#040135

VILLAGE OF LOMBARD
REQUEST FOR BOARD OF TRUSTEES ACTION

__X__ Resolution or Ordinance (Blue) *Waiver of First requested* __
______ Recommendations of Boards, Commissions & Committees (Green)
______ Other Business (Pink)

TO: PRESIDENT AND BOARD OF TRUSTEES

FROM: William T. Lichter, Village Manager

DATE: April 23, 2004 (B of T) Date: May 6, 2004

TITLE: A Resolution authorizing Approval of President & Clerk on an Agreement for Blue Cross/Blue Shield PPO Health Insurance, HMO Illinois Health Insurance, & HMO Blue Advantage Insurance

SUBMITTED BY: Joanne Jakubowski, Human Resources Manager

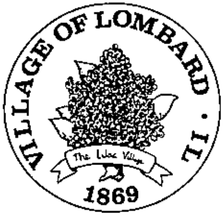
BACKGROUND/POLICY IMPLICATIONS:

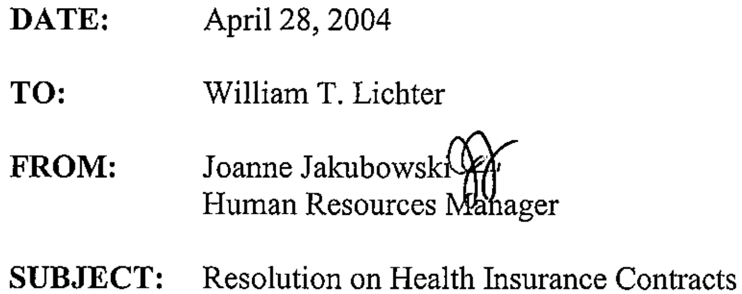
Please find attached a renewal benefit program application with BlueCross BlueShield of Illinois for Fiscal Year 2004/2005 Health Insurance Programs.

See attached memorandum for more information.

FISCAL IMPACT/FUNDING SOURCE: $

Village Attorney ______________________ Date ________
Finance Director ______________________ Date ________
Village Manager W. Thomas Lichter Date 4/28/04





DATE: April 28, 2004

TO: William T. Lichter

FROM: Joanne Jakubowski
Human Resources Manager

SUBJECT: Resolution on Health Insurance Contracts

The attached resolution provides for new contracts between the Village of Lombard and Blue Cross/Blue Shield of Illinois. These contracts provide for a PPO option, and two HMO choices. The two HMO options are HMO Illinois and Blue Advantage. The new HMO, Blue Advantage, will have a smaller network of physicians, medical groups, and hospitals but will minimize cost increases for those who choose this option.

R E S O L U T I O N
R_________04

A RESOLUTION AUTHORIZING APPROVAL OF
<u>PRESIDENT AND CLERK ON AN AGREEMENT</u>

WHEREAS, the Corporate Authorities of the Village of Lombard have received applications for Blue Cross/Blue Shield PPO Health Insurance, HMO Illinois Health Insurance and HMO Blue Advantage Insurance; and

WHEREAS, the Corporate Authorities deem it to be in the best interest of the Village of Lombard to approve the applications as attached hereto and marked Exhibit "A".

NOW, THEREFORE, BE IT RESOLVED BY THE PRESIDENT AND BOARD OF TRUSTEES OF THE VILLAGE OF LOMBARD, DU PAGE COUNTY, ILLINOIS AS FOLLOWS:

Section 1: That the Village President be and hereby is authorized to approve on behalf of the Village of Lombard said Agreement as attached hereto.

Section 2: That the Village Clerk be and hereby is authorized to approve said Agreement as attached hereto.

Adopted this____________ day of________________________, 2004.

Ayes: ____________________________________

Nays: ____________________________________

Absent:____________________________________

Approved this ____________day of ________________________, 2004.

____
William J. Mueller
Village President

ATTEST:

____
Barbara A. Johnson
Deputy Village Clerk

BlueCross BlueShield of Illinois

The HMOs of Blue Cross and Blue Shield of Illinois

A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company,
An Independent Licensee of the
Blue Cross and Blue Shield Association

Benefit Program Application

Customer Number:
HMO Illinois Group Number(s): H56789
HMO Illinois Section Number(s): 0100,0200,0400,0500,8888
BlueAdvantage HMO Group Number(s): B56789
BlueAdvantage HMO Section Number(s): 0100,0200,0400,0500,8888
Group Name: Village of Lombard
(Specify the Group or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)
Address: 255 E. Wilson
City: Lombard State: IL Zip: 60148
Group Administrator: Joanne Jakubowski Phone Number: 630 620*5714
Effective Date of Coverage: June 1, 2004 Anniversary Date: June 1, 2005

1. Eligible Person means a person who resides in the Service Area of a Participating IPA and is:

   ☒ A full-time employee of the Group.

