Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

APPLICATION FOR GROUP COVERAGE

❑ **NEW GROUP** ❑ **NEW SUBGROUP**

SECTION A - COVERAGE SELECTION

Blue Cross and Blue Shield of Louisiana

❑ GroupCare PPO (Plan) _____ ❑ BlueSaver (Plan) _____ ❑ Premier Blue (Plan) _____ ❑ Other (Plan) _____

HMO Louisiana, Inc.

❑ HMO (Plan) _____ ❑ Blue POS (Plan) _____ ❑ Community Blue POS (Plan) _____ ❑ BlueConnect POS (Plan) _____

❑ Signature Blue POS (Plan) _____ ❑ BlueConnect Savings Plus (Plan) _____ ❑ Blue Advantage - Medicare Advantage for Employers (Plan) _____ ❑ Precision Blue POS (Plan) _____

NOTICE - YOUR EMPLOYEES MUST PERSONALLY BEAR ALL COSTS IF THEY UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

Southern National Life Insurance Company, Inc.

❑ Group Term Life ❑ AD&D* ❑ Dependent Life*

❑ Voluntary Life ❑ AD&D - Voluntary** ❑ Spouse** ❑ Child**

*Only available with Group Term Life coverage **Only available with Voluntary Life coverage

Blue Dental for Small Group Certified: ❑ Preferred Plus ❑ Preferred ❑ Essential

Traditional Blue Dental: ❑ Group ❑ Voluntary

Plan name: _____ or Other _____ (Indicate dual option if applicable)

Will coverage replace existing policy? ❑ Yes ❑ No

Vision

❑ Group ❑ Voluntary

Plan #_____

Will coverage replace existing policy? ❑ Yes ❑ No

SECTION B - GROUP INFORMATION

Legal Name of Policyholder/Group				Requested Effective Date
Contact Name and Title		Group Number		Subgroup
Physical Address	City	State	Zip Code	Telephone Number
Mailing Address	City	State	Zip Code	Fax Number
Federal Tax ID Number	Domiciled State	Office Headquarters State	Contact Name's E-mail Address	

Type of Business
❑ Proprietorship ❑ Partnership ❑ Corporation ❑ LLC ❑ Other _____

SIC

Church plan? ❑ Yes ❑ No
Collectively bargained plan? ❑ Yes ❑ No
Government plan? ❑ Yes ❑ No
Association? ❑ Yes ❑ No
School board or charter school? ❑ Yes ❑ No
If yes: ❑ LABI ❑ LADA ❑ LFA

SECTION C - SUBGROUP/BILLING LOCATIONS

Note: All groups by default have one Subgroup/Billing location, resulting in one invoice. If you want separate invoices by Subgroup/Billing Location complete this section. Each subgroup listed will receive a separate invoice. For separate Classes, but not separate invoices, see Section E.

Name	Address	Subgroup ID

SECTION D - PRODUCT INFORMATION/EMPLOYER CONTRIBUTION/PARTICIPATION

Name of previous carrier Medical _____ Dental _____ Vision _____

Were you covered with Blue Cross and Blue Shield of Louisiana within the last three years? ❑ No ❑ Yes – Group Number _____

Financial Arrangement: ❑ Fully-Insured ❑ Self Funded - SBFS ❑ Self Funded - Traditional ❑ Other _____

Group Subject to: ❑ COBRA ❑ State Continuation ❑ Other

ATTACH SIGNED MEDICAL, DENTAL, VISION AND LIFE PROPOSALS FOR COVERAGES SELECTED ADMINISTRATIVE SERVICES ONLY (ASO) AND NON-STANDARD FULLY-INSURED GROUPS: YOUR GROUP MEDICAL/DENTAL BENEFITS CHECKLIST MUST BE ATTACHED

Medical Loss Ratio (MLR)

The Patient Protection and Affordable Care Act (Affordable Care Act) requires insurance companies report their medical loss ratio (MLR) to state and federal agencies, and pay rebates if certain MLR targets are not met. The calculation of the MLR is based, in part, on the size of the insurance companies' employer groups. Based on the information you provide, your group will be categorized as "small" or "large" for the purpose of applying the MLR requirements. This categorization will be used to determine whether your group will be eligible for rebates.

