

**BOARD OF COUNTY COMMISSIONERS
ESCAMBIA COUNTY, FLORIDA**

OFFICE OF PURCHASING

213 PALAFOX PLACE, 2nd Floor
P.O. BOX 1591
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CERTIFICATION OF CONTRACT

TITLE: Group Medical, Life & Disability Insurance

CONTRACT NO.: PD 08-09.042

AWARD DATE: July 23, 2009

EFFECTIVE DATE: October 1, 2009

AWARD: Awarding a Contract to Blue Cross and Blue Shield of Florida, Inc., for one year, from October 1, 2009, to September 30, 2010, to provide health insurance coverage in the form of plans Blue Option 1352, Blue Option 1552, Health Saving Accounts (HSA), and Blue Medicare and Group Medicare Supplement Plan "F" for retirees who are Medicare-eligible; Awarding a Contract for \$10,000 additional life insurance to The Standard Life Insurance Company, for a total of \$50,000 of Group Term Life and Accidental Death and Dismemberment Insurance, and offset dental insurance premiums by \$12.98 for employees electing not to take the County's health insurance coverage, effective October 1, 2009; the Health Indemnity Program will be eliminated as of October 1 2009; Approving the employee and retiree health insurance premiums; *Attachment 1* shows premiums reflecting a \$20 discount for employees who do not smoke; *Attachment 2* shows the health insurance premiums for the County's retirees; retirees will be responsible for paying their full premium, whether they are Medicare-eligible or not.

STATUS: For a period of 12 months

CONTRACTOR(S): Blue Cross and Blue Shield of Florida, Inc

ANY QUESTIONS, SUGGESTIONS, OR CONTRACT SUPPLIER PROBLEMS WHICH MAY ARISE SHALL BE BROUGHT TO THE ATTENTION OF Joe Pillitary, Purchasing Coordinator (850) 595-4878 (850)695-4878 E-MAIL joe_pillitary@co.escambia.fl.us

- A. **AUTHORITY** - Upon affirmative action taken by the Board of County Commissioners on July 23, 2009, an agreement has been executed between the Board of County Commissioners, Escambia County Florida and the designated contractor(s).
- B. **EFFECT** - This contract was entered into to provide economies in the purchase of (**Service or Commodity**) as described within the solicitation. Therefore, in compliance with **County Ordinance Chapter 46 Finance, Article II Division 3, Section 46-81**, all purchases of these commodities shall be made under the terms, prices, and conditions of this contract and with the suppliers specified.
- C. **ORDERING INSTRUCTIONS** - All purchase orders shall be issued in accordance with **Codified County Ordinance, Chapter 46 Finance, Article II Purchases and Contracts; and, as supplemented by Ordinance 2001-9 and Ordinance 2001-60**. Purchases shall be at the prices indicated, exclusive of all Federal, State and local taxes. All contract purchase orders shall show the contract number, product number, quantity, description of item, with unit prices extended and purchase order totaled. (This requirement may be waived when purchase is made by a blanket purchase order.)

- D. CONTRACTOR PERFORMANCE - Departments shall report any vendor failure to perform according to the requirements of this contract on Report of Unsatisfactory Materials and/or Service, Form F0140 to this office.
- E. VENDOR PERFORMANCE EVALUATION FORM - Contract Appraisal, form F0190 should be used to provide your input and recommendations for improvements in the contract to the Office of Purchasing for receipt no later than 90 days prior to the expiration date of this contract.



EMPLOYER APPLICATION (True Group Application)

New Business Renewal Business

Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:
List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions FamPhy Plan 1351 - Std		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Coinsurance:		Coinsurance:	
Per Person	\$500 / Combined with In-Network	In-Network / Participating	80
Per Family	\$1,500 / Combined with In-Network	Out-of-Network / Non-Participating	60
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	\$20
Rates:		All Other Providers	CYD + 80%
Employee	\$282.51	Employee/Spouse	\$672.58
		Employee/Child(ren)	\$605.43
		Family	\$874.06
		Other	

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions PhyCopay Plan 1550 - NSId		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Coinsurance:		Coinsurance:	
Per Person	\$300 / Combined with In-Network	In-Network / Participating	80%
Per Family	\$900 / Combined with In-Network	Out-of-Network / Non-Participating	60%
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	\$15
Rates:		All Other Providers	\$30
Employee	\$312.84	Employee/Spouse	\$744.95
		Employee/Child(ren)	\$670.55
		Family	\$968.13
		Other	

