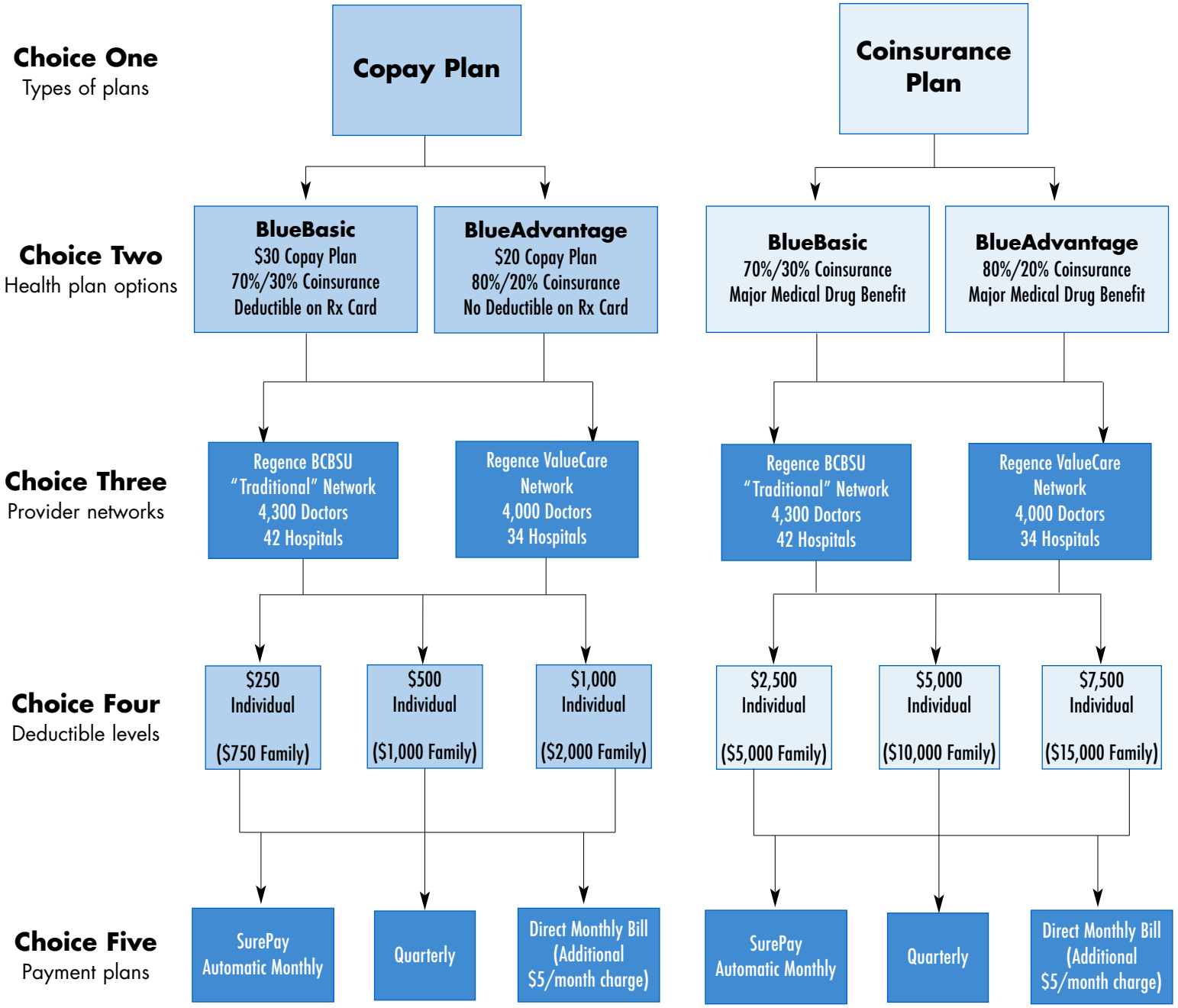
Please contact us if you have any questions regarding the application or enrollment process. You may reach us at (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

Thank you for giving us this opportunity to serve you. We want to earn the right to have you as one of our Clients for Life.