   ☐ A member of (name of union):

   ☒ Other (please specify): Active elected officials who pay the fully applicable payment with no Village contribution per Village Board Policy 98-3. Retirees per IMRF guidelines.

2. Full-Time Employee means:

   ☒ A person who is regularly scheduled to work a minimum of 40 hours per week and is on the payroll of the Group.

   ☐ Other (please specify):

3. Limiting Age:

   The limiting age for covered unmarried children is 19; age 23 if a full-time student.

   ☒ Coverage is terminated at the end of the month in which the limiting age is reached.

   ☐ Coverage is terminated on the last day of the year in which the limiting age is reached.

   ☐ Other (please specify):

4. Total number of employees: (indicate the total number of actual employees, not enrollees)

   In the Group 291 Illinois employees 291 National employees

5. Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Group's health care plan:

☒ The date of employment.

☐ The _____ day of employment.

☐ The _____ day of the month following _____ month(s) or _____ days of employment.

☐ The _____ day of the month following the date of employment.

☐ Other (please specify):

☐ A full month's premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the first and fifteenth day of the Premium Period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth day and the end of the Premium Period.

6. Enrollment:

Open Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Group's Open Enrollment Period.

- Specify Open Enrollment Period: April 26 - May 21

Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by Blue Cross and Blue Shield of Illinois, A Division of Health Care Service Corporation, A Mutual Legal Reserve Company ("HCSC") and the Group. Such date shall be subsequent to the open enrollment period.

Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the date of application of coverage.

7. Effective Date of Termination for a person who ceases to meet the definition of an Eligible Person:

☐ The date such person ceases to meet the definition of Eligible Person.

☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.

☐ Other (please specify):

8. Extension of Benefits due to Temporary Layoff, Disability or Leave of Absence:

Temporary Layoff: 0 days; Disability: 0 days; Leave of Absence: 0 days

☐ Other (please specify):

(However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with the Family and Medical Leave Act of 1993, as amended.)

9. Funding Arrangement:

☒ Premium Prospective (complete section 11.)

☐ Cost Plus (complete section 12.)

10. Group Contribution:

☒ HMO Illinois: 96% of the Individual Coverage Premium, and
86% of the Family Coverage Premium.

☒ BlueAdvantage HMO: 96% of the Individual Coverage Premium, and
86% of the Family Coverage Premium.

☐ Other (please specify): ______

11. Premium Period and Premium Rates:

☒ The first day of each calendar month through the last day of each calendar month.

☐ The ______ day of each calendar month through the ______ day of the next calendar month.

Premium Rates		
Health Coverage		
1. Employee only	HMO Illinois $323.93	BlueAdvantage HMO $294.77
2. Employee plus one dependent	HMO Illinois $	BlueAdvantage HMO $
3. Employee plus two or more dependents	HMO Illinois $	BlueAdvantage HMO $
4. Employee plus Spouse	HMO Illinois $	BlueAdvantage HMO $
5. Employee plus Child(ren)	HMO Illinois $	BlueAdvantage HMO $
6. Family	HMO Illinois $888.87	BlueAdvantage HMO $808.87
Single Tier rate structure – complete item 1.		
Two Tier rate structure – complete items 1. and 6.		
Three Tier rate structure – complete items 1., 2., and 3.		
Four Tier rate structure – complete items 1., 4., 5., and 6.		
Indicate "N/A" in any rate field that does not apply		
Medicare Eligible Rates (When HCSC is Secondary Payer)		
Single Coverage	HMO Illinois $323.93	BlueAdvantage HMO $294.77
Family Coverage	HMO Illinois $647.85	BlueAdvantage HMO $589.55

12. Cost Plus Program:

a) Service Charges for Claim Payments:

☐ HMO Illinois: ______% of Claim Payments; $______ per Enrollee per month for health Claim Payments

☐ BlueAdvantage HMO: ______% of Claim Payments; $______ per Enrollee per month for health Claim Payments

b) Physician's Services Fees:

☐ HMO Illinois: $______ per month per single Enrollee; $_____per month per Enrollee with one or more Dependents

☐ BlueAdvantage HMO $______ per month per single Enrollee; $_____per month per Enrollee with one or more Dependents

c) ☐ Transfer Payment Method:

☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify): _____

Tentative Final Settlement Period - Transfer payments required after termination for:

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

d) ☐ Post Payment Method

e) Payment Period:

☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (please specify): _____

f) Claim Settlement Period:

☐ Monthly ☐ Quarterly ☐ Other (please specify) _____

g) Prescription Drug Rebate:
$_____ per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Group, has provided the information requested in this Benefit Program Application (BPA) and on behalf of the Group offers to purchase the benefit program as outlined in the proposal document submitted to the Group by the Sales Representative. The benefit program and funding arrangements are as outlined in this BPA. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Group Policy. This BPA is subject to acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, A Mutual Legal Reserve Company ("HCSC"). Upon acceptance, this BPA shall be incorporated and made a part of the Group Policy. In the event of any conflict between the proposal document and the Group Policy, the provisions of the Group Policy shall prevail.

The undersigned representative hereby acknowledges that the Employee Retirement Income Security Act of 1974, as amended, (ERISA), establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Group, the Group agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Group is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Group Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS:

1. Certificate of Creditable Coverage: ☒ Yes ☐ No

   (applicable to 100 plus groups only; automatic issuance for groups under 100 lives)

   If yes: It is understood and agreed that HCSC will issue to individuals, whose coverage under the Group Policy terminates during the term of the Group Policy, a Certificate of Creditable Coverage based upon coverage under the Group Policy and information provided to HCSC by the Group.

   If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Group Policy.

2. Reimbursement Provision: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will deduct 25% of the net recovery from the amount credited to the Group's experience after attorneys' fees, if any, have been paid.

3. Domestic Partners Covered: : ☐ Yes ☒ No

   If yes, a Domestic Partner, as defined in the Group Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Enrollees with Domestic Partners.

4. Excess Loss Coverage purchased: ☐ Yes ☒ No

   If yes: Complete separate Application for Excess Loss Coverage.

ADDITIONAL PROVISIONS: State mandated coverage for contraceptive services added

Cindy Nelson [signature]
Sales Representative

887
District Phone No.

T. Schaffler
Producer Representative

Lockton Co
Producer Firm

8755 W. Higgins Road, Chicago, IL 60631
Producer Address

Tax ID No.

Signature of Authorized Purchaser

Title

Date

Witness

$______ Amount Submitted (for new groups only)

INTERNAL USE ONLY	UNDERWRITING AUTHORIZATION
	Date BPA approved by Underwriting: ______
	Printed Name and Signature of Underwriter

CERTIFICATE AND POLICY INFORMATION

Certificate Booklets: ☐ **Individual Mail** ☐ **Ship to:** _____

Attn: ______
Quantity: ______

Mail Policy to: ☐ **Group**
☐ **District**

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and
Blue Shield Association

Benefit Program Application

(Applicable to 151 Plus Insured Group Accounts)

Customer Number (9-digit #):
Employer Group Number(s): P06522
Account Number(s): 206522
Section Number(s): 0300 and 8889
Employer Name: Village of Lombard
(Specify the employer, the employee trust or the association applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)
Address: 255 East Wilson
City: Lombard State: IL Zip: 60148
Subsidiaries:
Affiliated Companies:
Administrative Contact: Joanne Jakubowski Phone Number: 630 620-5714 Fax Number:
Effective Date of Coverage: June 1, 2004 Anniversary Date: June 1, 2005

SCHEDULE OF ELIGIBILITY

1. Eligible Person means:
   - [x] A full-time employee of the Employer.
   - [ ] A full-time employee who is a member of:
     (name of union or association)
   - [x] Other: Active elected officials who pay the fully applicable payment with no Village contribution per Village Board Policy 98-3. Retirees per IMRF guidelines

2. Full-Time Employee means:
   - [x] A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.
   - [ ] Other:

3. Applicable to *Cost-Plus* Groups only, the Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
   - [ ] The date such person ceases to meet the definition of Eligible Person.
   - [ ] The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - [ ] Other:

4. Limiting Age:
   - [ ] The limiting age for covered unmarried children is .
   - [x] The limiting age for covered unmarried children is 19; age 23 if a full–time student.
   - [ ] Other:

   Termination of coverage upon reaching the Limiting Age:

☒ Coverage is terminated on the birthday.

☐ Coverage is terminated on the last day of the month in which the limiting age is reached.