**EMPLOYER APPLICATION
 (True Group Application)**

Health Plan Name BlueCare NFO LG Grp Plan 15 - Std		Rx Option (indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person		In-Network / Participating	
Per Family		Out-of-Network / Non-Participating	
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	
Rates:		Family Phy.	
Employee	\$372.80	All Other Providers	
Employee/Spouse	\$887.99		
Employee/Child(ren)	\$799.28	Family	\$1,154.06
		Other	

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
 (if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount
 HMO: Discount

E. Rate Comments: Rates for +Housing Authority - Active Emps / Retirees <65 No Med*

EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by
BCBSF Corporate Headquarters

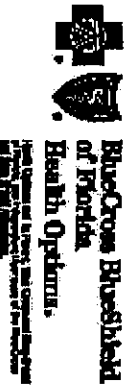
Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
4/29/06	<i>Georgie Touart</i>	George Touart, County Administrator
7/5/06	<i>Jimmy Kelly</i>	Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)

Signature of Agent	Agent License Identification Number
<i>Jimmy Kelly</i>	7183

Witnesses to Applicant Signature

Witness: *Paul Brown* Witness: *Douglas Young*



EMPLOYER APPLICATION (True Group Application)

New Business Renewal Business Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation Insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be
Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %



EMPLOYER APPLICATION (True Group Application)

Health Options and Programs are provided by BlueCross of Florida, a member of the BlueCross of Florida Group.

III. Health Plan Summary Information (select the appropriate box(es)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan

Blue Packages

Health Plan Name HIP - Std	Rx Option (indicate copayments)
Calendar Year Deductible:	Coinsurance:
Per Person	In-Network / Participating
Per Family	Out-of-Network / Non-Participating
Pre-Existing	Office Visit Copay: Family Phy.
Rates:	All Other Providers
Employee <input type="text" value="\$28.40"/>	Employee/Spouse <input type="text"/>
	Employee/Child(ren) <input type="text"/>
	Family <input type="text"/>
	Other <input type="text"/>

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's Integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be:

B. **Regular Billing-** Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: HMO:

E. Rate Comments:

EMPLOYER APPLICATION
 (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with **BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters.
 Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
6/29/06	<i>George Tourant</i>	George Tourant, County Administrator
7/5/06	<i>Jimmy Kelly</i>	
	Signature of Agent	Agent License Identification Number
	<i>Jimmy Kelly</i>	2003

Witnesses to Applicant Signature

Witness: *Paul Brant* Witness: *Doreen Young*



EMPLOYER APPLICATION (True Group Application)

New Business Renewal Business

Other Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

SIC Code:

Mailing Address:

Email Address:
List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name

Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box(s)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
<input type="text" value="BlueOptions FamPhy Plan 1351 - Std"/>		<input type="text" value="BlueScript C Copay Plan 10/25/40 C - Std"/>	
Calendar Year Deductible:			
Per Person		Coinsurance:	
<input type="text" value="\$500 / Combined with In-Network"/>		In-Network / Participating <input type="text" value="80"/>	
Per Family		Out-of-Network / Non-Participating <input type="text" value="60"/>	
<input type="text" value="\$1,500 / Combined with In-Network"/>		Office Visit Copay:	
Pre-Existing		Family Phy. <input type="text" value="\$20"/>	
<input type="text" value="Pre-Existing Applies"/>		All Other Providers <input type="text" value="CYD + 80%"/>	
Rates.			
Employee	<input type="text" value="\$196.65"/>	Employee/Spouse	<input type="text" value="\$515.22"/>
		Employee/Child(ren)	<input type="text" value="\$463.79"/>
		Family	<input type="text" value="\$669.48"/>
		Other	<input type="text" value=""/>

Health Plan Name		Rx Option (indicate copayments)	
<input type="text" value="BlueOptions PhyCcopy Plan 1550 - NStd"/>		<input type="text" value="BlueScript C Copay Plan 10/25/40 C - Std"/>	
Calendar Year Deductible:			
Per Person		Coinsurance:	
<input type="text" value="\$300 / Combined with In-Network"/>		In-Network / Participating <input type="text" value="80%"/>	
Per Family		Out-of-Network / Non-Participating <input type="text" value="60%"/>	
<input type="text" value="\$900 / Combined with In-Network"/>		Office Visit Copay:	
Pre-Existing		Family Phy. <input type="text" value="\$15"/>	
<input type="text" value="Pre-Existing Applies"/>		All Other Providers <input type="text" value="\$30"/>	
Rates.			
Employee	<input type="text" value="\$217.72"/>	Employee/Spouse	<input type="text" value="\$570.62"/>
		Employee/Child(ren)	<input type="text" value="\$513.67"/>
		Family	<input type="text" value="\$741.52"/>
		Other	<input type="text" value=""/>