Providing this information does not impact eligibility or participation requirements. Information needed to verify eligibility or participation will be requested separately.

What was the average number of employees employed by your company in the previous calendar year including owners? _____

Employer groups not in existence last year should base your response on the average number of employees you reasonably expect to employ this year.

Please note: Average must include all individuals owning or employed by the company and any affiliated company in the preceding calendar year, whether an employee was full-time, part-time and/or seasonal. Employees include all those issued a W-2, regardless of hours worked or enrollment in the health plan.

Employer Contribution	Employee %	Dependent %	Employee $	Dependent $
Medical				
Dental				
Vision				

Participation

	Total Eligible	No. Total Ineligible	No. Serving Eligibility	No. COBRA/LA Continuation	No. Retirees Covered	No. Elsewhere Credits	No. Waivers	Total No. Enrolled
Medical								
Dental								
Vision								

Medicare Secondary Payer (MSP)

1. Did your company employ 100 or more full-time, part-time, intermittent, leased and/or seasonal employees on 50 percent or more of its regular business days during the previous or current calendar year, whether or not the employees are enrolled in Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. health coverage?

   Yes ❑ No ❑

   Please provide the date the above threshold was reached: _____/_____/_____

2. Did your company employ 20 or more full-time, part-time, intermittent, leased and/or seasonal employees for each working day in 20 or more calendar weeks in the previous or current calendar year, whether or not the employees are enrolled in Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. health coverage?

   Yes ❑ No ❑

   Please provide the date the above threshold was reached: _____/_____/_____

   If no, and at any point if your company employs 20 or more employees, as defined above, you must promptly notify Blue Cross. To download the form, go to www.bcbsla.com, log in to AccessBlue, select "Forms for Employers," then choose the MSP Federal Tax ID and Group Size Information Sheet, or call Customer Service at 1-800-495-2583 to request the form.

3. If your company participates in a multiple-employer plan (such as an association) or a multi-employer plan (such as a collectively bargained health and welfare fund), and the Centers for Medicare & Medicaid Services (CMS) has granted a Small Employer Exception request for any of your employees who are enrolled in Blue Cross or HMO Louisiana health coverage, please provide a copy of any relevant Small Employer Exception approval letters.

   Note: if you answer Yes to both question #1 and question #2, we will report your answer to #1 in our mandatory report to CMS.

SECTION E - ELIGIBILITY/WAITING PERIOD

Are retirees eligible for coverage? ❑ Yes ❑ No Are owners eligible for coverage? ❑ Yes ❑ No Are elected officials eligible for coverage? ❑ Yes ❑ No

1. For groups excluding classes of employees from coverage, please attach the most current SUTA (Quarterly Wage & Tax Report) indicating all employees by corresponding job titles.
2. School Boards will receive OGB eligibility rules as required by Louisiana law.
3. Please complete the following:

Applies to Product(s) below:		
❑ Medical ❑ Dental ❑ Vision ❑ Life ❑ Voluntary Dental ❑ Voluntary Life ❑ Voluntary Vision	❑ Medical ❑ Dental ❑ Vision ❑ Life ❑ Voluntary Dental ❑ Voluntary Life ❑ Voluntary Vision	❑ Medical ❑ Dental ❑ Vision ❑ Life ❑ Voluntary Dental ❑ Voluntary Life ❑ Voluntary Vision
Eligibility	**Eligibility**	**Eligibility**
❑ Date of Hire ❑ First billing date on or after date of hire ❑ First billing date on or after 30 days from the date of hire ❑ First billing date on or after 60 days from the date of hire; not to exceed 90 days	❑ Date of Hire ❑ First billing date on or after date of hire ❑ First billing date on or after 30 days from the date of hire ❑ First billing date on or after 60 days from the date of hire; not to exceed 90 days	❑ Date of Hire ❑ First billing date on or after date of hire ❑ First billing date on or after 30 days from the date of hire ❑ First billing date on or after 60 days from the date of hire; not to exceed 90 days
Eligibility Class Description(s): Insert specific eligible job titles under Eligibility Class Description		
❑ All Active Eligible ❑ Management* ❑ Non-management* ❑ Other* *Note all eligible job titles below for custom Classes	❑ All Active Eligible ❑ Management* ❑ Non-management* ❑ Other* *Note all eligible job titles below for custom Classes	❑ All Active Eligible ❑ Management* ❑ Non-management* ❑ Other* *Note all eligible job titles below for custom Classes

