

**Underwriting Requirements for Sole Proprietors in the Bene-Care
Association Group through Excellus BlueCross BlueShield**

- _____ 1. Group Information Form (see "Enrollment Questionnaire Instructions" for assistance completing this form)

- _____ 2. Tax Returns and Business Documentation (see "Documentation Requirements")

- _____ 3. Attestation Form

- _____ 4. Completed Application

- _____ 5. Company check for first month's premium made payable to Bene-Care

- _____ 6. Original signed Broker of Record Letter (printed on company letterhead)

- _____ 7. Cancel letter for current carrier (Must be on company letterhead and signed)

Small Group Enrollment Checklist (1-50)

1. _____ **Group Information Form-** Must be completed and signed by the Employer Group
2. _____ **Tax Returns and Business Documentation-** a copy of the most recent quarterly **NYS45-ATT**.
Please make notations indicating eligible employees (those working a minimum of 20 hrs per week) and ineligible employees (part-time employees working fewer than 20 hrs per week, seasonal employees and others persons not eligible for health ins.)
Note: For new businesses that have not filed their first **NYS45-ATT**, copies of the **W-4** may be substituted.
3. _____ If you are submitting enrollment applications for partners or business owners not listed on the **NYS45-ATT**, then please submit the following:
 - Partnerships: a copy of the most recent 1065- K1 forms for all partners
 - Corporations: a copy to the most recent 1120C, 1120E or 1120S
 - Charitable organizations: IRS form 990 is required, unless exempt from filing tax returns from the IRS, a copy of the exemption is then required**Note:** If a 2+ business has been in operation less than one year, a copy of the DBA certificate, partnership certificate, certificate of incorporation or other similar tax documentation verifying the business is authentic.
4. _____ **Attestation Form** signed for any newly hired employees, owners, partners or retirees **not** listed on the **NYS45-ATT** and all sole proprietors.
5. _____ **Subscriber Application Form-** must be completed and signed by the subscriber. Group number and Employer name and signature must be filled in.
6. _____ **Waiver of Group Coverage Form-** must be completed by all employees not taking coverage.
7. _____ **Handicapped Dependent Form** (when applicable)
8. _____ Completed **Medicare** eligible/ over 65 forms (when applicable).
9. _____ For **new** groups, a copy of group's first month premium check written on the business account
10. _____ **Signed** Group Contract/ Rate Sheet (all pages to be returned)
11. _____ **Eligibility Policy** form

Instructions for Group Information Form:

- 5. Organization Type: If you are a single owner or partner, circle privately held non-incorporated.
- 6. TIN # - the group's tax identification number.
- 10a. Enter the total number of all active employees working at the employer group. This number should include employees working at all locations of the company. Owners should be included on 10a.
- b. Enter the total number of retirees eligible for coverage. The employer group must have a consistently applied business policy governing retirees and their dependents.
- c. Enter the number of people who have elected continuation of coverage through COBRA or New York State extension.
- d. Enter the number of active employees not eligible for coverage.

New hires that have not met the group's new hire eligibility policy	
Employees working less than 20 hours per week	
Seasonal employees	
Employees covered through a union sponsored health plan	
Total (<i>Enter this number in 10d.</i>)	

- e. Add lines 10a through 10c, subtract 10d and enter total.
- f. Valid waivers include:
 - Spousal coverage through a commercial carrier
 - Spousal coverage through Tricare
 - Coverage with a parent through a commercial carrier
 - Retiree coverage through a former employer through a commercial carrier
- g. Subtract the number entered on line f from line e. ($g = e - f$)
- h. Enter the total number of eligible employees enrolling in this product.
- i. To determine group participation, divide line 10h by line 10g.

Documentation Requirements:

Regarding #13 on page 1 of the Group Information Form, attach the following supporting documentation to confirm that the company was not formed solely for obtaining insurance and the employees or eligible retirees were not added to the Employer solely to obtain insurance:

- **For groups with 2 or more employees:**

1. Each Employer with 2 or more employees must provide a copy of the most recent **NYS45-ATT-MN**, with notations indicating eligible employees (those working a minimum of 20 hours per week) and ineligible employees (part-time employees working fewer than 20 hours per week, seasonal employees and other persons not eligible for health insurance).