EMPLOYER APPLICATION (True Group Application)

Health Plan Name BlueCare NFQ LG Grp Plan 15 - Std		Rx Option (indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person		In-Network / Participating	
Per Family		Out-of-Network / Non-Participating	
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	
Rates:		Family Phy:	\$15
Employee	\$259.39	All Other Providers	\$35
Employee/Spouse	\$660.14	Family	\$883.87
Employee/Child(ren)	\$612.23	Other	

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

- A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

- A. Premium/Prepayment fee are payable monthly on or before the due date which will be:
- B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.
- C. The Rates established for this Policy will not be changed for the first twelve (12) months following the Initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

- D. Funding Arrangements: BCBSF: Discount

HMO: Discount

- E. Rate Comments: Rates for *Retirees with Medicare / Spouse without Med*



EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with **BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters
Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date 6/29/06 Signature of Applicant George Touart Print/Type Name & Title George Touart, County Administrator

Date 7/6/06 Signature of Agent Jimmy Kelly Agent License Identification Number 4003

Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)

Witnesses to Applicant Signature

Witness: Paul Davis Witness: Sheryl Young



EMPLOYER APPLICATION (True Group Application)

New Business Renewal Business

Other Group # (BCBSF): (HMO):

I. Group Information
A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	Address
<input type="text"/>	<input type="text"/>

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be
Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

**EMPLOYER APPLICATION
(True Group Application)**

III. Health Plan Summary Information (select the appropriate box(s)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions FamPhy Plan 1351 - Std		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Per Person	\$500 / Combined with In-Network	Coinsurance:	In-Network / Participating 80%
Per Family	\$1,500 / Combined with In-Network		Out-of-Network / Non-Participating 60%
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	Family Phy. \$20
Rates.		All Other Providers	CYD + 80%
Employee	\$282.51	Employee/Spouse	\$515.22
		Employee/Child(ren)	\$463.79
		Family	\$669.48
		Other	

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions PhyCcopy Plan 1550 - NStd		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Per Person	\$300 / Combined with In-Network	Coinsurance:	In-Network / Participating 80%
Per Family	\$900 / Combined with In-Network		Out-of-Network / Non-Participating 60%
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	Family Phy. \$15
Rates.		All Other Providers	\$30
Employee	\$312.84	Employee/Spouse	\$570.62
		Employee/Child(ren)	\$513.67
		Family	\$741.52
		Other	

EMPLOYER APPLICATION
(True Group Application)

Health Plan Name		BlueCare NFO LG Grp Plan 15 - Std		Rx Option (indicate copayments)		BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		[]		Coinsurance:		[]	
Per Person		[]		In-Network / Participating		[]	
Per Family		[]		Out-of-Network / Non-Participating		[]	
Pre-Existing		Pre-Existing Applies		Office Visit Copay:		[]	
Rates:		All Other Providers		Family Pny.		[]	
Employee	\$372.80	Employee/Spouse	\$680.14	Employee/Child(ren)	\$612.23	Family	\$883.87
						Other	[]

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
 (if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: []

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the Initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount []
 HMO: Discount []

E. Rate Comments: Rates for *Retirees <65 without Med / Spouse with Med* []



EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
4/29/04		George Touart, County Administrator

Date	Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)	
7/6/06	Signature of Agent	Agent License Identification Number
		403

Witnesses to Applicant Signature

Witness:		Witness:	
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EMPLOYER APPLICATION (True Group Application)

Blue Cross and BlueShield of Florida are Equal Opportunity and Affirmative Action Employers. Minorities and women are encouraged to apply.

New Business Renewal Business

Other Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	Address
<input type="text"/>	<input type="text"/>

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box(es)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan

Blue Packages

Health Plan Name BlueOptions FamPhy Plan 1351 - Std	Rx Option (Indicate copayments) BlueScript C Copay Plan 10/25/40 C - Std
Calendar Year Deductible: Per Person <input type="text" value="\$500 / Combined with In-Network"/> Per Family <input type="text" value="\$1,500 / Combined with In-Network"/> Pre-Existing <input type="text" value="Pre-Existing Applies"/>	Coinsurance: In-Network / Participating <input type="text" value="80"/> Out-of-Network / Non-Participating <input type="text" value="60"/> Office Visit Copay: Family Phy. <input type="text" value="\$20"/> All Other Providers <input type="text" value="CYD + 80%"/>
Rates: Employee <input type="text" value="\$196.67"/> Employee/Spouse <input type="text" value="\$391.81"/> Employee/Child(ren) <input type="text" value="\$352.73"/> Family <input type="text" value="\$509.05"/> Other <input type="text"/>	

