HMO Employer Enrollment Application/Change Form
EmployeeElect for 2-50 Employee Small Groups in Nevada

Please complete in black ink.

<table>
<thead>
<tr>
<th>PURPOSE</th>
<th>COVERAGE TYPE(S)</th>
<th>REQUESTED EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Submit a new application</td>
<td>□ Health</td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>□ Request change(s) for group no.</td>
<td>□ Life and/or disability</td>
<td></td>
</tr>
<tr>
<td>□ Vision</td>
<td></td>
<td></td>
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</tbody>
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SECTION 1: Please tell us about your company

<table>
<thead>
<tr>
<th>Company name</th>
<th>Group administrator name (company contact person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Business phone no.</td>
<td></td>
</tr>
<tr>
<td>Billing address (if different from above)</td>
<td>Fax no.</td>
</tr>
<tr>
<td>City (if different from above)</td>
<td>State</td>
</tr>
<tr>
<td>Email address</td>
<td></td>
</tr>
<tr>
<td>Nature of business (please be specific)</td>
<td>Employer Tax ID no.</td>
</tr>
<tr>
<td>Standard Industrial Classification code (SIC)</td>
<td></td>
</tr>
</tbody>
</table>

Organization type

- □ Proprietorship
- □ Partnership
- □ Corporation
- □ Government unit/Agency
- □ Other ____________________________

Date business established

SECTION 2: HEALTH COVERAGE PREFERENCES — What payment option and health plan(s) would you like to select

2a. My employer health contribution each month will be: (only 1 contribution choice is allowed)

- Traditional option: I will contribute (50% to 100%): ______% per employee ______% per dependent (optional).
- Percentage of plan option (excludes Nevada-mandated plans): I will contribute: ______% to ____________________ plan.
- Fixed-dollar option (excludes Nevada-mandated plans).
  I will contribute (at least $125) $ __________ per employee and $ __________ per dependent (optional).

2b. I choose to offer:

- □ All EmployeeElect HMO plans
- OR
  - Designated Plan(s) (Designated single plan or mix and match by checking as many plans below as desired; employees may then select any one of the designated EmployeeElect plans)
    - □ BlueAdvantage HMO $15/15%
    - □ BlueAdvantage HMO $20/20%
    - □ BlueAdvantage HMO $25/25%
    - □ Premier HMO
    - □ Saver HMO

OTHER

- □ ____________________________

OR NEVADA — MANDATED PLANS

- □ HMO Basic (For Groups with 2-14 eligible employees: Are you excluding coverage for maternity benefits? □ Yes □ No ______ Employer initial)
- □ HMO Standard

SECTION 3: DENTAL COVERAGE

A separate Dental application is required to enroll in Dental coverage. Please contact your broker to obtain the necessary forms.

SECTION 4: VISION COVERAGE PREFERENCES — What payment option and vision plan(s) would you like to select

4a. My employer vision contribution each month will be (50% to 100%): ______% per employee ______% per dependent (optional).

4b. I choose to offer:

- □ Blue View AND/OR □ Blue View Plus
SECTION 5: LIFE/DISABILITY BENEFIT SELECTIONS — What employer contribution(s) and product(s) would you like to select

TERM LIFE
$25,000 in employee term life insurance will be included with your medical policy. The employer contribution will default to 100% for employees and 0% for dependents unless otherwise noted below. If you wish to offer additional life insurance to your employees, please check one of the boxes below. For Schedules A and B, specify amount (at least $25,000 in $1,000 increments, with a maximum of $200,000). For Schedule C, specify the percentage of salary, to a maximum of $200,000.

If you wish to opt out of term life insurance, please check Schedule D.

Note: 2-9 enrolled employees minimum is $25,000

10+ enrolled employees minimum is $15,000

☐ Schedule A - Benefit is the same for all job titles: $__________

☐ Schedule B - Benefit differs by job titles
  Class I, officers, managers, supervisors $ _____________
  Class II, all other group members $ _____________
  (Class I amount cannot exceed 2.5 times Class II amount)

☐ Schedule C - Benefit is a percentage of salary;
  (check one of the following for all employees)
  ☐ 1 x annual salary up to $ _____________
  ☐ 2 x annual salary up to $ _____________

☐ Schedule D - Opt out of term life insurance

SUPPLEMENTAL LIFE
Only available if other life options are also selected.

