

**BETTER BUSINESS BUREAU OF KANSAS, INC.**  
**POS CDHP PLAN SA2000**  
**Option 1**  
**SUMMARY OF BENEFITS**

**Benefit Period: Benefits accumulate from January 1 to December 31**

Employees and all covered Dependents covered under a POS benefit Plan must select a Primary Care Physician (PCP). When You or Your Dependents are in need of Health Care Services, to receive the PCP Option benefit level, services must be provided or referred in advance by Your PCP. Services which are not provided or referred by Your PCP are covered at the Self-Referral Option benefit level. **If the Physician or Provider does not contract with the Plan to accept Our Allowed Amounts, You will be responsible for the difference between billed charges and Allowed Amounts in addition to the applicable Deductible and Coinsurance, which could be substantial. For Non-Covered Services or services that exceed a benefit maximum, You will be responsible for the entire billed charges of a Provider.**

BENEFIT CATEGORY	MEMBER RESPONSIBILITY	
	PCP OPTION	SELF-REFERRAL OPTION
<b>PHYSICIAN OFFICE VISIT</b> PCP office visit Specialist office visit  <i>OB/GYN services do not require a Referral Authorization.</i>	\$20 Copayment \$40 Copayment after the Deductible	Deductible + Coinsurance Deductible + Coinsurance
<b>DEDUCTIBLE</b> (per Benefit Period) Includes medical and prescription benefits  Individual Family (at least three (3) family members must contribute toward the family Deductible)  The Deductibles for PCP Option and Self-Referral Option services accumulate separately. <b>All services are subject to Deductible unless otherwise indicated.</b> The following do not count toward meeting the Deductible: Copayments; penalties; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts.	\$2,000 \$6,000	\$4,000 \$12,000
<b>COINSURANCE</b> (The portion of the Allowed Amount You pay <b>after the Deductible has been met</b> )	0%	30%
<b>COINSURANCE MAXIMUM</b> Individual Family (at least three (3) family members must contribute toward the family Coinsurance Maximum)  After the Coinsurance Maximum has been reached, benefits will increase to 100% of the Allowed Amounts for the remainder of the Benefit Period. You will still be responsible for the difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts. The following do not count towards meeting the Coinsurance Maximum: Copayments; Deductibles; penalty for failure to prior authorize inpatient services; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Participating Provider and Allowed Amounts.	\$0 \$0	\$7,000 \$21,000
<b>ANNUAL MAXIMUM ON ESSENTIAL BENEFITS</b> This annual maximum applies only to Essential Health Benefits as defined by Section 1302(b) of the Patient Protection and Affordable Care Act. Essential Health Benefits include the following benefit categories: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). If the Annual Maximum on Essential Benefits is exhausted, there will be no Coverage until the beginning of the following Benefit Period.	\$2,000,000	
<b>PREVENTIVE CARE SERVICES</b> Includes services such as immunizations (covered at 100% for Dependents up to 72 months of age), well-woman exam, mammograms, well-man exam, PSA test, and osteoporosis screenings. For a complete list, please visit Our website.	\$0	Deductible + Coinsurance unless otherwise noted
<b>OUTPATIENT LAB</b>	\$0	Deductible + Coinsurance
<b>OUTPATIENT X-RAY AND DIAGNOSTIC TESTING</b>	Deductible	Deductible + Coinsurance
<b>MRI, CT SCANS, AND PET SCANS</b>	Deductible	Deductible + Coinsurance
<b>INPATIENT BENEFITS</b> ( <i>Semi-Private Room, ICU, SNU, Hospice</i> ) \$1,000 penalty for use of non-Participating Hospital within the Service Area. \$1,000 penalty per non-emergency admission if services are not prior authorized.	\$250 Copayment per admission after the Deductible	Deductible + Coinsurance