5. The Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

   ☒ The date of employment.
   ☐ The day of employment.
   ☐ The day of the month following month(s) or days of employment.
   ☐ The day of the month following the date of employment.
   ☐ Other:

6. Enrollment:

   Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the date of application of coverage.

   Late Enrollment: ☒ Yes ☐ No (Not available under the Community Participating Option)
   An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer.

   Annual Open Enrollment: ☒ Yes ☐ No

   An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Annual Open Enrollment Period.

   - Specify Annual Open Enrollment Period: April 26 - May 21

   Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by HCSC and the Employer. Such date shall be subsequent to the annual open enrollment period.

7. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:
   Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 days
   (However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with the Family and Medical Leave Act of 1993, as amended.)

8. Funding Arrangement:

   ☒ Standard Premium - Prospective
   ☐ Standard Premium - Retrospective
   ☐ Minimum Premium Program (MPP)
   ☐ Cost Plus Program
   ☐ Contingent Premium - Separate Agreement

COMPLETE THE APPLICABLE FUNDING INFORMATION BELOW

PREMIUM INFORMATION:

(a) Premium Period:

   ☒ The first day of each calendar month through the last day of each calendar month.
   ☐ The day of each calendar month through the day of the next calendar month.
   ☐ Other:

(b) The Employer contribution is:

   ☐ 100% of the Individual Coverage Premium and an amount equal to 100% of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.

☒ 90% of the Individual Coverage Premium and 70% of the Family Coverage Premium.
☐ Other:

(c) It is understood that no Policy will be issued or renewed on a contributory basis unless at least % of the Eligible Persons and, for Family Coverage, % of the Eligible Persons with eligible dependents have enrolled for coverage.

Standard Premium Rates

	For Internal Use Only - BlueStar Ben.Agree#: ____ **PPO Health Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ **Dental Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ ____ **Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ ____ **Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ ____ **Coverage:**	**Total**
1. Employee only :	$382.28	$	$	$	$	$
2. Employee with one dependent:	$	$	$	$	$	$
3. Employee and two or more dependents:	$	$	$	$	$	$
4. Employee plus Spouse:	$	$	$	$	$	$
5. Employee plus Child(ren):	$	$	$	$	$	$
6. Employee plus Family:	$1084.15	$	$	$	$	$
7. Other:	$	$	$	$	$	$
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$248.48	$	$	$	$	$
Family Coverage:	$496.96	$	$	$	$	$

Minimum Premium Program

Monthly Minimum Premium: ☐ Rate per Employee **or** ☐ Single and Family Rates
Health Coverage: $ Dental Coverage: $

Monthly CAP (Claims as Paid) Maximum: ☐ Rate per Employee **or** ☐ Single and Family Rates
Health Coverage: $ Dental Coverage: $

Individual Pooling Limit per Covered Person: $

Terminal Liability Payment: $; ☐ Rate per Employee **or** ☐ Single and Family Rates

Terminal Administrative Fee: $; ☐ Rate per Employee **or** ☐ Single and Family Rates **or** ☐ N/A

Rates are based on an enrollment of: Single Coverage Units and Family Coverage Units

Cost-Plus Program

Service Charges:

☐ % of Net Claim Payments **or** $ per employee per month.
☐ Applies to all coverage

☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:
For Coverage: % of Claim Payments **or** $ per employee per month
For Coverage: % of Claim Payments **or** $ per employee per month
Other (please specify):
☐$ per employee per month for administration of the Medical Services Advisory Program (MSA)
☐$ per employee per month for administration of Utilization Management

Payment Method: ☐ Transfer Payment ☐ Post Payment

If Transfer Payment --
Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer
☐ Other (please specify):

Payment Period: ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly
☐ Other (please specify):

Claim Settlement Period: ☐ Monthly ☐ Quarterly ☐ Other (please specify):

If Transfer Payment --
Tentative Final Settlement Period:
Transfer Payments to be made for:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify):
after termination. *(Applicable to Transfer Payment only)*

Prescription Drug Rebate: $ per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

Plan Provider Access Fee(s) (applicable to Minimum Premium and Cost-Plus Groups only)

Group Number(s):
☐% of ADP Savings: %
☐ $ Per Employee per Month (For MPP, this amount also included in Monthly Minimum Premium): $

Group Number(s):
☐% of ADP Savings: %
☐ $ Per Employee per Month (For MPP, this amount also included in Monthly Minimum Premium): $

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Group, has provided the information requested in this Benefit Program Application (BPA) and on behalf of the Group offers to purchase the benefit program as outlined in the Request For Proposal (RFP) submitted to the Group by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Group Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, this BPA shall be incorporated and made a part of the Group Policy. In the event of any conflict between the RFP and the Group Policy, the provisions of the Group Policy shall prevail.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, (ERISA) establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Group (or any Group member if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member if the Group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Group Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS APPLICABLE:

(a) Reimbursement Provision: ☒ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery (under cost-plus funding) or deduct 25% of the net recovery from the amount credited to the group's experience (under premium funding) after attorneys' fees, if any, have been paid.