Note: If the Employer's rules require a minimum of more than 20 hours per week in order to be eligible for coverage (e.g., 30 hours), then the notations should be based on the employer's eligibility rule.
2. If there are any persons who are eligible for health insurance and are not listed on the **NYS45-ATT-MN**, the Employer must provide the following forms of documentation to demonstrate the person works at least 20 hours per week or is otherwise eligible for coverage:
 - (i) Partnerships, a copy of the most recent **1065K-1 for each partner**; OR
 - (ii) Corporations, a copy of the most recent Schedule **K-1** to Form **1120S**, or Schedule **F**; or Form **1120** AND
 - (iii) The Attestation is always required for eligible employees not listed on the **NYS45-ATT-MN** (e.g. retirees, new hires, COBRA/NYS extension). For a new business that has not yet filed an NYS-45-ATT-MN, all employees must be listed on the attestation.
3. If the employer group has been in existence for less than one year, it must provide a copy of a **DBA** certificate, certificate of incorporation, business certificate or letter from the IRS assigning a new business its EIN number.

- **For persons in business alone (sole proprietors with no employees).**

1. If the employer group has been in operation for MORE than one year, it must provide a copy of one of the following tax forms: Schedule **C**, Schedule **F** or **W-2**.
2. If the employer group has been in operation **LESS** than one year, it must provide a business certificate, a **DBA** certificate, OR similar tax documentation that the business is authentic and in operation.
3. Each employer must provide a signed Attestation to attest that the sole proprietor works *at least* 20 hours per week in the business.
4. If applicable, a copy of the most recent NYS-45-ATT-MN. If the sole proprietor does not file an NYS-45-ATT-MN, a copy of a pay stub, estimated tax form or other documentation of active employee status will be accepted.

Eligibility Policy for New Employees

Group Name: _____

Group Number {If Assigned}: _____

Our Standard new hire waiting period for eligibility for health insurance is:

(type of employee: salaried, hourly, etc.)

_____ Date of Hire _____

_____ First of the month following date of hire _____

_____ First of month following 30 days of employment _____

_____ First of month following 60 days of employment _____

_____ First of month following 90 days of employment _____

_____ First of month following 6 months of employment _____

_____ First of month following 1 year of employment _____

_____ Other _____

Our Standard rehire waiting period for eligibility for health insurance is:

_____ Same guidelines as new hire _____

_____ Date of rehire _____

_____ First of the month following rehire _____

_____ Other _____

Minimum hours per week that an employee must work to be eligible:

_____ 20 hours _____

_____ 25 hours _____

_____ 30 hours _____

_____ 40 hours _____

Note: Employer can determine full time status as stated above but may not select under 20 hours.

The above policies have been submitted for business indicated above. I understand that these policies are accepted and must remain in effect for at least one full year before they are eligible to be changed.

Authorized Group Signature: _____

Date Signed: _____ Date Effective: _____

WAIVER OF GROUP COVERAGE

Company Name: _____

Employee Name: _____ Date of Birth: _____

Please Check Applicable:

- I waive my employer's group **health** insurance coverage for myself and my dependents (if any).
- I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).
- I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents.

Reason for Waiving Coverage - Please Check One:

- Covered through spouse's employer Covered through a parent's employer

Employer Name: _____

Insurance Company: _____

- Other reason (explain): _____

As a result, I waive my and/or my dependents (if any) eligibility to enroll in my employer's group plan at this time.

I understand that I and/or my dependents may enroll under this plan in the future only; within 30 days of involuntarily loss of other group coverage; or, at the time of my employer's open enrollment.

Employee Signature: _____ Date: _____



HealthyBlue GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on Back. All Dates = mm/dd/yy [] Check if name change [] Check if new address

PLEASE PRINT CLEARLY

Form section for selecting medical or dental plan and checking desired actions like 'Add Subscriber' or 'Change Coverage'.

SUBSCRIBER INFORMATION - Must be completed. Includes fields for Social Security #, Last Name, First Name, Date of Birth, and Address.

FAMILY MEMBER INFORMATION. Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.

OTHER COVERAGE INFORMATION. In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

RELEASE - You must sign and date this form to be eligible for insurance. Any person who knowingly and with intent to defraud...

EMPLOYER INFORMATION (Must be completed by Group Administrator/Representative) and Group Rep Signature/Date.

A Group Enrollment Form is not required for a change of address or correction to a date of birth. Please contact Customer Service at the number listed on your member ID card.

DESIRED ACTION Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the Event Date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible	CE – Cobra End Date
PC -- Preferred Care	SR – Subscriber Request
CP -- Commercial	SD – Subscriber Deceased
CB -- Cobra Begin Date	SB – Spouse's Excellus BCBS
CD -- Cobra Disabled Date	MC – Medicaid

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA – Marriage	MB – COBRA Begin Date
OA – Dependent Over Age	MR – Subscriber Request
DM – Deceased	DV – Divorce

DESIRED COVERAGE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than five members please use an additional form.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group:
 - Unmarried child, natural, adopted or stepchild
 - Chiefly dependent on you for support
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

Dependents pending adoption, foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a handicapped dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**

I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative.