Health Plan Name BlueOptions PhyC Copay Plan 1550 - NSId	Rx Option (Indicate copayments) BlueScript C Copay Plan 10/25/40 C - Std
Calendar Year Deductible: Per Person <input type="text" value="\$300 / Combined with In-Network"/> Per Family <input type="text" value="\$900 / Combined with In-Network"/> Pre-Existing <input type="text" value="Pre-Existing Applies"/>	Coinsurance: In-Network / Participating <input type="text" value="80%"/> Out-of-Network / Non-Participating <input type="text" value="60%"/> Office Visit Copay: Family Phy. <input type="text" value="\$15"/> All Other Providers <input type="text" value="\$30"/>
Rates: Employee <input type="text" value="\$217.74"/> Employee/Spouse <input type="text" value="\$433.92"/> Employee/Child(ren) <input type="text" value="\$390.63"/> Family <input type="text" value="\$563.78"/> Other <input type="text"/>	



EMPLOYER APPLICATION (True Group Application)

Health Plan Name BlueCare NFO LG Grp Plan 15 - Std		Rx Option (Indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person		In-Network / Participating	
Per Family		Out-of-Network / Non-Participating	
Pre-Existing	Pre-Existing Applies	Office Visit Copay: Family Phy.	\$15
Rates:		All Other Providers	\$35
Employee	\$259.41	Employee/Spouse	\$517.15
		Employee/Child(ren)	\$465.53
		Family	\$671.99
		Other	

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

- A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

- A. Premium/Prepayment fee are payable monthly on or before the due date which will be:
- B. **Regular Billing-** Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

- C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

- D. Funding Arrangements: BCBSF: Discount
HMO: Discount

- E. Rate Comments:
Rates for *Retirees - Both with Medicare*



EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by
BCBSF Corporate Headquarters
 Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
6/25/06	<i>George Touart</i>	George Touart, County Administrator
7/5/06	<i>Timmy Kelly</i>	Timmy Kelly, Licensed Agent (Print)
	Signature of Agent	Agent License Identification Number
	<i>Sheryl Kelly</i>	AB3

Witnesses to Applicant Signature

Witness: *Sheryl Kelly* Witness: *Sheryl Young*



**EMPLOYER APPLICATION
(True Group Application)**

New Business Renewal Business

Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business:

SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name

Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance

HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation Insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %



**BlueCross BlueShield
of Florida**
Health Options.
Member of the United Health Group

EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box(es)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions FamPhy Plan 1351 - Std		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	\$500 / Combined with In-Network	In-Network / Participating	80
Per Family	\$1,500 / Combined with In-Network	Out-of-Network / Non-Participating	60
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	Family Phy: \$20
Rates:		All Other Providers:	CYD + 80%
Employee	\$282.51	Employee/Spouse	\$672.58
		Employee/Child(ren)	\$605.43
		Family	\$874.06
		Other	

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions PhyCoplay Plan 1550 - NSId		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	\$300 / Combined with In-Network	In-Network / Participating	80%
Per Family	\$900 / Combined with In-Network	Out-of-Network / Non-Participating	60%
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	Family Phy: \$15
Rates:		All Other Providers	\$30
Employee	\$312.84	Employee/Spouse	\$744.95
		Employee/Child(ren)	\$670.55
		Family	\$968.13
		Other	



EMPLOYER APPLICATION (True Group Application)

BlueCross BlueShield of Florida Health Options
The Group Health Plan of Florida, Inc.
1000 North West 13th Street, Suite 1000
Fort Lauderdale, FL 33311

Health Plan Name BlueCare NFO LG Grp Plan 15 - Std		Rx Option (Indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	<input type="text"/>	In-Network / Participating	<input type="text"/>
Per Family	<input type="text"/>	Out-of-Network / Non-Participating	<input type="text"/>
Pre-Existing	<input type="text"/> Pre-Existing Applies	Office Visit Copay: Family Phy.	<input type="text"/> \$15 <input type="text"/> \$35
Rates:		All Other Providers	<input type="text"/>
Employee	<input type="text"/> \$372.80	Employee/Spouse	<input type="text"/> \$887.99
		Employee/Child(ren)	<input type="text"/> \$799.28
		Family	<input type="text"/> \$1,154.06
		Other	<input type="text"/>