(b) Certificate of Creditable Coverage: ☒ Yes ☐ No

If yes: It is understood and agreed that HCSC will issue to individuals, whose coverage under the Group Policy terminates during the term of the Group Policy, a Certificate of Creditable Coverage based upon coverage under the Group Policy and information provided to HCSC by the Employer.

If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Group Policy.

(c) DentaCap Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(d) Fort Dearborn Life Insurance purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(e) Excess Loss Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(f) Medical Services Advisory (MSA)/Individual Benefits Management Program (IBMP): ☒ Yes ☐ No

If yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Group Policy.

(g) Domestic Partners covered: ☐ Yes ☒ No

If yes: A Domestic Partner, as defined in the Group Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Insureds with Domestic Partners.

ADDITIONAL PROVISIONS: State mandate contraceptive services coverage added. No other benefit changes

☐ Additional Provisions are specified in the Exhibit attached hereto and made a part of this BPA.

Cindy Nelson [signature]
Sales Representative

887
District

T. Schaffler
Producer Representative

Lockton Co.
Producer Firm

8755 W. Higgins Road, Chicago, Il 60631
Producer Address

Tax I.D. No.

Signature of Authorized Purchaser

Title

Date

Witness

$ Amount Submitted

UNDERWRITING USE ONLY
Date BPA approved:
Signature of Underwriter

CERTIFICATE BOOKLET INFORMATION
Number of Certificate Booklets: 150
☐ Mail booklets to: ☐ GROUP ☐ DISTRICT

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Benefit Program Application

(Applicable to 151 Plus Insured Group Accounts)

Customer Number (9-digit #):
Employer Group Number(s): P06522
Account Number(s): 206522
Section Number(s): 0100,0200,0400,0500,8888
Employer Name: Village of Lombard
(Specify the employer, the employee trust or the association applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)
Address: 255 East Wilson
City: Lombard State: IL Zip: 60148
Subsidiaries:
Affiliated Companies:
Administrative Contact: Joanne Jakubowski Phone Number: 630 620-5714 Fax Number:
Effective Date of Coverage: June 1, 2004 Anniversary Date: June 1, 2005

SCHEDULE OF ELIGIBILITY

1. Eligible Person means:
   - [x] A full-time employee of the Employer.
   - [ ] A full-time employee who is a member of:

     (name of union or association)
   - [x] Other: Active elected officials who pay the fully applicable payment with no Village contribution per Village Board Policy 98-3. Retirees per IMRF guidelines.

2. Full-Time Employee means:
   - [x] A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.
   - [ ] Other:

3. Applicable to *Cost-Plus* Groups only, the Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
   - [ ] The date such person ceases to meet the definition of Eligible Person.
   - [ ] The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - [ ] Other:

4. Limiting Age:
   - [ ] The limiting age for covered unmarried children is .
   - [x] The limiting age for covered unmarried children is 19; age 23 if a full–time student.
   - [ ] Other:

   Termination of coverage upon reaching the Limiting Age:

☒ Coverage is terminated on the birthday.

☐ Coverage is terminated on the last day of the month in which the limiting age is reached.

5. The Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

   ☒ The date of employment.

   ☐ The day of employment.

   ☐ The day of the month following month(s) or days of employment.

   ☐ The day of the month following the date of employment.

   ☐ Other:

6. Enrollment:

   Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the date of application of coverage.

   Late Enrollment: ☒ Yes ☐ No (Not available under the Community Participating Option)
   An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer.

   Annual Open Enrollment: ☒ Yes ☐ No

   An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Annual Open Enrollment Period.

   - Specify Annual Open Enrollment Period: April 26 - May 21

   Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by HCSC and the Employer. Such date shall be subsequent to the annual open enrollment period.

7. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:
   Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 days
   (However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with the Family and Medical Leave Act of 1993, as amended.)