<p><b>MATERNITY BENEFIT</b> Prenatal and Postpartum Office Visits</p> <p>Inpatient services For other services, such as lab and x-ray, refer to the Outpatient Lab and Outpatient X-Ray and Diagnostic Testing sections. <i>In order to receive the PCP Option level of benefits, services must be rendered by Your PCP or Participating OB/GYN (no referral required).</i></p>	<p>\$20 Copayment for initial visit only Subject to Inpatient Benefits</p>	<p>Deductible + Coinsurance Deductible + Coinsurance</p>
<p><b>OUTPATIENT SURGERY</b></p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>ALLERGY TREATMENT</b></p>	<p>\$0</p>	<p>Deductible + Coinsurance</p>
<p><b>DEPENDENT OUT OF AREA CARE</b> For Dependents who live outside the Service Area, Coverage will be provided at the PCP Option level of benefits for all Medically Necessary Covered Services when received from Participating Providers. Services rendered by Non-Participating Providers will be covered at the Self-Referral Option level of benefits. Dependents wishing to utilize this benefit must notify the Plan at 1-800-660-8114 that they are living outside the Service Area.</p>	<p>Subject to applicable benefits</p>	<p>Deductible + Coinsurance</p>
<p><b>INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE</b> <i>Services must be prior authorized by the Plan</i> \$1,000 penalty per non-emergency admission if services are not prior authorized.</p>	<p>Subject to Inpatient Benefits</p>	<p>Deductible + Coinsurance</p>
<p><b>OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE</b> <i>Some services must be prior authorized by the Plan</i> This benefit includes intensive outpatient programs, partial day hospitalization, and psychological testing. <i>You may self-refer to Participating Providers and receive services at the PCP Option level of benefits.</i></p>	<p>\$20 Copayment</p>	<p>Deductible + Coinsurance</p>
<p><b>EMERGENCY SERVICES</b> <b><i>There is no coverage for non-Emergency Medical Conditions treated in a Hospital emergency room.</i></b> Urgent Care Facility</p> <p>Emergency Room <i>If admitted, emergency room Copayment will be waived and inpatient benefits will apply.</i> If You receive Emergency Services from a non-Participating Hospital within the Service Area under circumstances where You have the ability to determine when and where to seek such services, You will be responsible for the difference between the Provider's billed charges and Allowed Amounts. In situations where You require Emergency Services and have no control when or where such services are rendered, such services will be covered at the PCP Option level and You will not be responsible for the difference between the Provider's billed charges and Allowed Amounts.</p>	<p>\$40 Copayment after the Deductible Deductible + \$150 Copayment</p>	<p>\$40 Copayment after the Deductible PCP Option Deductible + \$150 Copayment</p>
<p><b>AMBULANCE</b></p>	<p>Deductible + \$100 Copayment</p>	<p>PCP Option Deductible + \$100 Copayment</p>
<p><b>DURABLE MEDICAL EQUIPMENT</b></p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>DISPOSABLE MEDICAL SUPPLIES</b></p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>DIABETIC EQUIPMENT AND SUPPLIES</b> <i>To receive the PCP Option level of benefits, purchases must be from Participating Providers and referred by Your PCP.</i></p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>HOME HEALTH CARE</b></p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>THERAPEUTIC INJECTIONS AND IV INFUSIONS</b></p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>OUTPATIENT HOSPICE SERVICES</b></p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>INPATIENT REHABILITATION</b> (<i>Speech, Physical, Occupational</i>)</p>	<p>Subject to Inpatient Benefits</p>	<p>Deductible + Coinsurance</p>
<p><b>OUTPATIENT REHABILITATION</b> (<i>Speech, Physical, Occupational, Cardiac, Pulmonary, and Spinal Manipulations</i>) PCP office visit Specialist office visit</p> <p>Coverage is provided following injuries, surgeries, or acute medical conditions.</p>	<p>\$20 Copayment \$40 Copayment after the Deductible</p>	<p>Deductible + Coinsurance Deductible + Coinsurance</p>
<p><b>ORTHOTICS AND PROSTHETICS</b> Coverage is limited to the original device unless repair and/or replacement is Medically Necessary.</p>	<p>Deductible</p>	<p>Deductible + Coinsurance</p>
<p><b>DENTAL/ORAL SURGERY SERVICES</b> PCP office visit Specialist office visit</p> <p>Inpatient services Services for accidental injury to sound natural teeth will be covered up to a <b>maximum of \$1,000 of Allowed Amounts</b>, if provided within twelve (12) months from the date of injury. This benefit maximum does not apply to individuals under 18 years of age.</p>	<p>\$20 Copayment \$40 Copayment after the Deductible Subject to Inpatient Benefits</p>	<p>Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance</p>