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount
HMO: Discount

E. Rate Comments: Rates for *Active Emps / Retires <65 No Medicare*



EMPLOYER APPLICATION
(True Group Application)

New Business Renewal Business

Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

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D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

III. Health Plan Summary Information (select the appropriate box(s)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name HIP - Std	Rx Option (Indicate copayments)
Calendar Year Deductible:	Coinsurance:
Per Person	In-Network / Participating
Per Family	Out-of-Network / Non-Participating
Pre-Existing	Office Visit Copay:
Rates.	Family Phy.
Employee	All Other Providers
Employee/Spouse	Employee/Child(ren)
Employee/Child(ren)	Family
Other	Other

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? (if left blank, the response is assumed to be No.) Yes No

V. Rate Information

- A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st
- B. **Regular Billing-** Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.
- C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount
HMO:

E. Rate Comments: Rates for *Housing Auth - Hospital Indemnity Plan (HIP)*

EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
6/25/04	<i>George Tount</i>	George Tount, County Administrator
7/5/04	<i>George Tount</i>	Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)
	<i>George Tount</i>	Signature of Agent
		Agent License Identification Number

Witnesses to Applicant Signature

Witness: *Paul Brown* Witness: *Sheryl Young*



EMPLOYER APPLICATION
(True Group Application)

New Business Renewal Business

Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

**EMPLOYER APPLICATION
(True Group Application)**

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions FamPhy Plan 1351 - Std		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Coinsurance:		Coinsurance:	
Per Person	\$500 / Combined with In-Network	In-Network / Participating	80
Per Family	\$1,500 / Combined with In-Network	Out-of-Network / Non-Participating	60
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	\$20
Rates:		All Other Providers	CYD + 80%
Employee	\$282.51	Employee/Spouse	\$672.58
		Employee/Child(ren)	\$605.43
		Family	\$874.06
		Other	

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions PhyCopay Plan 1550 - NStd		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Coinsurance:		Coinsurance:	
Per Person	\$300 / Combined with In-Network	In-Network / Participating	80%
Per Family	\$900 / Combined with In-Network	Out-of-Network / Non-Participating	60%
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	\$15
Rates:		All Other Providers	\$30
Employee	\$312.84	Employee/Spouse	\$744.95
		Employee/Child(ren)	\$670.55
		Family	\$968.13
		Other	

**EMPLOYER APPLICATION
 (True Group Application)**

Health Plan Name BlueCare NFO LG Grp Plan 15 - Std		Rx Option (indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person		In-Network / Participating	
Per Family		Out-of-Network / Non-Participating	
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	
Rates:		Family Phy.	
Employee	\$372.80	All Other Providers	
Employee/Spouse	\$887.99		
Employee/Child(ren)	\$799.28	Family	\$1,154.06
		Other	

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
 (if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount
 HMO: Discount

E. Rate Comments: Rates for +Housing Authority - Active Emps / Retirees <65 No Med*

EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by
BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
4/29/06	<i>Georgie Touart</i>	George Touart, County Administrator
7/5/06	<i>Jimmy Kelly</i>	Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)
	Signature of Agent	Agent License Identification Number
	<i>Jimmy Kelly</i>	7183

Witnesses to Applicant Signature

Witness: *Paul Brown* Witness: *Douglas Young*



EMPLOYER APPLICATION (True Group Application)

New Business Renewal Business Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation Insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be
Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

EMPLOYER APPLICATION (True Group Application)

Health Options and Programs are provided by BlueCross of Florida Health Options, Inc. Member of BlueCross of Florida. Member of the Sun Life Group.

III. Health Plan Summary Information (select the appropriate box(es)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan

Blue Packages

Health Plan Name HIP - Std		Rx Option (indicate copayments)	
Calendar Year Deductible:		Coinsurance:	
Per Person	<input type="text"/>	In-Network / Participating	<input type="text"/>
Per Family	<input type="text"/>	Out-of-Network / Non-Participating	<input type="text"/>
Pre-Existing	Pre-Existing Applies	Office Visit Copay: Family Phy.	<input type="text"/> <input type="text"/>
Rates:		All Other Providers	<input type="text"/>
Employee	\$28.40	Employee/Spouse	<input type="text"/>
		Employee/Child(ren)	<input type="text"/>
		Family	<input type="text"/>
		Other	<input type="text"/>

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's Integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