Or, visit us at: www.excellusbcbs.com



GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on Back. All Dates = mm/dd/yy [] Check if name change [] Check if new address Please print clearly.

Form section for checking desired actions (Add Subscriber, Add Dependent, Change Coverage) and medical/dental/vision coverage options (Classic Blue, Blue Healthy Choices A/B, PPO, EPO, etc.).

SUBSCRIBER INFORMATION - Must be completed. Includes fields for Social Security #, Sex, Birthdate, Last Name, First, Street, City, State, Zip, Day Phone, and E-Mail Address.

FAMILY MEMBER INFORMATION. Table with columns for relationship (Spouse, Dependent, Student, etc.), Social Security #, Sex, Birthdate, Medical Center, Primary Care Physician, and Current patient? status.

OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information. Includes fields for certificate of coverage, previous insurance company, and plan name.

RELEASE - You must sign and date this form to be eligible for insurance. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information...

EMPLOYER INFORMATION (Must be completed by Group Administrator) *Deductible Amt., Dept. # and Employee # is optional. Was the employee subject to a waiting period before enrolling in your employer health plan?

Table with columns: Coverage, Group/Sub Group #, Chk digit, Pkg #, Deductible Amount*, Employer Name, Employee Status, Department #*, Employee #*, Group Rep Signature/Date.

Instructions for completing the Group Enrollment Form

DESIRED ACTION Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the Event Date. Please see your Group Administrator for events that fall outside the 30-day period. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible	CE - Cobra End Date
PC - Preferred Care	SR - Subscriber Request
CP - Commercial	SD - Subscriber Deceased
CB - Cobra Begin Date	SB - Spouse's BCBSRA
CD - Cobra Disabled Date	MC - Medicaid

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA - Marriage	MB - COBRA Begin Date
OA - Dependent Over Age	MR - Subscriber Request
DM - Deceased	DV - Divorce

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.

- Address
- Birthdate
- PCP
- OB/GYN
- Medical Center

DESIRED COVERAGE All products may not be applicable to your employer group. Please check with your Group Administrator.

PCP Information

Blue Choice members must select a **Medical Center OR Primary Care Physician (PCP)**. Females may select an OB/GYN.

FAMILY MEMBER AND DOCTOR INFORMATION

Use an additional form, if more than four persons.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group
 - Unmarried child, natural, adopted or stepchild
 - A full time student (indicate under Relationship)
 - Chiefly dependent on you for support
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.**
Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your employer group.

RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents).
- I hereby accept responsibility for payment of any portion of the premium.
- I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.
- I understand that this contract is subject to a twelve (12) month waiting period for pre-existing conditions that have existed for a six (6) month period prior to my applying for this benefit, unless prior coverage affords credits for some or all of this time period.
- **BLUE CHOICE**
I understand that if I have elected a managed care product that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**
I understand that the Preferred Provider Organization (PPO) coverage is comprised of and in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- **EXCLUSIVE PROVIDER ORGANIZATION (EPO)**
I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

EMPLOYER INFORMATION

This section to be completed and signed by the Employer Group Administrator.
Complete only the coverage section (Medical/Dental/Vision) that is applicable to the employee's request.

If you have any questions, please contact Customer Service at:
Excellus BlueCross BlueShield, Rochester Region (585) 325-3630 or 1-800-847-1200
Blue Choice Member Services (585) 454-4810 or 1-800-462-0108



SimplyBlue GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

9 - Additional Dependents

Please provide all information for each person to be covered.

Form for the first dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the second dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the third dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the fourth dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the fifth dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request

To process a Subscriber or Dependent cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
Ineligible Student	Medicare

COVERAGE TYPE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than seven members please use an additional form.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group:
 - Unmarried child, natural, adopted or stepchild
 - Chiefly dependent on you for support
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.
 - Dependents pending adoption and/or a handicapped dependent who is over the dependent age for your employer group.**

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**
I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative.

www.excellusbcb.com

AGENT/BROKER OF RECORD LETTER

____/____/200__

Broker Program Manager
Excellus BCBS
165 Court Street
Rochester, NY 14647

Dear Caitlin Hryzak:

This is to notify you that our company has appointed Bene-Care Agency LLC, whose business address is 1260 Creek Street, Webster, NY 14580 as our sole insurance representative, with respect to coverage provided to this organization by Excellus.

I understand that if our company elects to purchase coverage from your company that Bene-Care Agency LLC may be entitled to base and/or bonus compensation for our business.

This designation will remain in effect until we notify Excellus in writing to the contrary.

Sincerely,

Signature of Company Officer

Please print (Officer Name)

Title of Company Officer