<p><b>TRANSPLANT SERVICES</b>  PCP office visit  Specialist office visit</p> <p>Inpatient services  Limited to two (2) procedures for the same condition per lifetime</p>	<p>\$20 Copayment  \$40 Copayment after the Deductible  Subject to Inpatient Benefits</p>	<p>Deductible + Coinsurance  Deductible + Coinsurance  Deductible + Coinsurance</p>
<p><b>ANNUAL ROUTINE VISION EXAM</b>  Limited to one (1) exam and refraction per Benefit Period.</p>	<p>\$0</p>	<p>Deductible + Coinsurance</p>
<p><b>PRESCRIPTION DRUGS</b>  Certain medications require Prior Authorization  The Copayments under this section will apply to Covered Prescriptions dispensed at a Participating Mail Order or Retail Pharmacy who agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any Participating Mail Order Pharmacy.</p> <p>Retail Pharmacy: A 34-day supply, as specified by the quantity sufficient for a standard course of therapeutic treatment as defined by the Plan.</p> <p>Mail Order Pharmacy: A 90-day supply, as specified by the quantity sufficient for a standard course of therapeutic treatment as defined by the Plan.</p> <p>Oral Anti-Cancer Medications if these have an equivalent intravenous or injectable.</p> <p><i>Please refer to the Prescription Drug Rider for complete plan provisions and limitations.</i></p>	<p><b>34-day Supply:</b>  Tier 1A Formulary - \$3 Copayment  Tier 1B Formulary - \$15 Copayment  Tier 2 Formulary - \$30 Copayment after the Deductible  Tier 3 Non-Formulary - \$55 Copayment after the Deductible</p> <p><b>90-day Supply:</b>  Tier 1A Formulary - \$7.50 Copayment  Tier 1B Formulary - \$37.50 Copayment  Tier 2 Formulary - \$75 Copayment after the Deductible  Tier 3 Non-Formulary - \$137.50 Copayment after the Deductible</p> <p>\$0</p>	<p><b>34-day Supply:</b>  Tier 1A Formulary - \$3 Copayment  Tier 1B Formulary - \$15 Copayment  Tier 2 Formulary - \$30 Copayment after the Deductible  Tier 3 Non-Formulary - \$55 Copayment after the Deductible</p> <p><b>90-day Supply:</b>  Tier 1A Formulary - \$7.50 Copayment  Tier 1B Formulary - \$37.50 Copayment  Tier 2 Formulary - \$75 Copayment after the Deductible  Tier 3 Non-Formulary - \$137.50 Copayment after the Deductible</p> <p>\$0</p>

**The following rules apply for this plan:**

**Self-Referral Option:** If You elect to self-refer to a Participating Provider rather than obtain a referral from Your PCP, eligible payments You make will only accrue toward the Self-Referral Option Deductibles and Out-of-Pocket Maximums.

**Some services require Prior Authorization.** Prior Authorization is the process of the Plan determining whether the Health Care Service is a Covered Service, Medically Necessary, and being rendered by Participating Providers. Coverage is subject to eligibility and benefits remaining at the time services are rendered. The Prior Authorization List is subject to change. An up-to-date Prior Authorization List can be found at [www.phsystems.com](http://www.phsystems.com) or by calling the Customer Services department at 316-609-2390 or 1-800-660-8114 (outside Wichita).