Disclaimer: For groups excluding classes of employees from coverage, job titles not listed above are considered ineligible. Applications received with ineligible job titles will not be processed and will be returned to the Group Leader.

Prior Carrier Eligibility for Medical	Prior Carrier Eligibility for Dental

SPECIAL INFORMATION FOR NON-GRANDFATHERED GROUPS THAT VIOLATE SALARY NONDISCRIMINATION RULES AND REGULATIONS
(IRS enforcement of this law has been delayed until federal regulations are issued)

The Affordable Care Act requires insured groups comply with Salary Nondiscrimination rules and regulations. Previously these rules applied only to self funded groups. Nondiscrimination testing applies to eligibility, benefits, utilization (actual participation) and controlled groups. Testing failure may require the group to pay excise tax penalties ($100 per day per impacted person).

Group understands if it performs, or requests the carrier perform any of the following non-exclusive acts, it could implicate the need for Group to perform nondiscrimination testing under section 105(h) of the Internal Revenue Code. Group understands the carrier does not perform nondiscrimination testing and Group assumes all obligations of testing.

- Failure to offer coverage to all eligible employees
- Having too many highly compensated or key employees on the plan relative to rank and file employees
- Failure to provide the same waiting periods to all eligible employees
- Treating employees differently based on age, years of service or compensation
- Contributing a different percentage of premium for different classes of employees
- Providing different benefits for different classes of employees
- Creating any differences in coverage or cost of coverage for any class of employee

Group understands legal and tax implications of all requests it has made to Carrier, and understands if it violates Salary Nondiscrimination rules and regulations group may have to pay excise taxes of up to $100 per day per impacted person, to be self reported to the Internal Revenue Service.

SECTION F - LIFE INSURANCE

If multiple benefit classes, attach copy of this page indicating class coverage per proposal	Group Term Life/AD&D	Voluntary Term Life/AD&D
	❑ All Active Eligible ❑ Management ❑ Non-Management ❑ Other class #_____ (must coincide with class # in section E)	❑ All Active Eligible ❑ Management ❑ Non-Management ❑ Other class #_____ (must coincide with class # in section E)
Accidental Death & Dismemberment	❑ Include	❑ Include
Coverage Amount **GI = Guarantee Issue** **Max = Maximum**	❑ _____Times Salary ❑ Flat Amount $_____ GI $_____ Max $_____	❑ Up to 5 times salary ❑ ____, ____, ____ times salary (not to exceed 5 times salary) ❑ Flat $10,000 increments GI $_____ Max $_____
Reduction Schedule	Composite & age rated LABI (By 35% at 65, by 50% at 70, term at retirement) Age-Rated (non-LABI) (By 35% at 65, to $2,000 at 70, term at retirement) ❑ Other _____	By 35% at age 70 By 50% at age 75 By 70% at age 80 Terminates at retirement ❑ Other _____
Portability	Standard: Not Included ❑ Other _____	Included - VGTL Only
Dependent Life	Spouse: ❑ $5,000 ❑ $10,000 — Children 14 Days - Age 26: $2,500 / $5,000 Spouse (LABI Only): ❑ $5,000 ❑ $10,000 — Children (LABI Only): $5,000 / $10,000	Spouse ❑ Include Child(ren) ❑ $10,000 (6 months old - age 26) ❑ Other _____