8. Funding Arrangement:

   ☒ Standard Premium - Prospective

   ☐ Standard Premium - Retrospective

   ☐ Minimum Premium Program (MPP)

   ☐ Cost Plus Program

   ☐ Contingent Premium - Separate Agreement

COMPLETE THE APPLICABLE FUNDING INFORMATION BELOW

PREMIUM INFORMATION:

(a) Premium Period:

   ☒ The first day of each calendar month through the last day of each calendar month.

   ☐ The day of each calendar month through the day of the next calendar month.

   ☐ Other:

(b) The Employer contribution is:

   ☐ 100% of the Individual Coverage Premium and an amount equal to 100% of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.

☒ 90% of the Individual Coverage Premium and 70% of the Family Coverage Premium.
☐ Other:

(c) It is understood that no Policy will be issued or renewed on a contributory basis unless at least % of the Eligible Persons and, for Family Coverage, % of the Eligible Persons with eligible dependents have enrolled for coverage.

Standard Premium Rates

	For Internal Use Only - BlueStar Ben.Agree#: ____ **PPO Health Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Dental Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Coverage:**	**Total**
1. Employee only :	$359.93	$	$	$	$	$
2. Employee with one dependent:	$	$	$	$	$	$
3. Employee and two or more dependents:	$	$	$	$	$	$
4. Employee plus Spouse:	$	$	$	$	$	$
5. Employee plus Child(ren):	$	$	$	$	$	$
6. Employee plus Family:	$1020.70	$	$	$	$	$
7. Other:	$	$	$	$	$	$
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$233.95	$	$	$	$	$
Family Coverage:	$467.90	$	$	$	$	$

Minimum Premium Program

Monthly Minimum Premium: ☐ Rate per Employee **or** ☐ Single and Family Rates
Health Coverage: $ Dental Coverage: $

Monthly CAP (Claims as Paid) Maximum: ☐ Rate per Employee **or** ☐ Single and Family Rates
Health Coverage: $ Dental Coverage: $

Individual Pooling Limit per Covered Person: $

Terminal Liability Payment: $; ☐ Rate per Employee **or** ☐ Single and Family Rates

Terminal Administrative Fee: $; ☐ Rate per Employee **or** ☐ Single and Family Rates **or** ☐ N/A

Rates are based on an enrollment of: Single Coverage Units and Family Coverage Units

Cost-Plus Program

Service Charges:

☐ % of Net Claim Payments **or** $ per employee per month.
☐ Applies to all coverage

☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:
For Coverage: % of Claim Payments **or** $ per employee per month
For Coverage: % of Claim Payments **or** $ per employee per month
Other (please specify):
☐$ per employee per month for administration of the Medical Services Advisory Program (MSA)
☐$ per employee per month for administration of Utilization Management

Payment Method: ☐ Transfer Payment ☐ Post Payment

If Transfer Payment --
Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer
☐ Other (please specify):

Payment Period: ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly
☐ Other (please specify):

Claim Settlement Period: ☐ Monthly ☐ Quarterly ☐ Other (please specify):

If Transfer Payment --
Tentative Final Settlement Period:
Transfer Payments to be made for:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify):
after termination. (*Applicable to Transfer Payment only*)

Prescription Drug Rebate: $ per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

Plan Provider Access Fee(s) (applicable to Minimum Premium and Cost-Plus Groups only)

Group Number(s):
☐% of ADP Savings: %
☐ $ Per Employee per Month (For MPP, this amount also included in Monthly Minimum Premium): $

Group Number(s):
☐% of ADP Savings: %
☐ $ Per Employee per Month (For MPP, this amount also included in Monthly Minimum Premium): $

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Group, has provided the information requested in this Benefit Program Application (BPA) and on behalf of the Group offers to purchase the benefit program as outlined in the Request For Proposal (RFP) submitted to the Group by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Group Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, this BPA shall be incorporated and made a part of the Group Policy. In the event of any conflict between the RFP and the Group Policy, the provisions of the Group Policy shall prevail.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, (ERISA) establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Group (or any Group member if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member if the Group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Group Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS APPLICABLE:

(a) Reimbursement Provision: ☒ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery (under cost-plus funding) or deduct 25% of the net recovery from the amount credited to the group's experience (under premium funding) after attorneys' fees, if any, have been paid.

(b) Certificate of Creditable Coverage: ☒ Yes ☐ No

If yes: It is understood and agreed that HCSC will issue to individuals, whose coverage under the Group Policy terminates during the term of the Group Policy, a Certificate of Creditable Coverage based upon coverage under the Group Policy and information provided to HCSC by the Employer.

If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Group Policy.