The Benefits Manager Team

Individual BlueChoices

Choosing the Plan That's Right for You



Summary of Benefits

Benefits	BlueBasic				BlueAdvantage			
Deductibles. Once an individual deductible is met, benefits begin for that member, OR when the family sugarbowl (aggregate) deductible is met, benefits begin for the entire family. No one member can contribute more than his or her individual deductible towards the family deductible.	**Deductibles**	**Individual Out-of-Pocket Maximum**	**Family Deductibles**	**Family Out-of-Pocket Maximum**	**Deductibles**	**Individual Out-of-Pocket Maximum**	**Family Deductibles**	**Family Out-of-Pocket Maximum**
	$250	$3,000	$750	$6,000	$250	$2,500	$750	$5,000
	$500	$4,000	$1,000	$8,000	$500	$3,000	$1,000	$6,000
	$1,000	$5,000	$2,000	$10,000	$1,000	$3,500	$2,000	$7,000
Out-Of-Pocket (OOP) Maximums. Deductible amounts and other OOP expenses as defined by the Plan apply to OOP Max. Copayments and Mental Health Coinsurance do not apply towards OOP Max.	$2,500	$6,000	$5,000	$11,000	$2,500	$4,000	$5,000	$8,000
	$5,000	$7,000	$10,000	$13,000	$5,000	$6,500	$10,000	$12,000
	$7,500	$10,000	$15,000	$18,000	$7,500	$9,000	$15,000	$17,000
Coinsurance • **In-Network** • **Out-of-Network**	70% / 30% 55% / 45%				80% / 20% 60% / 40%			
Maximum Benefits	$2 Million				$2 Million			
PROFESSIONAL SERVICES:								
Office/Clinic and Urgent Care Center • **Including Minor Surgical Procedures and Diagnostic Tests** • **Including Preventive Services**	**Low Deductible Plans** After $30 Copayment, We pay 100% of EME.		**High Deductible Plans** After Deductible, We pay 70% and You pay 30% of EME.		**Low Deductible Plans** After $20 Copayment, We pay 100% of EME.		**High Deductible Plans** After Deductible, We pay 80% and You pay 20% of EME.	
Inpatient and Outpatient Professional Care • **Outpatient Rehab and Chiropractic Care** • **Chemotherapy, Radiation and Dialysis** • **Major Surgical Procedures and Major Diagnostic Tests** • **Professional services not otherwise specified**	After Deductible, We pay 70% and You pay 30% of EME.				After Deductible, We pay 80% and You pay 20% of EME.			
FACILITY SERVICES:								
Inpatient Hospital/SNF, Outpatient Hospital Care • **Major Diagnostic Tests** • **Ambulatory Service Facility** • **Home Health Care** • **Home Infusion Therapy**	After Deductible, We pay 70% and You pay 30% of EME.				After Deductible, We pay 80% and You pay 20% of EME.			
Emergency Department	After Deductible and $100 Copayment, We pay 70% and You pay 30% of EME.				After Deductible and $75 Copayment, We pay 80% and You pay 20% of EME.			
OTHER COVERED SERVICES:								
Mental Health Condition Services (including use/abuse of alcohol/drugs)	After Deductible, 50% to Maximum benefit of $1,500. Coinsurance does not apply to out-of-pocket maximum.				After Deductible, 50% to Maximum benefit of $1,500. Coinsurance does not apply to out-of-pocket maximum.			
DME and Supplies, Prosthetic and Orthotic Devices	After Deductible, We pay 70% and You pay 30% of EME.				After Deductible, We pay 80% and You pay 20% of EME.			
Maternity Care • **All Covered Services**	After $5,000 Copayment, We pay 100%. (Copayment does not apply to Out-of-Pocket Maximum)				After $5,000 Copayment, We pay 100%. (Copayment does not apply to Out-of-Pocket Maximum)			
ADDITIONAL BENEFITS:								
Supplemental Accident Benefit	N/A				$1,000 per member per calendar year.			
Rx Card	Rx Deductibles	Rx Classes	Rx Copayments		Rx Deductibles	Rx Classes	Rx Copayments	
$250 Medical Deductible	$100	Generic Formulary Non-Formulary	$10 25% 50%		N/A	Generic Formulary Non-Formulary	$5 25% 50%	
$500 Medical Deductible	$200	Generic Formulary Non-Formulary	$10 25% 50%		N/A	Generic Formulary Non-Formulary	$5 25% 50%	
$1,000 Medical Deductible	$400	Generic Formulary Non-Formulary	$10 25% 50%		N/A	Generic Formulary Non-Formulary	$5 25% 50%	
$2,500 Medical Deductible **$5,000 Medical Deductible** **$7,500 Medical Deductible**	Your identification card also works as a discount card at the pharmacy. Present your card at the pharmacy, pay 100% of the discounted amount, and then submit your receipt to Us. Prescription drugs will then be reimbursed at 70% after the medical plan Deductible per Calendar Year has been met. The Member's 30% Coinsurance can be applied toward the Out-of-Pocket Maximum.				Your identification card also works as a discount card at the pharmacy. Present your card at the pharmacy, pay 100% of the discounted amount, and then submit your receipt to Us. Prescription drugs will then be reimbursed at 80% after the medical plan Deductible per Calendar Year has been met. The Member's 20% Coinsurance can be applied toward the Out-of-Pocket Maximum.			

EME = Eligible Medical Expenses

INDIVIDUAL BLUECHOICES DEDUCTIBLE PLANS

Regence BlueCross BlueShield of Utah
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 30270
Salt Lake City, Utah 84130-0270

APPLICATION

for **Individuals and Family**

Member Number
☐ BAR _____
☐ UMA _____
☐ FBL _____
☐ Other _____

FOR OFFICE USE ONLY
Group # _____
Eff. Date _____
PAYMENT PLAN:
☐ SurePay ☐ Monthly ☐ Quarterly

☐ Condition Specific Rider

Please follow instructions carefully. Inaccurate, incomplete, or illegible applications will be returned.