☐ Check for supplemental life (100% employee-paid)

DEPENDENT LIFE
Check only one
(please note that Option 1 is only available if the employee life benefit is $20,000 or more)

☐ Option 1: $10,000 spouse; $10,000 children 6 months to age 26; $1,000 children under 6 months

☐ Option 2: $5,000 spouse; $5,000 children 6 months to age 26; $500 children under 6 months

LIFE PRODUCTS - Employer contributions:

<table>
<thead>
<tr>
<th></th>
<th>Per employee</th>
<th>Per dependent</th>
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</thead>
<tbody>
<tr>
<td>Long term disability</td>
<td>______%</td>
<td>______% (optional)</td>
</tr>
<tr>
<td>Short term disability</td>
<td>______%</td>
<td></td>
</tr>
</tbody>
</table>

DISABILITY PRODUCTS - Employer contributions (25% to 100%)

<table>
<thead>
<tr>
<th></th>
<th>Long term disability (LTD)</th>
<th>Short term disability (STD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold</td>
<td>☐ $6,000 maximum/90 day elimination period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ $6,000 maximum/180 day elimination period</td>
<td></td>
</tr>
<tr>
<td>Silver</td>
<td>☐ $6,000 maximum/90 day elimination period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ $6,000 maximum/180 day elimination period</td>
<td></td>
</tr>
<tr>
<td>Bronze</td>
<td>☐ $3,000 maximum/180 day elimination period</td>
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</table>

LTD AND STD
Check one of three options for LTD and/or one of six options for STD:

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Flat amount</th>
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<tbody>
<tr>
<td>Gold</td>
<td>☐ 1/8/13³</td>
<td>☐ 1/8/18³</td>
</tr>
<tr>
<td>Silver</td>
<td>☐ 1/8/13³</td>
<td>☐ 1/8/26³</td>
</tr>
<tr>
<td>Bronze</td>
<td>☐ 15/15/26³</td>
<td>☐ 15/15/26³</td>
</tr>
</tbody>
</table>

1 Percentage: 66.67% of weekly salary, $750 maximum
2 Flat amount: $200 per week
3 Day benefits begin: Accident benefits/Illness benefits/Duration of benefits in weeks
SECTION 6: ELIGIBILITY — Please tell us more about your group

A. How many employees (including employed owners/officers) work at least 30 hours/week, not including those working on a temporary or substitute basis? _______

B. How many have met the required probationary/waiting period? _______

C. How many are enrolling in this employer’s groups coverage? _______

D. How many are enrolling in group coverage elsewhere, or have an individual policy? _______

E. How many work or live outside the state of Nevada? _______

F. Will coverage be restricted to a certain classification of employees? Yes No
   If yes, please explain what class(es) __________________________
   __________________________________________________________

G. Would you like to offer coverage for domestic partners? Yes No
   Under Nevada law, employers may voluntarily provide coverage to domestic partners.

H. Please identify the probationary/waiting period for new employees as being the first of the month after:
   □ hire date □ 1 month □ 2 months □ 3 months
   □ 4 months □ 5 months □ 6 months □ 12 months

   Would you like to offer the probationary/waiting period by class? Yes No
   Please explain classes:
   Class 1: ___________________ Waiting period: ________________
   Class 2: ___________________ Waiting period: ________________

I. Would you like to waive the probationary period for ALL existing employees at initial enrollment? Yes No

J. Is your company currently subject to COBRA? Yes No
   (Employed 20 or more employees on at least 50% of working days in previous calendar year.)

K. Is your company subject to State Continuation Coverage? Yes No
   (Employed 2-19 employees on at least 50% of working days in previous calendar year.)

L. Under TEFRA/DEFRA, which one applies to your group? Yes No
   □ Medicare is primary (for groups with fewer than 20 employees)
   □ HMO Nevada is primary (for groups with more than 20 employees)

M. Is your company subject to small group reform in the State of Nevada? Yes No

   **Definition of Small Group Health Reform**: A company headquartered in State of Nevada employing 2-50 employees working a minimum of 30 hours a week at least 50% of the preceding/forthcoming calendar year.

N. How many months are employees eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum six months)?
   □ none □ 1 month □ 2 months □ 3 months
   □ 4 months □ 5 months □ 6 months

O. How many months are employees eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum three months)?
   □ none □ 1 month □ 2 months □ 3 months

P. How will employer pay for premiums? Monthly Paper Bill* Yes No
   *A monthly bill fee could apply

SECTION 7: Please tell us if your group has had coverage within 63 days of this application’s signature date

Will this plan replace current Health coverage? Yes No
   If yes, the carrier is/was: ____________________________________________

   Termination date is/was (mm/dd/yyyy) __________________________

Will this plan replace current Vision coverage? Yes No
   ____________________________________________

SECTION 8: EMPLOYEE CERTIFICATES — The Employer has the option to receive employee certificates in the form of electronic or written copy

