BlueCross BlueShield Nebraska

Amendment of Application for Group Contract

Group Name	Account/Group Number	Sub Account/Department

A. Group Requested Changes

Change group name:

Change physical address:

Change mailing address (if different than physical address):

Change probationary period for new hire enrollment eligibility to: _____ days.

Medical Changes:

Dental Changes:

Family Deductible: ☐ Aggregate ☐ Embedded

Effective date of coverage changes: _____

B. Rates And Employer Contribution

Monthly Rates	Health	Employer Contribution	Dental	Employer Contribution
Single:				
Family:				
Employee & Spouse:				
Employee & Children:				
Medicare Supplement:				

Effective Date of Rates: _____

These rates are guaranteed until: _____ **As long as Company underwriting guidelines are met.** If the number of employees increases or decreases 5% or more, the Company reserves the right to change the rates.

NOTE: Rates may be indicated on the attached quote.

C. Authorized Plan Contacts

The HIPAA Privacy Rules provide that the Group Health Plan (GHP) is a separate legal entity from the Employer/Plan Sponsor. In compliance with the HIPAA Privacy Rules, it is necessary to designate Authorized Plan Contacts for the GHP.

The GHP Primary Contact is indicated on the Master Group Application. The GHP Primary Contact serves as Blue Cross and Blue Shield of Nebraska's (BCBSNE) primary contact for the GHP, and may also designate additional Authorized Plan Contacts for the GHP. The GHP Primary Contact shall notify BCBSNE of any additions or deletions to the following list, by noting changes/additions below.

If you want your GHP Agent as one of your Authorized Plan Contacts please submit an AOR.

In addition, the following individuals may be given access to our GHP information received from BCBSNE in accordance to the requirements set forth within the HIPAA Privacy Rules.

Authorized Plan Contacts:

Reason for change: ☐ New ☐ Delete

Agent Name: _____ Email: _____

_____ Phone: _____

Agency: _____ General Agency Name:

_____ (if applicable) _____

Allow Blues Enroll Access: ☐ Yes ☐ No

Reason for change: ☐ New ☐ Delete

Name: _____ Email: _____

Title: _____ Phone: _____

Allow Blues Enroll Access: ☐ Yes ☐ No

Reason for change: ☐ New ☐ Delete

Name: _____ Email: _____

Title: _____ Phone: _____

Allow Blues Enroll Access: ☐ Yes ☐ No

Reason for change: ☐ New ☐ Delete

Name: _____ Email: _____

Title: _____ Phone: _____

Allow Blues Enroll Access: ☐ Yes ☐ No

BCBSNE will not release protected health information (PHI) to fully insured groups, except as specifically agreed in writing by BCBSNE, the Plan and Plan Sponsor. When there is a written agreement, all disclosure of PHI from BCBSNE shall be made to the Plan, or an Authorized Plan Contact.

D. Acceptance By Applicant (Group and Broker)

I represent that I am authorized to obtain coverage on behalf of the Group.

Please Check each applicable box:

- ☐ I hereby apply for the coverage changes specified in Part A. I acknowledge that this Amendment of Application is subject to Company approval.
- ☐ I accept the quoted rates and certify the accuracy of the employer contribution amounts.

It is understood that the changes on this form supersede any previous Application or Amendment of Application. Unless otherwise amended, the contract information in the original Application shall apply.

By signing this amendment, I represent that I am authorized to obtain coverage on behalf of the Group.

The Group/Plan Administrator, on behalf of itself and any subgroups, acknowledges and agrees that it is responsible to provide notice of benefit, coverage or plan changes to enrolled employees, including persons on continuation coverage, prior to the effective date of such change(s).

Signature of Applicant (Group)	Title	Date
Signature of Agent	Printed Name of Agent	Date

E. Uniform Summary of Benefits & Coverage (If Applicable)

In compliance with the Affordable Care Act, BCBSNE makes available to the Group Leader/Group Health Plan Primary Contact the Group's Uniform Summary of Benefits and Coverage (SBC).

The Group, on behalf of itself and any of its Subgroups, acknowledges that it has:

- ☐ Received a copy of the SBC for the Group Health Plan; or
- ☐ Been given information about how to access the SBC online

The Group, on behalf of itself and any of its Subgroups, acknowledges and agrees as follows: (1) that it will provide the SBC to all active and eligible employees and their dependents who reside at another address (collectively "Employee"); (2) agrees to provide the SBC for all plan options available to the Employee; (3) agrees to provide the SBC in compliance with any instructions provided by BCBSNE; and (4) agrees to provide information to BCBSNE upon request to show compliance with this obligation.

The Group agrees to indemnify and hold BCBSNE harmless against any and all loss, damage, expenses and penalties imposed by law with respect to the Group's failure to provide Employees with the SBC as agreed to herein.

Other Provisions:

F. Acceptance By Company (Blue Cross and Blue Shield of Nebraska)

☐ This Amendment of Application is accepted.

☐ This Amendment of Application is accepted with the following changes:

Signature | Title | Date

The noted changes in Part D are acceptable.

Signature of Applicant | Date

If the Applicant's signature is required on Part F, sign both the original and the copy. Retain the copy and return the original to Blue Cross and Blue Shield of Nebraska.

For Official Use Only

	Contract NO.	Plan Code	Package NO.	Endorsements			
Health							
Med. Supp.							
Dental							