**Referral Process:** In order to receive the PCP Option level of benefits, You are responsible for obtaining a Referral Authorization from Your PCP for all Health Care Services rendered outside his/her office except Emergency Services, obstetrical and gynecological care (from a Participating OB/GYN), and annual diabetic retinal eye exam. Participating Providers must be utilized except for Emergency Services when You do not have control over where such services are rendered. Mental health and substance abuse services do not require a PCP Referral Authorization; however, some services must be prior authorized by the Plan.

**Basic Exclusions**

Services of Non-Participating Providers. \*Services not medically necessary. \*Cosmetic treatment/surgery. \*Surgical treatment of obesity, medical services in conjunction with prescription weight loss therapy, and weight loss programs unless approved by the Plan. \*Experimental and investigational treatment. \*Services for injuries or diseases related to employment and covered or required to be covered under a Workers Compensation program. \*Services resulting from injuries related to the use of a motor vehicle which are covered or required to be covered under automobile insurance. \*Duplication of benefits provided by Federal, State or local law. \*Items not strictly to treat a medical condition.\*Services or items for the convenience of the individual or Provider. \*Services or supplies related to an excluded service and subsequent complications.

**This is a brief summary of the coverage available under this plan. It is not a legal document. The complete plan provisions, limitations, and exclusions are contained in the Certificate You will receive when You enroll.**

**We retain the right to adjust benefits as necessary to comply with changes in any federal or state law, statute or regulation, including but not limited to the federal Patient Protection and Affordable Care Act, as amended.**

# BETTER BUSINESS BUREAU

## ENROLLMENT INFORMATION

The monthly premium rates for Better Business Bureau Member businesses with 1-50 employees (including working owners and self employed) are as follows:

Effective January 1, 2012 – December 31, 2012

### *PHS Age Band Rates – Monthly Premium Schedule Point of Service (POS) SA2000 Medical Plan*

<i>POS Medical/RX</i>						
<b>Age</b>	<b>Male Single</b>	<b>Female Single</b>	<b>ES</b>	<b>Male EC</b>	<b>Female EC</b>	<b>Family</b>
<b>&lt;25</b>	<b>\$124.72</b>	<b>\$270.34</b>	<b>\$395.06</b>	<b>\$346.29</b>	<b>\$491.91</b>	<b>\$663.31</b>
<b>25-29</b>	<b>\$119.15</b>	<b>\$394.36</b>	<b>\$513.51</b>	<b>\$376.25</b>	<b>\$651.47</b>	<b>\$827.75</b>
<b>30-34</b>	<b>\$153.29</b>	<b>\$366.49</b>	<b>\$519.78</b>	<b>\$475.88</b>	<b>\$689.09</b>	<b>\$913.45</b>
<b>35-39</b>	<b>\$186.73</b>	<b>\$330.96</b>	<b>\$517.69</b>	<b>\$545.56</b>	<b>\$689.79</b>	<b>\$964.31</b>
<b>40-44</b>	<b>\$225.05</b>	<b>\$348.38</b>	<b>\$573.43</b>	<b>\$574.82</b>	<b>\$698.15</b>	<b>\$1,012.39</b>
<b>45-49</b>	<b>\$286.37</b>	<b>\$388.09</b>	<b>\$674.46</b>	<b>\$631.26</b>	<b>\$732.99</b>	<b>\$1,084.15</b>
<b>50-54</b>	<b>\$463.34</b>	<b>\$420.84</b>	<b>\$884.18</b>	<b>\$762.95</b>	<b>\$720.45</b>	<b>\$1,221.41</b>
<b>55-59</b>	<b>\$532.32</b>	<b>\$522.57</b>	<b>\$1,054.89</b>	<b>\$799.88</b>	<b>\$790.12</b>	<b>\$1,346.83</b>
<b>60-64</b>	<b>\$663.31</b>	<b>\$643.11</b>	<b>\$1,306.42</b>	<b>\$898.12</b>	<b>\$877.91</b>	<b>\$1,550.28</b>
<b>65+</b>	<b>\$810.33</b>	<b>\$726.72</b>	<b>\$1,537.04</b>	<b>\$1,018.66</b>	<b>\$935.05</b>	<b>\$1,746.07</b>

