



Phone: 215-674-9400 Fax 215-674-0400

Complete all sections below, sign and date, and return this form at least 25 days prior to your anniversary date.

Contact Name _____ Title _____ Federal Tax ID# _____
 Group Name _____ City _____ State ____ Zip _____ Total Number of Employees _____
 Email Address _____ Telephone Number _____ Group/CID# _____

Please choose a new plan from the options listed below. **Note that all plans include prescription and vision coverage.** Please contact us at 215-674-9400 for additional information. For your convenience **you will be automatically enrolled in the IBC recommended coverage if we do not hear from you 30 days prior to your anniversary date.**

Please note: Groups with 2 - 4 enrolled contracts may select a maximum of one medical plan for all enrollees. Groups with 5 - 50 enrolled contracts may select a maximum of two medical plans.* If you currently have more options than what is permitted, you must reduce the number of plans you offer. Based on this requirement, please limit the number of plans you offer by selecting the option(s) you would like below and returning this form.

Keystone HMO*	Bill to account #	Keystone Direct POS*	Bill to account #	Personal Choice PPO*	Bill to account #	Personal Choice HSA-Qualified (all contract year)	Bill to account #
<input type="checkbox"/> 1 <input type="checkbox"/> 1.1	_____	<input type="checkbox"/> 1 <input type="checkbox"/> 1.1	_____	<input type="checkbox"/> 1 <input type="checkbox"/> 1.1	_____	<input type="checkbox"/> HDHP 1	_____
<input type="checkbox"/> 2 <input type="checkbox"/> 2.1	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 2.1	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 2.1	_____	<input type="checkbox"/> HDHP 2	_____
<input type="checkbox"/> 3 <input type="checkbox"/> 3.1	_____	<input type="checkbox"/> 3 <input type="checkbox"/> 3.1	_____	<input type="checkbox"/> 3 <input type="checkbox"/> 3.1	_____	<input type="checkbox"/> HDHP 3	_____
<input type="checkbox"/> 4 <input type="checkbox"/> 4.1	_____	<input type="checkbox"/> 4 <input type="checkbox"/> 4.1	_____	<input type="checkbox"/> 4 <input type="checkbox"/> 4.1	_____	<input type="checkbox"/> HDHP 4	_____
<input type="checkbox"/> 5 <input type="checkbox"/> 5.1	_____	<input type="checkbox"/> 5 <input type="checkbox"/> 5.1	_____	<input type="checkbox"/> 5 <input type="checkbox"/> 5.1	_____	<input type="checkbox"/> HDHP 5	_____
<input type="checkbox"/> 6 <input type="checkbox"/> 6.1	_____	<input type="checkbox"/> 6 <input type="checkbox"/> 6.1	_____	<input type="checkbox"/> 6 <input type="checkbox"/> 6.1	_____	<input type="checkbox"/> I have employees interested in opening an HSA account with Bancorp.	_____
<input type="checkbox"/> 7 <input type="checkbox"/> 7.1	_____	<input type="checkbox"/> 7 <input type="checkbox"/> 7.1	_____	<input type="checkbox"/> 7 <input type="checkbox"/> 7.1	_____		_____
<input type="checkbox"/> Basic Dental	_____	<input type="checkbox"/> Basic Dental	_____	<input type="checkbox"/> 8 <input type="checkbox"/> 8.1	_____		_____

*You may not select identical medical plans; for example, HMO 1 and HMO 1.1

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I would like to add coverage for dependents to age 30. I would like to add Domestic Partner Coverage.

Comments _____

 _____ UCCI Dental Plan: _____

Employer Signature _____ Effective Date _____

* Groups with 2-4 enrolled contracts may add a second medical option to an HMO/POS plan only if a PPO plan is needed for an out-of-area employee. Groups with 5-50 enrolled contracts may add a third medical option to a HMO/POS plan only if a PPO is needed for an out-of-area employee. **Sole proprietors may select either HMO 3 or HDHP 2.**

All benefit selections must meet Independence Blue Cross underwriting guidelines including number of plan offerings allowed based on group size.