(c) DentaCap Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(d) Fort Dearborn Life Insurance purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(e) Excess Loss Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(f) Medical Services Advisory (MSA)/Individual Benefits Management Program (IBMP): ☒ Yes ☐ No

If yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Group Policy.

(g) Domestic Partners covered: ☐ Yes ☒ No

If yes: A Domestic Partner, as defined in the Group Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Insureds with Domestic Partners.

ADDITIONAL PROVISIONS: State mandate contraceptive services coverage added. No other benefit changes

☐ Additional Provisions are specified in the Exhibit attached hereto and made a part of this BPA.

Cindy Nelson [signature]
Sales Representative

887
District

T. Schaffler
Producer Representative

Lockton Co.
Producer Firm

8755 W. Higgins Road, Chicago, Il 60631
Producer Address

Tax I.D. No.

Signature of Authorized Purchaser

Title

Date

Witness

$ Amount Submitted

UNDERWRITING USE ONLY
Date BPA approved:
Signature of Underwriter

CERTIFICATE BOOKLET INFORMATION
Number of Certificate Booklets: 150
☐ Mail booklets to: ☐ GROUP ☐ DISTRICT

BlueCross BlueShield of Illinois

The HMOs of Blue Cross and Blue Shield of Illinois

A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company,
An Independent Licensee of the
Blue Cross and Blue Shield Association

Benefit Program Application

Customer Number:
HMO Illinois Group Number(s): H56789
HMO Illinois Section Number(s): 0300 and 8889
BlueAdvantage HMO Group Number(s): B56789
BlueAdvantage HMO Section Number(s): 0300 and 8889

Group Name: Village of Lombard
(Specify the Group or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

Address: 255 E. Wilson
City: Lombard State: IL Zip: 60148
Group Administrator: Joanne Jakubowski Phone Number: 630 620*5714
Effective Date of Coverage: June 1, 2004 Anniversary Date: June 1, 2005

1. Eligible Person means a person who resides in the Service Area of a Participating IPA and is:

   ☒ A full-time employee of the Group.

   ☐ A member of (name of union):

   ☒ Other (please specify): Active elected officials who pay the fully applicable payment with no Village contribution per Village Board Policy 98-3. Retirees per IMRF guidelines

2. Full-Time Employee means:

   ☒ A person who is regularly scheduled to work a minimum of 40 hours per week and is on the payroll of the Group.

   ☐ Other (please specify):

3. Limiting Age:

   The limiting age for covered unmarried children is 19; age 23 if a full-time student.

   ☒ Coverage is terminated at the end of the month in which the limiting age is reached.

   ☐ Coverage is terminated on the last day of the year in which the limiting age is reached.

   ☐ Other (please specify):

4. Total number of employees: (indicate the total number of actual employees, not enrollees)

   In the Group 291 Illinois employees 291 National employees

5. Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Group's health care plan:

   ☒ The date of employment.

   ☐ The _____ day of employment.

   ☐ The _____ day of the month following _____ month(s) or _____ days of employment.

   ☐ The _____ day of the month following the date of employment.

   ☐ Other (please specify):

   ☐ A full month's premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the first and fifteenth day of the Premium Period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth day and the end of the Premium Period.

6. Enrollment:

   Open Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Group's Open Enrollment Period.

   - Specify Open Enrollment Period: April 26 - May 21

   Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by Blue Cross and Blue Shield of Illinois, A Division of Health Care Service Corporation, A Mutual Legal Reserve Company ("HCSC") and the Group. Such date shall be subsequent to the open enrollment period.

   Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the date of application of coverage.

7. Effective Date of Termination for a person who ceases to meet the definition of an Eligible Person:

   ☐ The date such person ceases to meet the definition of Eligible Person.

   ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.

   ☐ Other (please specify):

8. Extension of Benefits due to Temporary Layoff, Disability or Leave of Absence:

   Temporary Layoff: 0 days; Disability: 0 days; Leave of Absence: 0 days

   ☐ Other (please specify):

   (However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with the Family and Medical Leave Act of 1993, as amended.)

9. Funding Arrangement:

   ☒ Premium Prospective (complete section 11.)

   ☐ Cost Plus (complete section 12.)

10. Group Contribution:

☒ HMO Illinois: 96% of the Individual Coverage Premium, and 86% of the Family Coverage Premium.

☒ BlueAdvantage HMO: 96% of the Individual Coverage Premium, and 86% of the Family Coverage Premium.

☐ Other (please specify): ______

11. Premium Period and Premium Rates:

☒ The first day of each calendar month through the last day of each calendar month.