1. **MUST BE COMPLETED EXCLUSIVELY BY THE APPLICANT AND SIGNED AND DATED** on pg. 6.
2. Complete ALL items. Print in **BLACK** or **BLUE** ink.

COVERAGE APPLIED FOR

HEALTH PLAN AND DEDUCTIBLES
Choose one (BlueAdvantage or BlueBasic)

BlueAdvantage (80% / 20%)		BlueBasic (70% / 30%)	
Copay Plans	**Coinsurance Plans**	**Copay Plans**	**Coinsurance Plans**
☐ $250/$20	☐ $2,500/20%	☐ $250/$30	☐ $2,500/30%
☐ $500/$20	☐ $5,000/20%	☐ $500/$30	☐ $5,000/30%
☐ $1,000/$20	☐ $7,500/20%	☐ $1,000/$30	☐ $7,500/30%

PROVIDER NETWORKS
Choose one

☐ **Regence BlueCross BlueShield of Utah** "Traditional"
☐ **Regence ValueCare**

STATUS
Choose one

☐ **Single** (One Insured)
☐ **Two-Party** (Two Insureds)
☐ **Family** (Three or more Insureds)

GENERAL INFORMATION
COMPLETE THIS SECTION FOR APPLICANT AND SPOUSE (IF APPLICABLE)

APPLICANT

Last Name First Name Initial

Mailing Address/Box No.

City, State, ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone ( ) - Work Phone ( )

Email Address

Occupation Hours Per Week

Employer's Name Location (City, State) # of Employees

Name of employer's group health insurance company. **(If none, write "none")**

LAWFUL SPOUSE *(Must be completed even if spouse is not applying)*

Last Name First Name Initial

Mailing Address/Box No.

City, State, ZIP

Home Phone ( ) - Work Phone ( )

Email Address

Occupation Hours Per Week

Employer's Name Location (City, State) # of Employees

Name of employer's group health insurance company. **(If none, write "none")**

INDIVIDUAL AND FAMILY INFORMATION — REQUIRED FOR ALL APPLICANTS
LIST THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

Family Members First Name Last Name	Sex	Relationship To Applicant*	Birthdate Mo/Day/Yr	Height Ft - In	Weight Lbs.	Social Security Number	Name of Current Physician	PEC
Applicant	☐ M ☐ F	Applicant	/ /	-		- -		
Spouse	☐ M ☐ F	Spouse	/ /	-		- -		
Unmarried children (under 26 – eldest first)	☐ M ☐ F		/ /	-		- -		
	☐ M ☐ F		/ /	-		- -		
	☐ M ☐ F		/ /	-		- -		
	☐ M ☐ F		/ /	-		- -		
	☐ M ☐ F		/ /	-		- -		
	☐ M ☐ F		/ /	-		- -		
	☐ M ☐ F		/ /	-		- -		

* *e.g., child, stepchild, adopted child, child under legal guardianship, etc.*

HEALTH STATEMENT – (EACH CONDITION MUST BE CHECKED "YES" OR "NO")

If complete health information is not received, this application will be returned. Inaccurate health information may result in your policy being cancelled retroactively.

Have you or any listed Family Members EVER experienced problems with, been diagnosed with, or been treated for any of the following:	Yes	No
1. AIDS/HIV positive		
2. Amputation		
3. Arteries/Veins		
4. Arthritis or Rheumatism		
5. Autism		
6. Back/Neck Surgery		
7. Birth Defects		
8. Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis		
9. Blood Disease or Problems		
10. Bowel Disorder/Colitis		
11. Cancer		
12. Congenital Disorders/Defects		
13. Diabetes		
14. Endometriosis		
15. Epilepsy, Seizure, or Convulsions		
16. Heart Disease or Problems		
17. Liver Disorder/Cirrhosis		
18. Lung Disease/Tuberculosis		
19. Lupus		
20. Mental Retardation		
21. Neurological Disease		
22. Paralysis		
23. Polio (late effect)		
24. Suicide (attempted)		
25. Stroke/Brain		
26. Tumor or Growth (include location)		
Within the LAST FIVE YEARS have you or any listed Family Members experienced problems with, been diagnosed with, or been treated for any of the following:	**Yes**	**No**
27. Abnormal Pap Test		
28. Abnormal PSA (Prostate Specific Antigen)		

Within the LAST FIVE YEARS (continued)	Yes	No
29. Accidental Injuries		
30. Alcoholism		
31. Allergies/Hay Fever		
32. Asthma		
33. Bladder/Urinary Disorder		
34. Bone/Joint		
35. Back, neck, or spinal problems, that required medical attention and/or interfered with normal daily activities?		
36. Breast Disorder		
37. Jaw Problems		
38. Depression/Chemical Imbalance		
39. Digestive System		
40. Drug Abuse/Addiction		
41. Eyes, Ears, Nose, Throat		
42. Female or Menstrual Problems		
43. Foot Problems		
44. Fracture or Dislocation		
45. Gall Bladder/Gall Stones		
46. Glandular/Hormone System		
47. Gout		
48. Hemorrhoids/Rectal Problems/ Polyps		
49. Hernia		
50. High Blood Pressure		
51. Infertility		
52. Irritable Bowel Syndrome		
53. Kidney Disorder/Nephritis		
54. Kidney Stones		
55. Knee Problems		
56. Migraines/Headaches or Dizziness		
57. Mental Illness		
58. Muscular/Nervous System		
59. Pain (intractable or uncontrollable)		
60. Pregnancy (complications of)		
61. Premature Birth(s) (include gestational age & birth weight)		
62 Prostate Disorder/Male Organs/Impotence		
63. Sexually Transmitted Disease		
64. Sinus Disorder		
65. Skin Disorder		
66. Stomach/Intestine Disorder		