### EXCLUSIONS

1. Any services which are not Medically Necessary.
2. Experimental, Investigational, unproven or obsolete treatments, procedures or devices and related services, unless otherwise described in this Certificate.
3. Transplants, except as described in this Certificate.
4. Cosmetic treatment or surgical procedures primarily to restore or alter appearance unless specified in the Reconstructive Treatment/Surgery benefit section of this Certificate.
5. Vitamins, minerals, nutritional supplements, or special diet foods whether or not required by a Physician.
6. Costs associated with commercial pain management programs.
7. Cosmetic, health, and beauty aids.
8. Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning.
9. Evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody, or child visitation proceedings and any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto.
12. Treatment of teeth or structures directly supporting the teeth including, but not limited to: extraction of teeth (including bony impacted wisdom teeth), routine cleaning, dental examination, x-rays, and repairs, fillings, scaling, scraping and/or root planing, dentures, bridges, dental implants, casts, splints, straightening of teeth, services for dental malocclusion, maxillofacial orthognathic and prognathic treatment/surgery, orthodontics, periodontics, or hospitalizations for non-covered services, except as specified in the Oral Surgery and Other Related Services and the Transplant sections of this Certificate.
13. Services or supplies related to intersex surgeries.
14. Non-medical ancillary services including, but not limited to: legal services, social rehabilitation, vocational rehabilitation, work reintegration training, work hardening or conditioning, behavioral training, sleep therapy, employment counseling; educational testing, training, or therapy, unless approved by PHS as part of treatment for traumatic head injury or stroke, or as specified in the Diabetic Services and Maternity Care sections.

15. Items of wearing apparel, except as described under the Compression Stockings, Prosthetic Devices, Orthotic Devices or Reconstructive Treatment/Surgery sections of this Certificate.
16. All charges for or related to autopsies, except when requested by PHS.
17. All charges related to complementary/alternative medicine including, but not limited to: sensory integrative techniques, music therapy, guided imagery, therapeutic touch, aroma therapy, acupressure, hydro-massage, Vax-D therapy, reflexology, cranio-sacral therapy, acupuncture and therapy for the development of cognitive skills to improve attention, memory or problem solving, including compensatory training.
18. All prescription drugs, non-prescription drugs, and Investigational and Experimental drugs, except as described as covered in this Certificate.
19. Routine foot care including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity.
20. Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
21. Care for health conditions required by state or local law to be treated in a public facility.
22. Services for injuries or diseases related to your employment to the extent you are covered or are required to be covered by the workers' compensation law. If the Member enters into a settlement giving up rights to recover past or future medical benefits under workers' compensation law, PHS will not pay past or future medical benefits that are the subject of or related to that settlement. In addition, if the Member is covered by a workers' compensation program, which limits benefits other than specified by the program, PPK will not pay balances of charges from such non-specified Providers.
23. Benefits of this Certificate will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, CHAMPUS, Tricare and services in any veteran's facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not you choose to waive your rights to these services.
24. Services resulting from war or an act of war.
25. Whole blood, and blood plasma or payments to donors for blood or payment to a blood collection site.
26. Transportation, food, and lodging unless otherwise described in this Certificate.
27. The costs of health services resulting from accidental bodily injuries arising out of the ownership, operation, maintenance, or use of a motor vehicle to the extent such services are required to be covered by motor vehicle financial responsibility laws, regulations, or programs, or are payable under any medical expense payment provisions (by whatever terminology used-including such benefits mandated by law) of any automobile insurance policy.
28. Services performed by the Member or their parent, spouse, sibling, or child.
29. Injuries incurred while the Member is in the commission or attempted commission of a felony.
30. Services or items for the convenience of the Member or Provider including, but not limited to, home laboratory testing and duplication of covered durable medical equipment.
31. Services when the Member is not present including, but not limited to, case management team conferences, telephone calls, electronic communication, telemedicine, and consultations with family members.
32. Any service(s) rendered where the Member(s) receives monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).
33. Any service(s) rendered and/or billed by a Provider through misrepresentation of material fact or fraud.
34. Items not strictly for the purposes of treating a medical condition including, but not limited to: over the counter batteries, massagers, air/water purifiers, air conditioners, pillows, mattresses, communication devices/aids, whirlpools, bedwetting alarms, prenatal cradles, breast pumps, car seats, strollers, shower chairs, commodes, thermal therapy devices, or modifications to the Member's home or vehicle.
35. Any portion of a Claim that PHS determines to be incorrectly or inappropriately billed by a Physician, Health Professional, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.
36. Services related to the treatment of temporomandibular joint disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS).
37. Costs associated with smoking cessation programs.
38. Medical and hospital care and costs for the infant child of a Dependent.
39. Elective abortions.
40. Cost associated with the replacement of items that are damaged, lost or stolen
41. Any service or supply that is provided or obtained relative to an excluded service and subsequent complications, which may occur. "Provided relative to" would be a service of supply that would not have been required if the excluded service had not been obtained by the Member. This includes any inpatient or outpatient service by any Provider whether service is rendered face-to-face or without patient presence.