SECTION G - SOUTHERN NATIONAL LIFE EMPLOYER CONTRIBUTION/WAITING PERIOD/PARTICIPATION

Required	Employer Contribution EE	Employer Contribution Dep	(A) Eligible Employees	Company Use Only (B) Enrolled Employees	Company Use Only (B/A) % Participation	Prior Carrier Name (Include copy of policy)	Prior Carrier Effective Date	Prior Carrier Term Date
Life/AD&D	%	N/A						
Dependent Life	N/A	%						
Voluntary Life/AD&D	%	N/A						
Voluntary Spouse/Child Life	N/A	%						

SECTION H - GROUP AGREEMENT

BY ACCEPTING BENEFITS UNDER THESE BENEFIT PLANS, GROUP/POLICYHOLDER AGREES TO THE FOLLOWING:

Medical Products:

1. It is agreed the Group will maintain standard participation percentages of medical enrollment as indicated on the signed proposal.
2. It is agreed new employees will enroll for coverage immediately, to be effective according to the eligibility requirements stated in the Benefit Plan, with the employer paying a minimum of 50% or _____of each employee's premium.
3. It is agreed Blue Cross and Blue Shield of Louisiana and its subsidiaries will be the exclusively endorsed carriers for comprehensive medical coverage.
4. I recognize BCBSLA and HMOLA Producer # _____ as the producer of record for my Group's medical benefit plan(s) and acknowledge the producer may receive commissions as indicated below:

For Fully Insured

❑ 10% graded commission (2-99 Subscribers)
❑ 100+ Subscriber (Based on standardized commission schedule)

Group Contact Initials

I acknowledge producer may receive additional compensation and/or incentives based on other factors such as growth, premium volume, and loss ratio or claims experience. The additional compensation may be from 0 to 4 percent, with an average of 2 percent.

I also acknowledge that BCBSLA and HMOLA may pay a fee to certain entities. These fees are not directly related or attributable to the premiums paid by the group. Fees are for the purpose of administrative and consulting services.

For Self Funded

❑ Per employee per month _____ ❑ Other _____

Dental Products:

5. It is agreed the Group will maintain participation percentages of dental enrollment as indicated on the signed proposal.
6. It is agreed new employees will enroll for coverage immediately, to be effective according to the eligibility requirements stated in the Benefit Plan, with the employer paying a minimum of 0% or _____% of each employee's premium.
7. It is agreed BCBSLA and its subsidiaries will be exclusively endorsed carriers for the stand-alone dental coverage.
8. I recognize BCBSLA Producer #_____as the producer of record for my Group's dental benefit plan(s) and acknowledge that the producer may receive commissions as indicated below:

❑ Certified Blue Dental 10% level commission
❑ Traditional Blue Dental 10% level commission
❑ Traditional Other_____

Group Contact Initials

I acknowledge the producer may receive additional compensation and/or incentives based on other factors such as growth. The additional compensation may be from 0 to 4 percent, with an average of 2 percent.

Vision Products:

9. It is agreed the Group will maintain participation percentages of vision enrollment as indicated on the signed proposal.
10. I recognize BCBSLA Producer #_____ as the producer of record for my Group's Vision benefit plan(s) and acknowledge the producer may receive commissions as indicated. I acknowledge that producer may receive additional compensation and/or incentives based on other factors.
    ❑ 10% level commission ❑ Other _____ Group Contact Initials
11. It is agreed new employees will enroll for coverage immediately, to be effective according to the eligibility requirements stated in the Benefit Plan, with the employer paying a minimum of 0% or _____% of each employee's premium.

Life Products:

12. Employers must maintain all of their employees' life beneficiary information. SNL will require beneficiary documentation to be submitted at time of claim.
13. It is agreed the Group will maintain standard percentage of life enrollment as indicated in the SNL proposal or in this Application for Group Coverage document.
14. If enrolled with Southern National Life Insurance Company, Inc., it is understood and agreed life policies, if issued, shall include administrative provisions applicable to the life insurance; that such administrative provisions shall be binding upon the Group/Policyholder and Southern National Life Insurance Company, Inc., subject to all of the provisions of the life policies; and this application shall form part of the contract to be issued by Southern National Life Insurance Company, Inc.
15. It is agreed new employees will enroll for coverage immediately, to be effective according to the eligibility requirements stated in the Benefit Plan, with the employer paying a minimum of 0% or _____% of each employee's premium.
16. I recognize SNL Producer # _____ as the producer of record for my Group's life benefit plan(s) and acknowledge the producer may receive commissions as indicated below (G = Graded L = Level), please circle one. The Group/Policyholder expressly acknowledges the contract issued by Southern National Life Insurance Company, Inc. constitutes a contract solely between the Group/Policyholder and Southern National Life Insurance Company, Inc., that Southern National Life Insurance Company, Inc. is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Southern National Life Insurance Company, Inc. to use the Blue Cross and Blue Shield Service marks in the state of Louisiana and that Southern National Life Insurance Company, Inc. is not contracting as an agent of the Association.
    ❑ _____% G L Group Term Life
    ❑ _____% G L Voluntary Life
    Group Contact Initials
    I also acknowledge the producer may receive additional compensation and/or incentives based on other factors such as growth. The additional compensation may be from 0 to 4 percent, with an average of 2 percent.

All Products:

17. New employees who do not exercise the option to enroll self or dependents during their initial period of eligibility will be subject to the eligibility requirements stated in the Benefit Plan.
18. It is agreed the effective date of the Benefit Plan of an employee's coverage will be subject to approval.
19. All subscribers in the Group are full-time employees (30 hours per week minimum) or _____, except for retirees less than age sixty-five (65), unless the Company's records designate otherwise. Retirees are not eligible for SNL products unless specifically noted in the SNL proposal or as indicated in this Application for Group Coverage document.
20. All information provided on this application, payroll records, and/or SUTA form is correct to the best of my knowledge.
21. The Group will submit to Our Enrollment & Billing Department evidence of a Member's election of any applicable COBRA or other continuation of coverage within three (3) business days of the Group's receipt of signed continuation forms from the Member.
22. Group agrees it was not formed primarily for purposes of buying medical, vision, dental, and/or life insurance.
23. Company will provide the Summary of Benefits and Coverage to the Group/Policyholder for distribution to Participants and Beneficiaries in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation under this section of the Group Health Benefit Plan.
24. Employers must maintain all of their employees' eligibility supporting documentation. BCBSLA may require supporting documentation to be submitted for the following events in order for enrollments and changes to be processed: adoption, overage-dependents, loss of Medicare or Medicaid coverage, and court order mandates.
25. I recognize BCBSLA and HMOLA Producer # _____ as the producer of record for my Group's benefit plan(s) and acknowledge the producer may receive an agency fee.
    ❑ Agency Fee- available for Fully Insured groups with 100+ enrolling contracts _____ Agency Fee Form 01MK6648 08/17 required.
    According to LA RS 22:855, medical insurance producers can receive reimbursement from employer groups/plan sponsors for expenses they incur directly related to the insurance coverage being provided. In addition to this reimbursement, producers can also charge a reasonable agency fee related to the services provided.
26. Company may request copies of the group's SUTA forms to determine an employee is a "bona fide" employee even though wages may not be paid to the employee during the time the employee is not actually working.
27. **If Company terminates coverage for non-payment of premium or other amounts, company may require payment of all past due amounts owed to it or other companies in its control group, before agreeing to reinstate this coverage or accepting group for coverage on a future policy of insurance.**
28. Premiums must be paid in US dollars. Policyholder will be assessed a $25 NSF fee should its premium be paid with a check returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage or may require group to pay by an alternate method.
29. In the event federal or state law requires Company to rebate a portion of any premium payment, Company will pay the rebate to the Group/Policyholder. Group/Policyholder will use or distribute rebates in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation under this section of the Group Health Benefit Plan.
30. If enrolled with Blue Cross and Blue Shield of Louisiana, on behalf of the Group, I hereby constitute and appoint the directors of Louisiana Health Service & Indemnity Company, present in person or by proxy given to another director(s), to vote, on behalf of the Group, at membership meetings on any matter on which policyholders are entitled to vote. **I acknowledge the annual meeting of the policyholders is held on the third Tuesday in February or on the next business day following, if a legal holiday.** Notice of any such meeting given to such director(s) constitutes notice to me. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder as hereafter provided. I understand that if this proxy is revoked, the premium may continue to be paid without affecting the revocation of the Group's coverage. I understand any other policyholder may be designated a proxy by sending any form of writing to the Plan at P.O. Box 98029, Baton Rouge, Louisiana 70898-9029. I also hereby acknowledge I am authorized by the Group to grant such proxy on behalf of the Group. **Check this block if you do not want to grant this proxy.** ❑