(continued)	Yes	No
67. Surgical Operation(s)		
68. Thyroid Disorder or Goiter		
69. Ulcers		
70. Varicose Veins		
Complete the following questions for all immediate family members proposed for insurance.	**Yes**	**No**
71. Do you or does any listed Family Member have any serious medical problems, or deformities not listed here?		
72. In the past 5 years have you or has any listed Family Member experienced any condition for which future consultation, treatment or surgery is contemplated or advised?		
73. Do you smoke now or have you smoked in the past? Does any listed Family Member smoke now or has smoked in the past? If "Yes," please specify who smoked, for how long, and when the individual quit smoking (if applicable).		
74. Have you or has any listed Family Member received any treatments or tests within the last 12 months?		
75. Have you or has any listed Family Member received any medications, drugs or injections within the last 12 months?		
76. Have you or has any listed Family Member consulted a physician in the last 12 months? Give date(s) and reason(s).		
Complete the following questions for all immediate family members whether or not proposed for insurance.	**Yes**	**No**
77. Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period?		
78. Are you, your spouse or any eligible child (whether or not proposed for insurance) currently pregnant?		
79. Is anyone currently pregnant with your child, or your spouse's child?		

IF ANY OF THE ABOVE CONDITIONS OR QUESTIONS ARE CHECKED "YES," PLEASE EXPLAIN IN THE SPACES PROVIDED ON THE FOLLOWING PAGE.
(Attach additional pages if necessary)

HEALTH STATEMENT *(continued)*

IF YOU ANSWERED **'YES'** TO ANY OF THE QUESTIONS OR CONDITIONS LISTED UNDER THE HEALTH STATEMENT SECTION OF THE PREVIOUS PAGE, PLEASE EXPLAIN OR PROVIDE THE REQUESTED INFORMATION IN THE SPACES PROVIDED BELOW. *ATTACH ADDITIONAL PAGES IF NECESSARY.*

Question or Condition Number	Name of Family Member	Describe in detail each of the following that applies: (1) Name and nature of condition, (2) symptoms, (3) type of surgery, test, treatments, consultations, or medications (including dosages) received or contemplated, and (4) degree of recovery.	Was patient hospitalized	Name and Address of Attending Physician	Dates of Care Mo/Yr
			☐ YES ☐ NO		From To
			☐ YES ☐ NO		From To
			☐ YES ☐ NO		From To
			☐ YES ☐ NO		From To
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			☐ YES ☐ NO		From To

REQUIRED AND IMPORTANT INFORMATION. PLEASE ANSWER ALL QUESTIONS

IF ANSWER REQUIRES EXPLANATION OR ADDITIONAL INFORMATION, PLEASE PROVIDE INFORMATION, COMMENTS AND EXPLANATIONS BELOW.

	Yes	No
1. Are you, your spouse, and all eligible children applying for coverage? If no, please explain below.	☐	☐
2. Do you or any listed Family Member live, work, or attend school outside Utah? If yes, please explain below, including percent of time spent outside Utah.	☐	☐
3. Have you or all listed Family Members resided in Utah for at least the 12 consecutive months immediately preceding the date of this application? If no, please explain below.	☐	☐
4. Are you or any listed Family Member covered or eligible for coverage under any of the following: (a) public health insurance including, but not limited to, Medicare, Medicaid or the Utah Comprehensive Health Insurance Pool (HIP); (b) private health insurance including, but not limited to, (i) Medicare Supplement, (ii) conversion coverage, (iii) continuation or extension under COBRA, or (iv) Mini COBRA; (c) an association; (d) individual/group health plan coverage? If yes, please include name of health carrier and policy number below.	☐	☐
5. Are you or any listed Family Member **transferring** coverage from another BlueCross or BlueShield plan? If yes, please list insurance carrier and dates of coverage below.	☐	☐
6. Have you or any listed Family Member been covered by any health insurance program within the past 63 days from the date of this application? If yes, please attach a "Certification of Coverage" form provided by your prior employer or insurer.	☐	☐
7. Within the past 93 days, have you or any listed Family Member been covered, under any health or medical insurance plan or arrangement? If yes, please explain below.	☐	☐
8. Within the past 93 days, have you or any listed Family Member been declined to be covered under any health or medical insurance plan or arrangement? If yes, please explain below	☐	☐
9. Does your employer or any employer of a listed Family Member offer Regence BlueCross BlueShield of Utah or Regence ValueCare group health insurance coverage? If yes, please explain below why you are not enrolling the Family Members in that coverage.	☐	☐
10. To the best of your knowledge has any insurance company (including Regence BlueCross BlueShield of Utah) refused, up-rated or restricted any health coverage on you or any of the listed Family Members? If yes, please explain below. Please include insurance company's name, reason, and date.	☐	☐

Question #	First Name of Family Member	Relationship to Applicant	Additional Information, Comments and Explanations

CERTIFICATION, AUTHORIZATION and SIGNATURE

TO BE DISCLOSED TO REGENCE BLUE CROSS BLUE SHIELD OF UTAH (REGENCE BCBSU).
PLEASE COMPLETE AND RETURN THIS FORM WITH EACH APPLICATION.