- A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st
- B. **Regular Billing-** Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.
- C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount

HMO:

E. Rate Comments: Rates for *Hospital Indemnity Plan (HIP)*



Blue Cross of Florida Health Options. The General Agent, Licensed Agent, or Licensed Agent (Print)

EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
6/29/06	<i>George Tourant</i>	George Tourant, County Administrator
7/5/06	<i>Jimmy Kelly</i>	
	Signature of Agent	Agent License Identification Number
	<i>Jimmy Kelly</i>	2003

Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)

Witnesses to Applicant Signature

Witness: *Paul Brant* Witness: *Doreen Young*



EMPLOYER APPLICATION (True Group Application)

New Business Renewal Business

Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business:

SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	Address
<input type="text"/>	<input type="text"/>

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box(s)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
<input type="text" value="BlueOptions FamPhy Plan 1351 - Std"/>		<input type="text" value="BlueScript C Copay Plan 10/25/40 C - Std"/>	
Calendar Year Deductible:			
Per Person		Coinsurance:	
<input type="text" value="\$500 / Combined with In-Network"/>		In-Network / Participating <input type="text" value="80"/>	
Per Family		Out-of-Network / Non-Participating <input type="text" value="60"/>	
<input type="text" value="\$1,500 / Combined with In-Network"/>		Office Visit Copay:	
Pre-Existing		Family Phy. <input type="text" value="\$20"/>	
<input type="text" value="Pre-Existing Applies"/>		All Other Providers <input type="text" value="CYD + 80%"/>	
Rates.			
Employee	<input type="text" value="\$196.65"/>	Employee/Spouse	<input type="text" value="\$515.22"/>
		Employee/Child(ren)	<input type="text" value="\$463.79"/>
		Family	<input type="text" value="\$669.48"/>
		Other	<input type="text" value=""/>

Health Plan Name		Rx Option (indicate copayments)	
<input type="text" value="BlueOptions PhyCcopy Plan 1550 - NStd"/>		<input type="text" value="BlueScript C Copay Plan 10/25/40 C - Std"/>	
Calendar Year Deductible:			
Per Person		Coinsurance:	
<input type="text" value="\$300 / Combined with In-Network"/>		In-Network / Participating <input type="text" value="80%"/>	
Per Family		Out-of-Network / Non-Participating <input type="text" value="60%"/>	
<input type="text" value="\$900 / Combined with In-Network"/>		Office Visit Copay:	
Pre-Existing		Family Phy. <input type="text" value="\$15"/>	
<input type="text" value="Pre-Existing Applies"/>		All Other Providers <input type="text" value="\$30"/>	
Rates.			
Employee	<input type="text" value="\$217.72"/>	Employee/Spouse	<input type="text" value="\$570.62"/>
		Employee/Child(ren)	<input type="text" value="\$513.67"/>
		Family	<input type="text" value="\$741.52"/>
		Other	<input type="text" value=""/>

EMPLOYER APPLICATION (True Group Application)

Health Plan Name BlueCare NFQ LG Grp Plan 15 - Std		Rx Option (indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person		In-Network / Participating	
Per Family		Out-of-Network / Non-Participating	
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	
Rates:		Family Phy:	\$15
Employee	\$259.39	All Other Providers	\$35
Employee/Spouse	\$660.14	Family	\$883.87
Employee/Child(ren)	\$612.23	Other	

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

- A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
 (if left blank, the response is assumed to be No.)

V. Rate Information

- A. Premium/Prepayment fee are payable monthly on or before the due date which will be:
- B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.
- C. The Rates established for this Policy will not be changed for the first twelve (12) months following the Initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

- D. Funding Arrangements: BCBSF: Discount

HMO: Discount

- E. Rate Comments: Rates for *Retirees with Medicare / Spouse without Med*

**EMPLOYER APPLICATION
(True Group Application)**


VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, **with BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by
BCBSF Corporate Headquarters**



Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
<input type="text" value="6/29/06"/>		<input type="text" value="George Touart, County Administrator"/>

Date	Signature of Agent	Agent License Identification Number
<input type="text" value="7/6/06"/>		<input type="text" value="A003"/>

Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)

Witnesses to Applicant Signature

Witness:  Witness: 

**EMPLOYER APPLICATION
 (True Group Application)**

New Business Renewal Business

Other Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	Address
<input type="text"/>	<input type="text"/>

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
 HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be
 Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