Would you like to receive the employee certificates in electronic format? Yes No
SECTION 9: GENERAL AGREEMENT

The undersigned employer and/or authorized representative hereby request(s) approval for insurance coverage by HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life. Our signature below will indicate that HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life are approving coverage. By signing this application, the undersigned employer agrees to be bound by the terms of the contract. The employer agrees that:

1. The requested coverage is not in effect until this application is approved by HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life; that approval of coverage shall be evidence by issuing insurance contracts and/or policies to the employer; and an employee's coverage is not in effect unless and until the employee applies is approved for coverage by HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life. The employer must meet the minimum enrollment, participation and eligibility requirements according to the applicable Anthem underwriting policies and Nevada state law.

2. The advance premium check does not create temporary or interim insurance coverage, and receipt and deposit of that payment does not guarantee issuance of insurance coverage; rather, issuance of insurance coverage is expressly conditioned on HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life's determination that the employer satisfied HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life's current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on that part of HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life, except to refund the advance premium payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.

3. For HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life to accept this application, all the information requested on this application must be completed. If the application is not complete, HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life or their designated agent(s) are authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life may be different from the coverage applied for herein. If HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life notifies the employer of such different coverage, and the employer pays the appropriate premium, the employer will be deemed to have accepted the coverage as issued.

SECTION 10: SIGNATURES

<table>
<thead>
<tr>
<th>Name of company officer (Please print)</th>
<th>Title of company officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of company officer</td>
<td>Date (mm/dd/yyyy)</td>
</tr>
<tr>
<td>X</td>
<td></td>
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</tbody>
</table>

Accepted by officer HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life

Date (mm/dd/yyyy)
SECTION 11: AGENT CERTIFICATION — Please ask your agent to complete this section

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.

2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.

3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life to attribute such additions or changes to me.

4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer’s premium retroactive to the coverage effective date and that coverage shall not be effective until HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life reviews and approved the application and the employer receives a written notice from HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life.

5. I am the appointed agent and am receiving commissions for the submission of this client. No portion of my commission payments from HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life shall be paid to an agent/producer not appointed/approved by HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life.

6. I have advised the client not to terminate any existing coverage until receiving written notification from HMO Nevada and/or Anthem Blue Cross and Blue Shield/Anthem Life that the coverage being applied for by this application is accepted.

<table>
<thead>
<tr>
<th>11a. Writing Agent</th>
<th></th>
<th>11b. Second Writing Agent</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Federal Tax ID no. or Social Security no.</td>
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<td>Federal Tax ID no. or Social Security no.</td>
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<tr>
<td>Address</td>
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</tr>
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<td>City</td>
<td>State</td>
<td>ZIP code</td>
<td>City</td>
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<td>Signature</td>
<td>Date</td>
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FOR INTERNAL USE ONLY

<table>
<thead>
<tr>
<th>Agent name</th>
<th></th>
<th>Agent ID no.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

01-00-030 Rev. 5/13
CHECK LIST FOR HMO NEVADA NEW GROUP

☐ 1. Employer Master Application for Employer Group – Please make sure all fields within the application are completed, signed and dated. Incomplete applications may be returned, which could delay the processing of your application.

☐ 2. Original quote/proposal for all lines of coverage for which you are applying for the correct effective date.

☐ 3. Include a check for the first month’s premium payable to HMO Nevada. The check must be imprinted with the company name.

☐ 4. Copy of prior insurance carrier’s most recent billing statement (if applicable). Please make sure we receive the portion of the bill that lists the employees.

☐ 5. Include a copy of your most recent Nevada Quarterly Wage Report – needs to be justified. Indicate employee status next to each employee’s name, i.e., enrolling, waiving, terminated and date, part-time, not eligible, seasonal, etc.

Please note that if they have a new hire that does not show up on the quarterly wage report we will require the most recent payroll.

If owner(s) do not take a salary they are required to submit business documentation to verify eligibility. Please review our underwriting guidelines for appropriate documents to submit.

☐ 6. Employee Enrollment Form(s) for each eligible employee enrolling and/or Employee Waiver(s) for employees declining coverage.

☐ 7. 1099 Addendum – applicable for 1099 employees.

Please submit your New Group to:
Anthem Blue Cross and Blue Shield
Attn: Small Group Sales
9133 W. Russell Road
Las Vegas, NV 89148
Fax: 702 586 6101
Email: sgnewbusiness@anthem.com

Got questions? Contact your local Regional Sales Manager
For more information online, please visit anthem.com

Cut-Off-Dates
1st of the month effective date: application due by the last business day of the month
15th of the month effective date: application due by the 12th of the month

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.