CERTIFICATION OF COMPLETION AND CORRECTNESS

I, the undersigned, hereby make application for membership in Regence BCBSU, as specified above, hereinafter referred to as "the Plan." I understand that the services and benefits set forth in my contract with the Plan will be available only on or after the effective dates of said contract, as shall be determined by the enrollment regulations of the Plan.

I understand and agree that receipt of this application and/or my initial premium by an agent, employee or representative of Regence BCBSU in no way binds Regence BCBSU to cover any Family Members until and unless I receive written notice assigning the date coverage will start.

I understand and agree that if I am accepted for coverage, I will receive a Health Care Agreement which I will have ten days to review before acceptance. If the Health Care Agreement is not acceptable to me for any reason, I may return it to Regence BCBSU within the ten-day period and will receive a full refund of premiums paid.

Any matter in dispute between you and the Plan may be subject to arbitration as an alternative court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographers, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Utah. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with Regence and the other services your agent or broker provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your broker or agent.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage is subject to cancellation if any completed information is found to be false or incorrect.

INDIVIDUAL AUTHORIZATION FOR MY PROTECTED HEALTH INFORMATION

On behalf of ourselves and the family member(s) listed on the application, we authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence BCBSU or its representatives our health information (excluding health information relating to alcohol or chemical dependency, mental treatment, genetic testing, HIV treatment, or sexually transmitted diseases). We acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan or eligibility for benefits. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records or hospital records (including nursing records and progress notes).

We understand that we are not legally obligated to sign this authorization. However, if Regence BCBSU is unable to obtain information necessary to process our application for coverage no further action will be taken with my application. Once my information is received, Regence BCBSU will continue to process my application.

We understand that we may cancel this authorization at any time by sending a written request to Regence BCBSU. Our cancellation of this authorization will not affect any action Regence BCBSU took before it received our request. If we do not revoke this authorization, it will automatically expire upon termination of our coverage with Regence BCBSU or 24 months from the date below, whichever comes first.

CERTIFICATION, AUTHORIZATION and SIGNATURE *(continued)*

NAME OF APPLICANT (Please Print)**:** _____

SIGNATURE: _____ DATE: _____

* If signed by a Personal Representative of the applicant, please complete the following:

✔ Personal Representative's Name: _____

✔ Relationship to Applicant: ☐ Parent ☐ Legal Guardian** ☐ Holder of Power of Attorney**

** *Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.*

SPOUSE'S NAME (Please Print)**:** _____

SPOUSE'S SIGNATURE: _____ DATE: _____

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

NOTE: Careful consideration should be given before any existing health coverage is cancelled since your acceptance is not guaranteed and this program may have a waiting period for pre-existing conditions.

AGENT/AGENCY AGREEMENT

(This section to be completed by Insurance Agent when applicable.)

In order to receive proper credit for business written and to receive policy communications, please complete all applicable areas.

Agent/Agency Name Michael D. Oliphant

Agent/Agency E-mail mikeoliphant@benefitsmanager.net

Print Name of Agent Michael D. Oliphant

Signature of Agent _____

Date of Signature _____

Regence BCBSU Appointment No. 4959

Utah License No. _____

Tax I.D. Number (if Agency) _____

Business Address 1235 W. Stone Creek Lane

City, State, ZIP Layton, Ut 84041

Telephone Number (801) 444-0843 Fax (801) 444-7389

FBL Agent No. (if applicable) _____

I understand and agree that in acting as Agent for this Applicant:

a. **Application must be completed by the Applicant.**
b. I am in possession of a valid license issued by the State of Utah authorizing me to sell and service life insurance and health care service contracts.
c. I have no authority to: (1) make, alter, interpret, or discharge a contract in the name of **Regence BlueCross BlueShield of Utah** or (2) waive any of the terms or conditions of the contract.
d. I have no authority to assign effective dates or to effect membership changes.
e. Cancellation of this Health Care Agreement by either the subscriber or Regence BlueCross BlueShield of Utah will terminate this Agency Agreement.

