

ACKNOWLEDGMENTS, AGREEMENTS AND AUTHORIZATIONS APPLICABLE TO EMPLOYMENT-BASED HEALTH BENEFIT PLAN COVERAGE OFFERED BY OR ADMINISTERED THROUGH BLUE CROSS BLUE SHIELD OF ARIZONA (BCBSAZ), an independent licensee of the Blue Cross Blue Shield Association

On behalf of myself and the persons listed on this application as eligible dependents, I acknowledge, agree, and authorize the following:

- A. I have received information summarizing the terms and conditions of the health coverage available through my employment ("Coverage"). The Coverage is either (a) group health insurance that my employer has purchased from BCBSAZ; or (b) a group benefit plan, for which BCBSAZ provides certain administrative, claims payment, and utilization management services, and provider network access, but does not assume financial risk or obligation for claims.
- B. I have carefully reviewed this entire application form and the answers I've provided. My answers are material to BCBSAZ. BCBSAZ will rely on my information to determine my employer group's eligibility for BCBSAZ coverage or administrative services, and to establish premium rates or administrative fees for my employer group.
- C. My application includes any other enrollment forms I complete when applying for this coverage. This completed application becomes a part of my group's contract with BCBSAZ, except for any provisions related to life and disability coverage or separate financial accounts (HSA, FSA, HRA).
- D. BCBSAZ does not underwrite or guarantee any separate life and/or disability insurance that may be offered by my employer group health plan. BCBSAZ is independent from any companies that offer such coverage.
- E. BCBSAZ does not administer or guarantee any separate financial account or arrangement (HSA, HRA, FSA) that may be part of the group benefit plan sponsored by my employer. BCBSAZ is independent from any companies that administer such coverage or accounts.
- F. My coverage shall become effective only when BCBSAZ: (1) reviews and accepts this application and (2) issues coverage to my employer group and me on effective dates assigned by BCBSAZ in accordance with the employer's terms for coverage.
- G. The contract between my employer group and BCBSAZ controls the administration of this group coverage. The Coverage is subject to change, as permitted under applicable state and federal law, and in accordance with the terms of the contract between my employer and BCBSAZ. My employer is responsible for notifying me of all changes, including termination of the employer group contract for any reason.
- H. If the contract between my employer group and BCBSAZ is terminated, I may be eligible for other coverage as required under state and/or federal law.
- I. BCBSAZ, its reinsurers, or their respective authorized representatives may need to obtain medical information to process claims, and may collect personal information from someone other than me or one of the proposed covered persons. I authorize any physician, practitioner, hospital, clinic or other health related provider or facility to furnish my health information, including information related to drug use, alcoholism, mental illness, HIV, and AIDS (but not genetic testing or family history), to BCBSAZ, its reinsurers, and their respective authorized representatives. BCBSAZ may use this information, and any of my information already in its possession to process claims. When permitted by law BCBSAZ may disclose this information to third parties without my permission.
- J. If I am declining enrollment for myself or my dependents (including my spouse) because of other health or dental coverage, I may be able to enroll myself and my dependents in this BCBSAZ plan if my dependents or I lose eligibility for the other coverage (or if the employer group stops contributing towards my or my dependents' other coverage). I must request enrollment in this Coverage within 30 days after other coverage ends. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet.
- K. If I have a new dependent as a result of marriage, birth, adoption or placement of adoption, I may be able to enroll myself and/or my dependents, if I request enrollment within 31 days (60 days for small groups*) after marriage, birth, adoption or placement of adoption. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet. (To request special enrollment or obtain more information contact: Group Enrollment Services at (602) 864-4456 or (800) 232-2345, ext. 4456.)
- L. Information regarding other health plan coverage is not used to determine pre-existing conditions for BCBSAZ plans beginning or renewing on or after January 1, 2014.
- M. I am responsible for any costs associated with obtaining medical records needed to process claims.
- N. By including my e-mail address on this form, I authorize BCBSAZ to send me information via e-mail. I can change my e-mail address or rescind this permission at any time by contacting BCBSAZ through azblue.com.
- O. Federal statute and BCBSAZ business processes require BCBSAZ or my employer plan sponsor to obtain the Social Security number (SSN) for most applicants.

Reason Codes for Declining/Waiver Coverage

(subject to BCBSAZ's Group Underwriting Participation Guidelines)

- A - Does not wish to be covered – no other coverage**
- B - Covered by spouse's or parents' employer group plan**
- C - Covered by TRICARE**
- D - Covered by AHCCCS**
- E - Covered by IHS (Indian Health Services)**

- F - Covered by Medicare**
- G - Married Co-Workers**
- H - Individual coverage purchased directly from carrier**
- I - Individual coverage purchased on Healthcare Marketplace**

*Employers are considered small groups for purposes of the Affordable Care Act (ACA) if the average number of total employees on business days during the previous calendar year is 50 or fewer.

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de BCBSAZ, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884. Dii kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éeego bína'idííkidgo éi doodago Háida bíjá anilyeedígíí t'áadoolé'é yína'idííkidgo beehaz'áanii hólq dii t'áa hazaadk'ehij háka a'doowołgo bee haz'q doo baqah ílínigóó. Ata' halne'ígíí koj' bich'ij' hodlíniih 1-877-475-4799.