31. The Group will notify Our Enrollment & Billing Department of a Member's termination from medical and dental coverage no later than within the next billing cycle immediately following the billing cycle in which the Member (or any of the Member's Dependents) is terminated from the Group or eligibility for coverage ends. Company is under no obligation to refund any premium paid by Group or any Member because of the Group's failure to timely notify Company of a Member's or his/her Dependent's termination of coverage. Terminations notified or requested by Group beyond the period here provided will only be honored by Company prospectively after the date of receipt, and Group will be responsible for paying all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements. Whenever the Group submits a request to Company to terminate a Member's coverage or any Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his/her Dependent has made payments towards the cost of premiums for any coverage period beyond the date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his/her Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event the individual has a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual to continuation coverage in a separate process.
32. I attest on behalf of Group I will pay Group's first month's premium by the later of: (a) 15 days after the effective date; or (b) 15 days after the date the initial invoice is generated. I acknowledge if the first month's premium is not paid within this time frame, Group's coverage will automatically terminate retroactively as if no coverage had been implemented, without written notice to Group or to its members. Claims will not be processed and any sums that might have been paid on a member's behalf will be subject to repayment by Group or Member. I attest that Company should interpret lack of timely receipt of Group's initial premium payment as a request to cancel any attempt to procure coverage for Group. **I acknowledge on behalf of Group that I must create an AccessBlue account at www.bcbsla.com to use eBilling, the required method to pay Group's first and future invoices to Company.**
33. I attest by having a producer of record on file, I understand my producer can access my group's information.

Distribution of Plan Documents to Group's Covered Employees:

34. Fully Insured Groups: Member fulfilment kit* (including welcome letter, Schedule of Benefits, Contract booklet, mandated notices and provider directory postcard) will be mailed directly to group's employees, unless an exception is requested to mail to the group.

    *Fulfillment kits do not include ID cards. ID cards are mailed to the subscriber's address unless an exception is requested to mail to the group.

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Group/Policyholder Signature _____ Date _____

Producer Signature _____ Producer Number _____ Date _____

BCBSLA Representative Signature _____ Date _____

Underwriter Approval _____ Date _____

SECTION I - NOTES

SECTION J - eEnrollment/eBilling

Group Name____

This form is to be used by a group leader to activate and deactivate group representatives' eEnrollment and eBilling access.

Representative of Group:_________________________________Title:____________________________________

Email Address:____ Phone Number:___________________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

Representative of Group:_________________________________Title:____________________________________

Email Address:____ Phone Number:___________________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

Representative of Group:_________________________________Title:____________________________________

Email Address:____ Phone Number:___________________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

Representative of Group:_________________________________Title:____________________________________

Email Address:____ Phone Number:___________________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

____ ______________________________

Group Leader Signature Date

Group Name____

Representative of Group:____________________________Title:______________________________

Email Address:___________________________________ Phone Number:______________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

Representative of Group:____________________________Title:______________________________

Email Address:___________________________________ Phone Number:______________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

Representative of Group:____________________________Title:______________________________

Email Address:___________________________________ Phone Number:______________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

Representative of Group:____________________________Title:______________________________

Email Address:___________________________________ Phone Number:______________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

Representative of Group:____________________________Title:______________________________

Email Address:___________________________________ Phone Number:______________________

eEnrollment Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____

eBilling Access ❑ Activate ❑ Deactivate

Subgroup(s)/Billing Location(s) ❑ All ❑ (if not all, list):____