THIS SECTION IS TO BE COMPLETED BY REGENCE BLUECROSS BLUESHIELD OF UTAH

Subscriber Name _____

Effective Date _____

Agent No. _____

Contract No. _____

Group No. _____

PAYING YOUR PREMIUMS

CHOOSE ONE OF THE FOLLOWING THREE OPTIONS
(Check appropriate box):

SUREPAY		MONTHLY BILL	QUARTERLY BILL
☐ **Monthly Checking Account Deduction** — Complete the "SUREPAY Authorization Form" on page 8	☐ **Monthly Savings Account Deduction** — Please see **"Special Note"** below — Complete the "SUREPAY Authorization Form" on page 8	☐ **Every Month** — Additional $5 per month will be charged.	☐ **Every 3 Months**

SPECIAL NOTE — SAVINGS ACCOUNT DEDUCTIONS:
Banks do not allow manual drafts on savings accounts. If you are authorizing withdrawals from your savings account, you will be billed until such time that scheduled deductions can start.

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Regence BlueCross BlueShield of Utah insurance, the premiums will be deducted automatically from your checking or savings account on or about the 1st or the 16th day of the month depending on your policy's effective date.

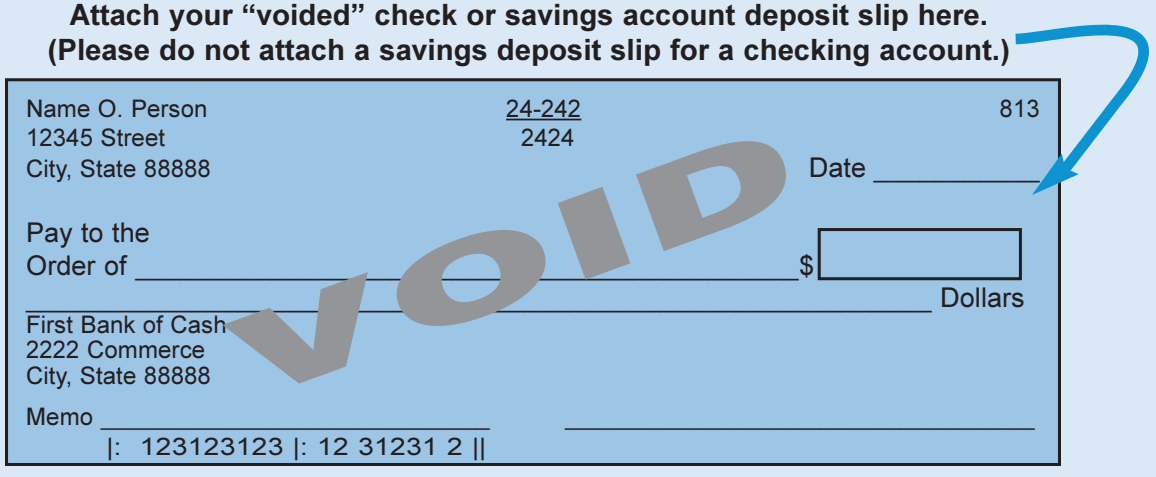
This will provide several advantages to you:

- You will have no premium statements to keep up with and return.
- Your premiums will always be paid on time (if funds are available in your account).
- Postage expenses will be eliminated.
- You won't have to worry about your policy accidentally lapsing due to forgotten payments.
- Your monthly bank statement will show a withdrawal notation, which is your receipt of payment.

GETTING STARTED is as easy as **1-2-3**

1. **COMPLETE**, date and sign the SUREPAY Authorization Form.
2. **FOR CHECKING ACCOUNT:** Attach a voided check (**not a deposit slip**) if funds are to be drawn monthly from your **checking** account. (Note: a checking account deposit slip does not contain the necessary routing numbers.)
   FOR SAVINGS ACCOUNT: Attach a voided savings deposit slip if funds are to be drawn monthly from your **savings** account. Please verify with your financial institution that your name, account and routing numbers are **accurate** and included on the deposit slip.
3. **RETURN** this completed application and SUREPAY Authorization Form with your "voided" check or savings deposit slip in the envelope provided by Regence BlueCross BlueShield of Utah (or self-addressed envelope to SUREPAY Dept. #2, P.O. Box 30270, Salt Lake City, Utah 84130-0270).

Attach your "voided" check or savings account deposit slip here.
(Please do not attach a savings deposit slip for a checking account.)



SOME SUGGESTIONS

- **CHECKBOOK REMINDERS —** Since you will not be receiving a monthly premium notice, you should put a notation or some other reminder in your checkbook to remind you to deduct the premiums from your account balance each month. This will help you keep your account in balance and avoid overdraft problems.
- **IF YOU CHANGE YOUR BANK** OR **WISH TO CANCEL** YOUR AUTOMATIC DEDUCTION
  1. Do this at least 15 days before your next premium is due. We suggest you leave enough money in your old bank account to cover your premiums in case there is a delay in processing the change.
  2. Just send us a copy of your new "voided" check and a note explaining that you have changed banks.
- **ADDRESS CHANGES —** Please be sure to let us know when you change your address. We need your current address to notify you of rate, policy or procedure changes, and claims information.