## HMO/POS Plans Enrollment Form *Please type or print.*

**IMPORTANT:** Enrollments cannot be processed without both pages being completed and returned.

Group # \_\_\_\_\_

Your Employer / Company Name:			
SSN:	Employee's Legal Last Name:	Legal First Name:	MI:
Street Address:		City, State and Zip:	
Home Phone:	Work Phone:	Birth Date:	Sex: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law Married (attach affidavit)
Primary Care Physician (PCP): <i>If not listed, we will select one for you.</i>		PCP ID #:	

**Please list spouse you wish to enroll in medical coverage.**

Legal Last Name	Legal First Name	MI	Birth Date	Sex	SSN	Primary Care Physician	PCP ID #

**Please list children and other eligible dependents you wish to enroll in medical coverage (list address if different).**

Legal Last Name	Legal First Name	MI	Birth Date	Sex	SSN	Relationship	Primary Care Physician	PCP ID #

Employee's Legal Last Name:	Legal First Name:	MI:
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Please complete the following:

1. After you are enrolled in the Plan, will you or any person listed above be covered by other health insurance?  No  Yes If yes, what insurance? \_\_\_\_\_  
Insurance Company's Phone Number: \_\_\_\_\_ Policyholder's I.D. # \_\_\_\_\_  
Policyholder's Name and Date of Birth: \_\_\_\_\_ Names of those covered: \_\_\_\_\_
2. Is a dependent child listed above mentally or physically disabled?  No  Yes (call Us to obtain form) If yes, name of child? \_\_\_\_\_
3. I hereby apply for enrollment for the individual(s) listed above. I understand and accept that covered services will only be provided by the specific health care providers and institutions authorized by the Plan subject to the terms of the employer group agreement contract. I authorize my employer to deduct from my earnings my contribution to the premium. I hereby consent to the release of information or medical records concerning services or supplies provided to me or my covered dependents by any health care provider, allied health professional, hospital or medical care institution to the Plan, or its designee for the purpose of quality or utilization review or payment of a claim. A copy of this consent is available upon request. The consent is valid for the duration of the coverage. I represent that the information I have provided on this form is correct and that I do hereby agree to the terms and conditions set out in the plan.

**Employee's Signature (required):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EMPLOYER: COMPLETE THE SECTION BELOW IN FULL, SIGN AND DATE - ALL INFORMATION IS REQUIRED (completed form may be faxed to: 316-609-2327)**

Check One and Furnish Dates:  Date of Employment of New Hire: \_\_\_\_\_  Open Enrollment  Loss of Other Group Coverage, Date of Loss: \_\_\_\_\_  
 Other, List Reason (e.g. family status change, PT to FT): \_\_\_\_\_ Date of Qualifying Event: \_\_\_\_\_

**Effective Date of Coverage:** \_\_\_\_\_ **Employer's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_