**EMPLOYER APPLICATION
(True Group Application)**

III. Health Plan Summary Information (select the appropriate box(s)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions FamPhy Plan 1351 - Std		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Per Person	\$500 / Combined with In-Network	Coinsurance:	
Per Family	\$1,500 / Combined with In-Network	In-Network / Participating	80
Pre-Existing	Pre-Existing Applies	Out-of-Network / Non-Participating	60
Rates:		Office Visit Copay:	\$20
Employee	\$282.51	Family Phy.	CYD + 80%
Employee/Spouse	\$515.22	All Other Providers	
Employee/Child(ren)	\$463.79		
Family	\$669.48		
Other			

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions PhyCcopy Plan 1550 - NStd		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:			
Per Person	\$300 / Combined with In-Network	Coinsurance:	
Per Family	\$900 / Combined with In-Network	In-Network / Participating	80%
Pre-Existing	Pre-Existing Applies	Out-of-Network / Non-Participating	60%
Rates:		Office Visit Copay:	\$15
Employee	\$312.84	Family Phy.	\$30
Employee/Spouse	\$570.62	All Other Providers	
Employee/Child(ren)	\$513.67		
Family	\$741.52		
Other			

EMPLOYER APPLICATION (True Group Application)

Health Plan Name		BlueCare NFO LG Grp Plan 15 - Std		Rx Option (indicate copayments)		BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Per Person		Coinsurance:		In-Network / Participating	
Per Family		Pre-Existing		Out-of-Network / Non-Participating		Office Visit Copay:	
Pre-Existing Rates:		Employee		Family Pny		All Other Providers	
Employee		Employee/Spouse		Employee/Child(ren)		Family	
Employee		\$372.80		\$680.14		\$612.23	
Employee/Spouse		\$680.14		Family		\$883.87	
Employee/Child(ren)		\$612.23		Family		\$883.87	
Family		\$883.87		Other		\$15	
Other		\$15				\$35	
		\$35					

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be:

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the Initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount

HMO: Discount

E. Rate Comments: Rates for *Retirees <65 without Med / Spouse with Med*



EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with **BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
4/29/04		George Touart, County Administrator

Date	Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)	
7/6/06	Signature of Agent	Agent License Identification Number
		403

Witnesses to Applicant Signature

Witness:		Witness:	
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EMPLOYER APPLICATION (True Group Application)

Blue Cross BlueShield of Florida Health Options
The Department of Health, Blue Cross of Florida
1000 North West 17th Street, Tallahassee, FL 32304-1000

New Business Renewal Business

Other Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	Address
<input type="text"/>	<input type="text"/>

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

<input type="text" value="Retirees, Cobra"/>

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box(es)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan

Blue Packages

Health Plan Name BlueOptions FamPhy Plan 1351 - Std		Rx Option (Indicate copayments) BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	\$500 / Combined with In-Network	In-Network / Participating	80
Per Family	\$1,500 / Combined with In-Network	Out-of-Network / Non-Participating	60
Pre-Existing	Pre-Existing Applies	Office Visit Copay: Family Phy.	\$20
Rates:		All Other Providers	CYD + 80%
Employee	\$196.67	Employee/Spouse	\$391.81
		Employee/Child(ren)	\$352.73
		Family	\$509.05
		Other	

Health Plan Name BlueOptions PhysCoplay Plan 1550 - NSId		Rx Option (Indicate copayments) BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	\$300 / Combined with In-Network	In-Network / Participating	80%
Per Family	\$900 / Combined with In-Network	Out-of-Network / Non-Participating	60%
Pre-Existing	Pre-Existing Applies	Office Visit Copay: Family Phy.	\$15
Rates:		All Other Providers	\$30
Employee	\$217.74	Employee/Spouse	\$433.92
		Employee/Child(ren)	\$390.63
		Family	\$563.78
		Other	



EMPLOYER APPLICATION (True Group Application)

Health Plan Name BlueCare NFO LG Grp Plan 15 - Std		Rx Option (Indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person		In-Network / Participating	
Per Family		Out-of-Network / Non-Participating	
Pre-Existing	Pre-Existing Applies	Office Visit Copay: Family Phy.	\$15
Rates:		All Other Providers	\$35
Employee	\$259.41	Employee/Spouse	\$517.15
		Employee/Child(ren)	\$465.53
		Family	\$671.99
		Other	

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be:

B. **Regular Billing-** Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount
HMO: Discount

E. Rate Comments: Rates for *Retirees - Both with Medicare*



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by
BCBSF Corporate Headquarters
 Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
6/25/06	<i>George Touart</i>	George Touart, County Administrator
7/5/06	<i>Timmy Kelly</i>	Timmy Kelly, Licensed Agent (Print)
	Signature of Agent	Agent License Identification Number
	<i>Sheryl Kelly</i>	AB3