SUREPAY
Authorization Form

☐ **Checking Account**
☐ **Savings Account**

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Regence BlueCross BlueShield of Utah, Salt Lake City, Utah. I agree that your rights to each such check or electronic debit shall be the same as if it were a check drawn on you and signed by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check. I further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Name of Applicant _____ **SSN#** _____-_____-_____
(please print)

Signature _____ **Date** _____
(as it appears on bank records)

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FORM # B05271-011-INDBC

BlueChoices Individual/Family Plans

Monthly Premium Rates Effective July 1, 2005

BlueBasic Copay Plans

(Copays before the Deductible for Office, Clinic and Urgent Care Center Visits)

BlueBasic — ValueCare Network

$30 Office Visits — 70 / 30% Coinsurance

	$250		$500		$1,000	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$91.30	$91.30	$75.90	$75.90	$64.90	$64.90
20 - 24	$108.90	$115.50	$90.20	$95.70	$78.10	$82.50
25 - 29	$114.40	$133.10	$94.60	$110.00	$81.40	$94.60
30 - 34	$146.30	$174.90	$121.00	$144.10	$104.50	$124.30
35 - 39	$160.60	$188.10	$133.10	$155.10	$114.40	$133.10
40 - 44	$192.50	$210.10	$159.50	$173.80	$137.50	$149.60
45 - 49	$217.80	$228.80	$180.40	$189.20	$155.10	$162.80
50 - 54	$259.60	$266.20	$214.50	$220.00	$184.80	$189.20
55 - 59	$292.60	$300.30	$242.00	$248.60	$207.90	$213.40
60 - 64	$346.50	$346.50	$286.00	$286.00	$246.40	$246.40
Child	$72.60*		$60.50*		$51.70*	

BlueBasic— Traditional Network

$30 Office Visits — 70 / 30% Coinsurance

	$250		$500		$1,000	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$96.80	$96.80	$80.30	$80.30	$69.30	$69.30
20 - 24	$115.50	$122.10	$95.70	$101.20	$82.50	$88.00
25 - 29	$121.00	$140.80	$100.10	$116.60	$85.80	$100.10
30 - 34	$155.10	$185.90	$128.70	$152.90	$111.10	$132.00
35 - 39	$170.50	$199.10	$140.80	$163.90	$121.00	$140.80
40 - 44	$204.60	$222.20	$169.40	$183.70	$146.30	$158.40
45 - 49	$231.00	$242.00	$191.40	$200.20	$163.90	$172.70
50 - 54	$275.00	$282.70	$227.70	$233.20	$195.80	$200.20
55 - 59	$310.20	$317.90	$256.30	$264.00	$220.00	$226.60
60 - 64	$367.40	$367.40	$303.60	$303.60	$260.70	$260.70
Child	$77.00*		$63.80*		$55.00*	

BlueBasic Coinsurance Plans

(The deductible is paid first then coinsurance begins — Office Visit copays not available)

BlueBasic — ValueCare Network

70 / 30% Coinsurance After Deductible

	$2,500		$5,000		$7,500	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$53.90	$53.90	$45.10	$45.10	$39.60	$39.60
20 - 24	$63.80	$68.20	$52.80	$56.10	$47.30	$49.50
25 - 29	$67.10	$78.10	$56.10	$64.90	$49.50	$57.20
30 - 34	$85.80	$102.30	$71.50	$84.70	$62.70	$74.80
35 - 39	$94.60	$110.00	$78.10	$91.30	$69.30	$80.30
40 - 44	$113.30	$123.20	$94.60	$102.30	$82.50	$90.20
45 - 49	$127.60	$134.20	$106.70	$111.10	$93.50	$97.90
50 - 54	$151.80	$156.20	$126.50	$129.80	$111.10	$114.40
55 - 59	$171.60	$176.00	$143.00	$146.30	$125.40	$129.80
60 - 64	$203.50	$203.50	$168.30	$168.30	$148.50	$148.50
Child	$42.90*		$35.20*		$30.80*	

BlueBasic — Traditional Network

70 / 30% Coinsurance After Deductible

	$2,500		$5,000		$7,500	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$57.20	$57.20	$47.30	$47.30	$41.80	$41.80
20 - 24	$67.10	$72.60	$56.10	$59.40	$50.60	$52.80
25 - 29	$71.50	$82.50	$59.40	$69.30	$52.80	$60.50
30 - 34	$91.30	$108.90	$75.90	$90.20	$66.00	$79.20
35 - 39	$100.10	$116.60	$82.50	$96.80	$73.70	$84.70
40 - 44	$119.90	$130.90	$100.10	$108.90	$88.00	$95.70
45 - 49	$135.30	$141.90	$113.30	$117.70	$99.00	$103.40
50 - 54	$160.60	$166.10	$134.20	$137.50	$117.70	$121.00
55 - 59	$181.50	$187.00	$151.80	$155.10	$133.10	$137.50
60 - 64	$215.60	$215.60	$178.20	$178.20	$157.30	$157.30
Child	$45.10*		$37.40*		$33.00*	

*Per child up to three children per family. No additional charge thereafter.

Rates are effective as of the date above. Any subsequent changes will be communicated in advance to members. If the birthday of a family member changes the age bracket, the next premium due will automatically reflect the increased premium. The rates shown on this sheet may vary based on underwriting. Rates for smokers are approximately 15% higher.

