



ALABAMA PHARMACY
ASSOCIATION
EST. 1988

Applicant:

Please find enclosed the following forms that you requested for enrollment in the APA Group Insurance Program. It is important that the application is complete when it is received. A completed application will include all of the items listed below.

The following is provided for your use as a **CHECKLIST** to ensure that your insurance application is complete when received and ready to be processed:

- 1. Blue Cross/Blue Shield Application for Enrollment (Mail to APA)**
- 2. Avesis Vision Application**
- 3. Automatic Bank Draft Authorization: Required for payment of insurance premiums. (Only owner needs to complete if signing up for new division)**

Your completed insurance application will be processed when received. **It is extremely important that you double check and be certain that you have included all of the items above, and that all applications and forms are filled out completely, signed and dated.**

Submitting incomplete applications may delay your insurance coverage. Take an extra minute and look back over your applications before mailing them.

Dental and Health Care Plan Books will be mailed at your request. These books explain the plan, what is covered and co-pays associated with the plan. If you wish to receive this information please request this when your application is mailed to APA.

If you should have any questions, please do not hesitate to call.

Sincerely,
Inga Hunter
Director of Membership Benefits

Rates:
Single without Life - \$310.00 per month
Single with Life - \$315.70 per month
Family without Life - \$723.00 per month
Family with Life - \$728.70 per month
Life Only - \$5.70 per month

APA Group Insurance Program Verification of Employment and Eligibility

The criterion for eligibility in this group insurance program is very specific. It is extremely important that both the **employer**, and the **employee**, understand their responsibility in adhering to the eligibility requirements, as well as the liability each incurs if individuals are insured that are **NOT** full-time employees, or are **NOT** a legal spouse or dependent of the applicant.

CRITERIA FOR INSURANCE PROGRAM:

1. Pharmacists licensed in Alabama, who are members of APA and keep their license and membership dues current are eligible to participate. (If you are a pharmacist you must be a member of APA to participate even if the pharmacist you are working for is a member) *Note: To be eligible for life insurance you must work at least 20 hours per week.*
2. Alabama Pharmacist who move out of state lose their eligibility to participate in this group program. This eligibility would be re-instated upon moving back to Alabama.
3. Full-time employees of a participating pharmacist are eligible to participate when they have completed 30 days of full-time employment.
4. The spouse of a pharmacist who has converted to C-Plus, or who is deceased is eligible to participate in the health insurance, but is **NOT** eligible for life insurance.
5. Family Coverage can only include your spouse, legal dependents until they are 19 years, or if they are a full-time student, until they are age 25 years.

The pharmacist (employer) is responsible for all insurance applications submitted from their pharmacy. If it is determined that an individual on your insurance billing does NOT work full-time at YOUR store, their coverage will be canceled immediately, and any claims that have been paid for them will have to be repaid to Blue Cross/Blue Shield.

By signing this verification of employment and eligibility, the applicant (employee) and the pharmacist (employer) acknowledges that they have read the criteria, understand their responsibility and liability, and confirm applicants employment and eligibility to participate in the Group Insurance Program.

Employees Signature

Date Signed

Employers Signature

Date Signed

APA Health Insurance Program
Insurance Information Request

This form must be completed and returned with your health and life insurance applications. Your insurance applications will not be processed without this completed and signed form. **Please print all information.**

APPLICANTS NAME: _____

APPLICANTS HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: Work _____ Home _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

DATE OF BIRTH: ____/____/____ COVERAGE: FAMILY ____ SINGLE ____

POSITION (JOB TITLE) : _____

PHARMACY NAME: _____

PHARMACY OWNER: _____ YES _____ NO

PHARMACY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE EMPLOYED: ____/____/____ FULL-TIME?: ____ YES ____ NO

IMPORTANT: *For family coverage please complete the Spouse and Dependent information below. Please note married children (of ANY age) cannot be included in your family coverage. Children 19 years of age, who are **NOT** full-time students, cannot be included as a dependent. Effective 9/1/91, children who are full-time students are eligible for dependent coverage until they reach 25 years of age.*

SPOUSE: _____ Date of Birth ____/____/____

DEPENDENT: _____ Date of Birth ____/____/____

DEPENDENT: _____ Date of Birth ____/____/____

DEPENDENT: _____ Date of Birth ____/____/____

DEPENDENT: _____ Date of Birth ____/____/____

DEPENDENT: _____ Date of Birth ____/____/____

Complete and return with Verification of Employment & Eligibility form to APA with your completed insurance application.

APPLICATION FOR ENROLLMENT

For Groups with 51 or more
Employees and Binding Arbitration

The person completing this application should keep the white copy and carefully read the information on the reverse side regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Women's Health and Cancer Rights Act of 1998.



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.



