BlueCross BlueShield of Illinois

Group Transmittal
To be submitted with the Group Application

Wheaton Park District	F024990
Policyholder	**Group Number**

1. *Contact Information*

Diane Hirshberg	(630) 510-4951
Administrative Contact (Daily Administration)	Fax Number
(630) 510-4952	dhirshberg@wheatonparks.org
Phone Number - Administrative Contact	Email Address
Diane Hirshberg	dhirshberg@wheatonparks.org
Group Administrator (Plan changes, etc.)	Email Address
Diane Hirshberg	dhirshberg@wheatonparks.org
Billing Contact (Billing Issues)	Email Address

102 E Wesley St
Billing Address

Wheaton	IL	60187
City:	State	Zip

2. *Benefits & Eligibility - As indicated in your proposal.*

Waiting Periods Subject to the actively at work provision contained in your proposal

New Hires: 0 [X] Days [ ] Months [ ] Years

Do you have any current employees that need to fulfill the waiting period: [ ] Yes [X] No

Employees are effective*:

- [ ] 1st day of the insurance month following completion of the eligibility waiting period
- [X] The day following completion of the eligibility waiting period
- [ ] Other: _____

Does any class have a different waiting period: [ ] Yes [X] No

If YES, Please describe in Special Request Section

Does the waiting period apply to all coverages: [X] Yes [ ] No

If NO, Please describe in Special Request Section

** If medical underwriting is required, an individual's coverage will not take effect until the date the application is approved. The effective date will be delayed for an employee who is not actively at work or for a dependent whose activities are limited due to sickness or injury on the date coverage would otherwise take effect.*

Minimum Hours 30 (standard is 30 hours per week)

Annual Enrollment

- [X] Life / AD&D / Accident / Critical Illness / Disability and/or Vision — From 12/01 To 12/31 ie: (9/1 to 9/30)
- [ ] Dental — From _____ To _____ ie: (9/1 to 9/30)
- [ ] Not Applicable

Prior Credit For Rehires

Is there prior employment credit for rehired employees? [ ] Yes [X] No

If YES, credit will be given for employees rehired within **6 months**, unless otherwise approved by The Company.

Does the credit for rehires apply to all coverages: [X] Yes [ ] No

If NO, Please describe in Special Request Section

Other

Do you have any Canadian Employees that work in the United States: [ ] Yes [X] No

Do you intend to cover any US Citizens working outside of the United States: [ ] Yes [X] No

Do you intend to cover any non-US citizens who work within the United States: [ ] Yes [X] No

Basic Dependent Life Policyholder will contribute: [X] NA [ ] Other [ ] 0%; or _____

Spouse Premium If applicable, calculate spouse premium: [ ] Based on Employee Date of Birth [X] Based on Spouse Date of Birth

Definition of Earnings

- [X] As stated in the proposal
- [ ] *Other _____

**If "Other" is selected, underwriting approval is required and the proposed rates are subject to change.*

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3. *Group Administration*

Certificates Email policy documents and certificates to:

- [X] Group Administrator
- [ ] Administrative Contact
- [ ] Billing Contact
- [X] Broker marlenea@cfmins.com
- [ ] Other
- [ ] Other
- [ ] Other

Disability/Accident Coverage If the employee pays all or a portion of the premium, how is it paid: [ ] Pre-Tax [ ] Post-Tax [ ] Not Applicable

For STD Coverage: [ ] Benefits begin after sick leave, vacation, salary, PTO end [ ] Benefits begin immediately after the STD elimination period

Do all eligible employees participate in Social Security: [ ] Yes [ ] No If No, Explain

Do all eligible employees participate in Medicare: [ ] Yes [ ] No If No, Explain

Mailing Address for Sick Pay Reports:

Form 5500, Schedule A Does this group have 100 or more eligible employees: [X] Yes [ ] No

If YES, what is the benefit plan month, day, and year 01/01/2020

Information will be sent to the Group Administrator as listed in Section1 above, unless otherwise stated below.

4. *Billing*

Billing Options
for groups with:

2-149 Lives	[X] List Billed Only	(We will provide an electronic bill with each employee's cost itemized with an option to pay on-line)
150-499 Lives	[ ] List Billed	(We will provide an electronic bill with each employee's cost itemized with an option to pay on-line)
	[ ] Self Administered, Paper	(You provide to us the number of lives, volume, and premium by coverage, on a monthly basis.)
500+ Lives	[ ] Self Administered, Paper	(You provide to us the number of lives, volume, and premium by coverage, on a monthly basis.)

*Note: Dental coverage is always List Billed regardless of size.