BlueChoices Individual/Family Plans

Monthly Premium Rates Effective July 1, 2005

BlueAdvantage Copay Plans

(Copays before the Deductible for Office, Clinic and Urgent Care Center Visits)

BlueAdvantage — ValueCare Network

$20 Office Visits — 80 / 20% Coinsurance

	$250		$500		$1,000	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$97.90	$97.90	$82.50	$82.50	$71.50	$71.50
20 - 24	$115.50	$123.20	$97.90	$104.50	$85.80	$91.30
25 - 29	$122.10	$141.90	$103.40	$119.90	$90.20	$104.50
30 - 34	$156.20	$184.80	$132.00	$156.20	$115.50	$136.40
35 - 39	$171.60	$199.10	$145.20	$168.30	$126.50	$147.40
40 - 44	$205.70	$223.30	$173.80	$189.20	$151.80	$165.00
45 - 49	$232.10	$243.10	$195.80	$205.70	$170.50	$179.30
50 - 54	$276.10	$283.80	$233.20	$239.80	$203.50	$209.00
55 - 59	$311.30	$320.10	$262.90	$270.60	$229.90	$236.50
60 - 64	$368.50	$368.50	$311.30	$311.30	$271.70	$271.70
Child	$77.00*		$64.90*		$56.10*	

BlueAdvantage — Traditional Network

$20 Office Visits — 80 / 20% Coinsurance

	$250		$500		$1,000	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$103.40	$103.40	$88.00	$88.00	$75.90	$75.90
20 - 24	$122.10	$130.90	$103.40	$111.10	$91.30	$96.80
25 - 29	$129.80	$150.70	$110.00	$127.60	$95.70	$111.10
30 - 34	$166.10	$195.80	$139.70	$166.10	$122.10	$144.10
35 - 39	$181.50	$211.20	$154.00	$178.20	$134.20	$156.20
40 - 44	$217.80	$236.50	$183.70	$200.20	$160.60	$174.90
45 - 49	$246.40	$257.40	$207.90	$217.80	$180.40	$190.30
50 - 54	$292.60	$300.30	$247.50	$254.10	$215.60	$221.10
55 - 59	$330.00	$338.80	$278.30	$287.10	$244.20	$250.80
60 - 64	$390.50	$390.50	$330.00	$330.00	$288.20	$288.20
Child	$81.40*		$69.30*		$59.40*	

BlueAdvantage Coinsurance Plans

(The deductible is paid first then coinsurance begins — Office Visit copays not available)

BlueAdvantage — ValueCare Network

80 / 20% Coinsurance After Deductible

	$2,500		$5,000		$7,500	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$60.50	$60.50	$49.50	$49.50	$42.90	$42.90
20 - 24	$72.60	$77.00	$59.40	$63.80	$51.70	$55.00
25 - 29	$77.00	$89.10	$62.70	$72.60	$53.90	$62.70
30 - 34	$97.90	$115.50	$80.30	$94.60	$69.30	$82.50
35 - 39	$107.80	$124.30	$88.00	$102.30	$75.90	$88.00
40 - 44	$128.70	$139.70	$105.60	$114.40	$91.30	$99.00
45 - 49	$145.20	$151.80	$118.80	$124.30	$103.40	$107.80
50 - 54	$172.70	$177.10	$140.80	$145.20	$123.20	$126.50
55 - 59	$194.70	$200.20	$159.50	$163.90	$138.60	$141.90
60 - 64	$229.90	$229.90	$188.10	$188.10	$163.90	$163.90
Child	$47.30*		$39.60*		$34.10*	

BlueAdvantage — Traditional Network

80 / 20% Coinsurance After Deductible

	$2,500		$5,000		$7,500	
AGE	Male	Female	Male	Female	Male	Female
Under 20	$63.80	$63.80	$52.80	$52.80	$45.10	$45.10
20 - 24	$77.00	$81.40	$62.70	$67.10	$55.00	$58.30
25 - 29	$81.40	$94.60	$66.00	$77.00	$57.20	$66.00
30 - 34	$103.40	$122.10	$84.70	$100.10	$73.70	$88.00
35 - 39	$114.40	$132.00	$93.50	$108.90	$80.30	$93.50
40 - 44	$136.40	$148.50	$112.20	$121.00	$96.80	$104.50
45 - 49	$154.00	$160.60	$125.40	$132.00	$110.00	$114.40
50 - 54	$182.60	$188.10	$149.60	$154.00	$130.90	$134.20
55 - 59	$206.80	$212.30	$169.40	$173.80	$147.40	$150.70
60 - 64	$244.20	$244.20	$199.10	$199.10	$173.80	$173.80
Child	$50.60*		$41.80*		$36.30*	

*Per child up to three children per family. No additional charge thereafter.

Rates are effective as of the date above. Any subsequent changes will be communicated in advance to members. If the birthday of a family member changes the age bracket, the next premium due will automatically reflect the increased premium. The rates shown on this sheet may vary based on underwriting. Rates for smokers are approximately 15% higher.