PLEASE PRINT: (USE BLACK BALL POINT PEN – PRESS FIRMLY)

EMPLOYEE NAME (LAST)			(FIRST)	(MI)	EMPLOYEE'S DATE OF BIRTH			
STREET ADDRESS			CITY	ST	ZIP			
EMPLOYEE'S SOCIAL SECURITY NO.	FILL IN ONE: <input type="radio"/> MALE <input type="radio"/> FEMALE	FILL IN ONE: <input type="radio"/> SINGLE <input type="radio"/> DIVORCED <input type="radio"/> MARRIED <input type="radio"/> WIDOWED		FILL IN ONE: <input type="radio"/> DR. <input type="radio"/> MS. <input type="radio"/> MISS <input type="radio"/> MR. <input type="radio"/> MRS.		GROUP NO.		DIV NO.
TYPE OF MEDICAL COVERAGE SELECTED <input type="radio"/> INDIVIDUAL <input type="radio"/> FAMILY		TYPE OF DENTAL COVERAGE SELECTED (if available) <input type="radio"/> INDIVIDUAL <input type="radio"/> FAMILY		EMPLOYEE NO.		PHONE NUMBER		

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.

LAST NAME	FIRST NAME	MI	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH				
					MM	DD	YYYY		
1.			<input type="radio"/> Husband <input type="radio"/> Wife						
2.			<input type="radio"/> Son <input type="radio"/> Daughter						
3.			<input type="radio"/> Son <input type="radio"/> Daughter						
4.			<input type="radio"/> Son <input type="radio"/> Daughter						
5.			<input type="radio"/> Son <input type="radio"/> Daughter						
6.			<input type="radio"/> Son <input type="radio"/> Daughter						

STUDENT EXTENSION CERTIFICATION – List any dependent child applying for student extension

NAME OF CHILD _____ NAME OF SCHOOL _____

NAME OF CHILD _____ NAME OF SCHOOL _____

NATURE OF APPLICATION

<input type="radio"/> NEW CONTRACT APPLICATION	<input type="radio"/> CANCEL CONTRACT <input type="radio"/> Medical Coverage <input type="radio"/> Dental Coverage <input type="radio"/> Medical and Dental Coverage	<input type="radio"/> CHANGE CONTRACT <input type="radio"/> Name Change <input type="radio"/> Address Change <input type="radio"/> Type of Coverage Change <input type="radio"/> Change COB Information	<input type="radio"/> ADD DEPENDENT <input type="radio"/> Add Spouse <input type="radio"/> Add Dependent Child	<input type="radio"/> REMOVE DEPENDENT <input type="radio"/> Marriage of Child under 19 <input type="radio"/> Entered Military Service <input type="radio"/> Divorce <input type="radio"/> Death <input type="radio"/> Remove Spouse
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DATE EVENT OCCURRED: (Example: Date of marriage, birthdate of child, etc.)

COORDINATION OF BENEFITS INFORMATION – If you, your spouse, or your dependents are covered by any other group health insurance, please complete the following information:

NAME OF CONTRACT HOLDER _____

EFFECTIVE DATE OF COVERAGE	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE COVERAGE <input type="radio"/> INDIVIDUAL <input type="radio"/> FAMILY	NAME OF INSURANCE COMPANY
EMPLOYER'S NAME	CITY	GROUP NUMBER	STREET ADDRESS
NAME OF MEMBER ENTITLED TO MEDICARE BENEFITS <input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> Part D	MEDICARE NUMBER	CITY, STATE, ZIP	

REASON FOR MEDICARE Age 65 or Older Disability End Stage Renal Disease

CURRENT BLUE CROSS COVERAGE – If you or your spouse are currently covered by a Blue Cross and Blue Shield contract and wish to transfer to this group, please complete below:

CURRENT BLUE CROSS AND BLUE SHIELD CONTRACT NUMBER _____

CITY AND STATE OF BLUE CROSS PLAN ENROLLED _____

**PLEASE READ THE FOLLOWING CAREFULLY;
IT AFFECTS YOUR LEGAL RIGHTS**

- I waive my rights to benefits and do not wish to enroll.
- I am requesting cancellation of my existing benefits as checked on page 1.

I apply for the Group Health Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you direct and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is to return any fees I paid. You may pay providers directly for services to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important notice printed on the cover of this application.

I understand that if I did not enroll within 30 days of my initial eligibility or as a special enrollee, I am a late enrollee and will be required to serve an 18 month waiting period (unless otherwise stated by your plan) for pre-existing conditions.

THE GROUP PLAN UNDER WHICH YOU ARE APPLYING FOR COVERAGE INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT OTHER THAN A CLAIM FOR BENEFITS UNDER SECTION 502(a) OF ERISA WILL BE SETTLED BY ARBITRATION – NOT A COURT. THE ARBITRATOR’S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN’T BE REVIEWED BY A COURT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE – AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE GROUP PLAN.

PRINT NAME	SOCIAL SECURITY NUMBER
SIGNATURE OF EMPLOYEE	DATE SIGNED
SIGNATURE AND TITLE OF EMPLOYER REPRESENTATIVE (Employer's Verification of Applicant's Employment)	DATE SIGNED
EMPLOYEEER'S NAME AND ADDRESS	DATE EMPLOYED () EMPLOYER PHONE NUMBER

IMPORTANT DISCLOSURE NOTICE

Notice of Group Health Plan Special Enrollment Rights

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

Notice of Group Health Plan Pre-existing Conditions Exclusion

This group health plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before enrolling in this plan, you might have to wait a certain period of time before this plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six month period. Generally, this six month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this pre-existing condition exclusion period by the number of days of your prior "creditable coverage" so long as you have not had a break in coverage of at least 63 days. Most prior health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, U.S. Military, TRICARE, State Children's Health Insurance Program (SCHIP), Federal Employee Program, Peace Corps Service, a state high-risk pool, or a public health plan established or maintained by a State, U.S. Government, foreign country or any political subdivision of a State, U.S. Government or foreign country. You may request a certificate of creditable coverage from a prior plan or issuer. There are also other ways that you can show you have creditable coverage.