☐ The ______ day of each calendar month through the ______ day of the next calendar month.

Premium Rates		
Health Coverage		
1. Employee only	HMO Illinois $344.06	BlueAdvantage HMO $313.09
2. Employee plus one dependent	HMO Illinois $	BlueAdvantage HMO $
3. Employee plus two or more dependents	HMO Illinois $	BlueAdvantage HMO $
4. Employee plus Spouse	HMO Illinois $	BlueAdvantage HMO $
5. Employee plus Child(ren)	HMO Illinois $	BlueAdvantage HMO $
6. Family	HMO Illinois $944.12	BlueAdvantage HMO $859.15
Single Tier rate structure – complete item 1.		
Two Tier rate structure – complete items 1. and 6.		
Three Tier rate structure – complete items 1., 2., and 3.		
Four Tier rate structure – complete items 1., 4., 5., and 6.		
Indicate "N/A" in any rate field that does not apply		
Medicare Eligible Rates (When HCSC Is Secondary Payer)		
Single Coverage	HMO Illinois $344.06	BlueAdvantage HMO $313.09
Family Coverage	HMO Illinois $688.09	BlueAdvantage HMO $626.16

12. Cost Plus Program:

a) Service Charges for Claim Payments:

☐ HMO Illinois: _____% of Claim Payments; $_____ per Enrollee per month for health Claim Payments

☐ BlueAdvantage HMO: _____% of Claim Payments; $_____ per Enrollee per month for health Claim Payments

b) Physician's Services Fees:

☐ HMO Illinois: $_____ per month per single Enrollee; $_____per month per Enrollee with one or more Dependents

☐ BlueAdvantage HMO $_____ per month per single Enrollee; $_____per month per Enrollee with one or more Dependents

c) ☐ Transfer Payment Method:

☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify): _____

Tentative Final Settlement Period - Transfer payments required after termination for:

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

d) ☐ Post Payment Method

e) Payment Period:

☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (please specify): _____

f) Claim Settlement Period:

☐ Monthly ☐ Quarterly ☐ Other (please specify) _____

g) Prescription Drug Rebate:
$_____ per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Group, has provided the information requested in this Benefit Program Application (BPA) and on behalf of the Group offers to purchase the benefit program as outlined in the proposal document submitted to the Group by the Sales Representative. The benefit program and funding arrangements are as outlined in this BPA. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Group Policy. This BPA is subject to acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, A Mutual Legal Reserve Company ("HCSC"). Upon acceptance, this BPA shall be incorporated and made a part of the Group Policy. In the event of any conflict between the proposal document and the Group Policy, the provisions of the Group Policy shall prevail.

The undersigned representative hereby acknowledges that the Employee Retirement Income Security Act of 1974, as amended, (ERISA), establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Group, the Group agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Group is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Group Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS:

1. Certificate of Creditable Coverage: ☒ Yes ☐ No

   (applicable to 100 plus groups only; automatic issuance for groups under 100 lives)

   If yes: It is understood and agreed that HCSC will issue to individuals, whose coverage under the Group Policy terminates during the term of the Group Policy, a Certificate of Creditable Coverage based upon coverage under the Group Policy and information provided to HCSC by the Group.

   If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Group Policy.

2. Reimbursement Provision: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will deduct 25% of the net recovery from the amount credited to the Group's experience after attorneys' fees, if any, have been paid.

3. Domestic Partners Covered: : ☐ Yes ☒ No

   If yes, a Domestic Partner, as defined in the Group Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Enrollees with Domestic Partners.

4. Excess Loss Coverage purchased: ☐ Yes ☒ No

   If yes: Complete separate Application for Excess Loss Coverage.

ADDITIONAL PROVISIONS: State mandated coverage for contraceptive services added

Cindy Nelson [signature]

Sales Representative

887

District Phone No.

T. Schaffler

Producer Representative

Lockton Co

Producer Firm

8755 W. Higgins Road, Chicago, IL 60631

Producer Address

Tax ID No.

Signature of Authorized Purchaser

Title

Date

Witness

$______ Amount Submitted (for new groups only)

INTERNAL USE ONLY	UNDERWRITING AUTHORIZATION
	Date BPA approved by Underwriting: ______
	Printed Name and Signature of Underwriter
	______________________________

CERTIFICATE AND POLICY INFORMATION		
Certificate Booklets:	☒ **Individual Mail**	☐ **Ship to:** _____
		Attn: _____
		Quantity: _____
Mail Policy to: ☐ **Group**		
☒ **District**		