Witnesses to Applicant Signature

Witness: *Sheryl Young* Witness: *Sheryl Young*



**EMPLOYER APPLICATION
(True Group Application)**

New Business Renewal Business

Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business:

SIC Code:

Mailing Address:

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name

Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance

HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation Insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %



**BlueCross BlueShield
of Florida**
Health Options.
Member of the United Health Group

EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box(es)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan Blue Packages

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions FamPhy Plan 1351 - Std		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	\$500 / Combined with In-Network	In-Network / Participating	80
Per Family	\$1,500 / Combined with In-Network	Out-of-Network / Non-Participating	60
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	Family Phy: \$20 CYD + 80%
Rates.		All Other Providers	
Employee	\$282.51	Employee/Child(ren)	\$605.43
		Family	\$874.06
		Other	

Health Plan Name		Rx Option (indicate copayments)	
BlueOptions PhyCoplay Plan 1550 - NSId		BlueScript C Copay Plan 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	\$300 / Combined with In-Network	In-Network / Participating	80%
Per Family	\$900 / Combined with In-Network	Out-of-Network / Non-Participating	60%
Pre-Existing	Pre-Existing Applies	Office Visit Copay:	Family Phy: \$15 \$30
Rates.		All Other Providers	
Employee	\$312.84	Employee/Spouse	\$744.95
		Employee/Child(ren)	\$670.55
		Family	\$968.13
		Other	



EMPLOYER APPLICATION (True Group Application)

BlueCross BlueShield of Florida Health Options
The Group Health Plan of Florida, Inc.
1000 North West 13th Street, Suite 1000
Fort Lauderdale, FL 33311-4000

Health Plan Name BlueCare NFO LG Grp Plan 15 - Std		Rx Option (Indicate copayments) BlueCare Rx 10/25/40 C - Std	
Calendar Year Deductible:		Coinsurance:	
Per Person	<input type="text"/>	In-Network / Participating	<input type="text"/>
Per Family	<input type="text"/>	Out-of-Network / Non-Participating	<input type="text"/>
Pre-Existing	<input type="text"/> Pre-Existing Applies	Office Visit Copay: Family Phy.	<input type="text"/> \$15 <input type="text"/> \$35
Rates:		All Other Providers	<input type="text"/>
Employee	<input type="text"/> \$372.80	Employee/Spouse	<input type="text"/> \$887.99
		Employee/Child(ren)	<input type="text"/> \$799.28
		Family	<input type="text"/> \$1,154.06
		Other	<input type="text"/>

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? Yes No
(if left blank, the response is assumed to be No.)

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount
HMO: Discount

E. Rate Comments: Rates for *Active Emps / Retires <65 No Medicare*



EMPLOYER APPLICATION (True Group Application)

New Business Renewal Business

Other

Group # (BCBSF): (HMO):

I. Group Information

A. Name of Group:

Nature of Business: SIC Code:

Mailing Address:

Email Address:
List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance
HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is:

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be

Effective Date of this Change to the Policy shall be

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the after days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: % Dependents: %

III. Health Plan Summary Information (select the appropriate box(s)):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental & Nervous Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol & Drug Dependency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammograms Waiver of Deductible & Coinsurance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteral Formulas

Single Plan

Blue Packages

Health Plan Name HIP - Std	Rx Option (Indicate copayments)
Calendar Year Deductible:	Coinsurance:
Per Person	In-Network / Participating
Per Family	Out-of-Network / Non-Participating
Pre-Existing	Office Visit Copay:
Rates.	Family Phy.
Employee	All Other Providers
Employee/Spouse	Employee/Child(ren)
Employee/Child(ren)	Family
Other	Other

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? (if left blank, the response is assumed to be No.) Yes No

V. Rate Information

- A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st
- B. **Regular Billing-** Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.
- C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: Discount

HMO:

E. Rate Comments:

Rates for *Housing Auth - Hospital Indemnity Plan (HIP)*

EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.
- B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, with BCBSF's preferred bank, for the purposes of initial enrollment in and administration of HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
6/25/04	<i>George Tount</i>	George Tount, County Administrator
Date	Signature of Agent	Agent License Identification Number
7/5/04	<i>George Tount</i>	403

Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)

Witnesses to Applicant Signature

Witness: *Paul Brown* Witness: *Sheryl Young*