To reduce the 12 month (or 18 month) exclusion period by your creditable coverage, you should attach a copy of any certificates of creditable coverage or other documentation you have to this enrollment application. If you do not have a certificate of creditable coverage, but you do have prior health coverage, Blue Cross and Blue Shield of Alabama will help you obtain one from your prior plan or issuer, if necessary.

All questions about pre-existing condition exclusions and creditable coverage should be directed to your employer at the telephone number and address listed for your employer in this enrollment application.

Even if you have no pre-existing conditions, benefits may not be available under other provisions of the plan. For example, the services may be excluded or may require preapproval. Be sure to read your Summary Plan Description for details.

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.



Alabama Pharmacy Association
 1211 Carmichael Way
 Montgomery, Alabama 36106

(334) 271-4222

Fax: (334) 271-5423

Avesis

INCORPORATED

ADVANTAGE VISION

UNDERWRITTEN BY FIDELITY SECURITY LIFE INSURANCE COMPANY
 GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT FORM

(PLEASE PRINT LEGIBLY)

CHANGE		ADD		TERM		Effective Date:
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Group Number _____ Plan Number _____ Division _____

Employer Group Name _____

Date of Employment _____ Plan Effective Date _____

Employee Name _____
Last First MI

Address _____ City _____ ST _____ Zip _____

Date of Birth ____/____/____ SSN _____ - _____ - _____ Male _____ Female _____

Do you wish to cover your eligible Dependents? Yes _____ No _____

If yes, please complete the following:

Names	Last	First	MI	Date of Birth
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

I hereby apply for coverage under AVESIS, TPA for which I am now entitled or may become entitled under the provisions of the plan. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I agree that once enrolled I will remain enrolled during the designated plan period.

(Signature) _____ (Date) _____

Avesis INCORPORATED	Advantage Plus Vision Care Monthly <u>Stand-Alone Voluntary</u> Vision Care Rates
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ADVANTAGE PLUS BENEFIT FREQUENCY AND PLAN DESIGN

PLAN B	EXAMINATION	SPECTACLE LENSES	FRAME	CONTACT LENSES
	12 MONTHS	12 MONTHS	24 MONTHS	12 MONTHS

ADVANTAGE PLUS SCHEDULE OF BENEFITS

	IN-NETWORK	OUT-OF-NETWORK
Eye Examination	Covered in full*	Reimbursed up to \$35.00
Spectacle Lenses (pair) - <i>Standard Single Vision</i> - <i>Standard Bifocal</i> - <i>Standard Trifocal</i> - <i>Standard Lenticular</i> - <i>Progressive Lenses</i>	Covered in full* Covered in full* Covered in full* Covered in full* 20% off the UCR, less \$50 plan allowance	Reimbursed up to \$25.00 Reimbursed up to \$40.00 Reimbursed up to \$50.00 Reimbursed up to \$80.00 Reimbursed up to \$40.00
Specialty Lenses (pair)	20% off U&C, minus the corresponding standard lens plan payment*	Corresponding standard lens reimbursement
Lens Options	Preferred Pricing (20% off retail)	Reimbursed up to \$0.00
Frame	\$50.00 wholesale allowance (approx. retail of \$100.00 to \$150.00)*	Reimbursed up to \$45.00
Contact Lenses - <i>Elective</i> - <i>Medically Necessary</i>	<i>(In lieu of frame and spectacle lenses)</i> \$130 allowance* After an Avesis preferred discount Covered in full*	Reimbursed up to \$130.00

ADVANTAGE PLUS MONTHLY VOLUNTARY RATES

PLAN B (12/12/24/12)	\$10/\$20 CO-PAY
Employee Only	\$12.00
Employee + One	\$18.00
Employee + Family	\$25.00

- *A \$10/\$20 co-pay includes a \$10 co-pay for the exam and a \$20 co-pay for materials (spectacle lenses & frame).
 - Co-pays do not apply for Contacts & out-of-network reimbursement.
 - Policies and rates are guaranteed for two (2) years.
 - Minimum group size and participation of ten (10) eligible employees.
 - Employees enrolling in the group voluntary plan must agree to remain enrolled during designated plan period.
 - Employees who elect not to enroll during the initial plan enrollment period must wait until the next plan enrollment period to enroll.
 - Funding may be stand-alone, 100% Voluntary by the Employee
- Insured vision care is underwritten by Fidelity Security Life Insurance Company, a rated A-(Excellent) company based on an analysis of financial position and operating performance by A.M. Best Company – an independent analyst of the insurance industry.*