Billing Method [X] **Monthly** [ ] **Quarterly**

Premium is payable on the first of the month unless mutually agreed upon otherwise and explained in the special requests section of this form

Billing Set Up For List Billing Only

- [X] **Alphabetically** You will receive **one bill**, with one total. Employees will be listed alphabetically.
- [ ] **By Account*** You receive **multiple bills.** Employees are separated by accounts. You can pay with multiple checks.
- [ ] **By Location*** You receive **one bill**, with subtotals and a grand total. Employees are separated by locations.

*Please indicate billing divisions on the enrollment census. Also include additional billing addresses in the special requests section of this form

[ ] **Third Party Benefits Administration**

Third Party Benefits Administration means the Policyholder chooses or contracts with a vendor to provide services which may include enrollment administration, billing and/or premium collection of the products requested in the Group Application.

If you use a third party benefits administrator, please complete a Policyholder Vendor Authorization and Change Form and submit the signed form along with the completed Group Transmittal and Group Application. Please contact your sales representative to obtain a copy of the form.

5. *Special Requests - Attach additional pages if needed.*

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6. *ERISA (SPD)*

Applicant is subject to ERISA?* ☐ Yes ☒ No

If this plan is an "employee welfare plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq., as amended("ERISA"), it is subject to certain requirements including those relating to reporting and disclosure and fiduciary responsibility. The plan must be established and maintained pursuant to a written instrument that designates a plan administrator, as defined in Section 3(16)(A) of ERISA, who has authority to control and manage the operation and administration of the plan.

You, as the plan Administrator or authorized representative, have selected us as the claims administrator of your plan, and you consent to the delegation of such authority to us. You acknowledge that, in some instances, we may delegate some or all of this authority to a third party administrator serving as the claims administrator and you consent to the delegation of such authority to a third party administrator.

We cannot be named as the plan administrator and is not responsible for the compliance of your plan with respect to any legal or tax matters, and it cannot offer any legal or tax advice. You are responsible for compliance with all applicable laws, including benefits, employment, and tax laws, relating to the sponsorship and administration of your plan. Our obligations to you are governed solely by the terms of the applicable policy provisions, except as otherwise required by law.

ERISA requires the distribution of SPD's for the majority of employee benefit plans. If as plan administrator of your employee benefit plan, you would like us to provide you with the required documents to create your plan's SPD, including certain additional documents such as a Statement of ERISA Rights and Claims Procedure, please indicate "Yes" and provide the following information:

☐ Yes ☐ No If Yes, provide the following: Plan Year Ends Annually On (Month/Day)** _____

Plan Number assigned to each line of coverage: (will be 3 digits starting with "5")**

Life/AD&D _____ STD _____ LTD _____ Dental _____ AD&D _____ Vision _____

Vol STD _____ Vol LTD _____ Vol Dental _____ Vol Life _____ Accident _____

Critical Illness _____ Vol Vision _____ Vol AD&D _____ Vol Accident _____ Vol Critical Illness _____

Plan Administrator**Required Fields (Address cannot be a P.O Box)

☐ Same as Policyholder ☐ Other, complete below

Name/Title _____ Phone _____

Address _____ City _____ State _____ Zip _____

Agent for Service of Process if different from plan administrator** (Address cannot be a P.O. Box)

Name/Title _____ Phone _____

Address _____ City _____ State _____ Zip _____

Plan Trustees (if applicable)** (Address cannot be a P.O. Box)

Name/Title _____ Phone _____

Address _____ City _____ State _____ Zip _____

Union Contracts/Collective Bargaining Agreements (if applicable) _____

**If you are not certain whether your plan is governed by ERISA, please visit the Department of Labor website for more information at: http://www.dol.gov/dol/topic/health-plans/erisa.htm*

***Required Fields*

7. *Broker Authorization for Group Changes*

☒ I authorize the Broker of Record, including any subsequently named Broker of Record, to submit policy change requests on our behalf for the policy contracts identified under the Group Policy Number above. I also agree that the policy change requests will not become effective until approved. It is also agreed to implement or revoke this consent, the Policyholder must submit a request in writing to Blue Cross and Blue Shield of Illinois, Attn: Policy Administration, 701 East 22nd Street, Lombard, IL 60148. This consent will not become effective until received by us and shall remain in effect until we receives revocation of the authorization in accord with the above.

8. *Signature - This section must be signed.*

DocuSigned by:
Michael J. Benard
10DAD236DBDE4E4...
Group Administrator's Signature (or other employee authorized to make plan changes)

11/13/2019
Date

Michael J. Benard
Typed or Printed Name

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Additional Special Requests