Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Group Name: Effective Date:
Agent:

Employee Choice Benefit Selection Form Groups 51-99

Group number(s)	Group Name	Effective Date

Instructions: Select grouping number, network(s), and plans from quote number #_____.

Employee Choice Grouping #_____

Select Network(s) − choose up to three networks:

☐ 1. Preferred ValueCare ☐ 2. Preferred FocalPoint ☐ 3. Participating

☐ 4. Preferred BlueOption (Single network only, cannot be paired with any other network.)

Select Plan(s): – choose up to five plans:

☐ A. BluePoint Unlimited Visits, $25/45 Copay, $500 Ded, 80/60 Coins, $3,000 OOP Max
☐ B. BluePoint Unlimited Visits, $25/45 Copay, $1,000 Ded, 80/60 Coins, $3,500 OOP Max
☐ C. BluePoint Unlimited Visits, $25/45 Copay, $1,500 Ded, 80/60 Coins, $4,000 OOP Max
☐ D. BluePoint Unlimited Visits, $25/45 Copay, $2,000 Ded, 80/60 Coins, $4,500 OOP Max
☐ E. BluePoint Unlimited Visits, $35/55 Copay, $2,000 Ded, 70/55 Coins, $5,500 OOP Max
☐ F. BluePoint Unlimited Visits, $25/45 Copay, $3,000 Ded, 80/60 Coins, $5,000 OOP Max
☐ G. BluePoint Unlimited Visits, $25/45 Copay, $5,000 Ded, 80/60 Coins, $6,350 OOP Max
☐ H. HSA 3.0 − $1,350 Ind / $2,700 Fam Ded, 80/60 Coins, $3,600 Ind / $7,200 Fam Out of Pocket Max
☐ I. HSA 3.0 − $1,500 Ind / $3,000 Fam Ded, 80/60 Coins, $3,000 Ind / $6,000 Fam Out of Pocket Max
☐ J. HSA 3.0 − $2,000 Ind / $4,000 Fam Ded, 100/80 Coins, $2,000 Ind / $4,000 Fam Out of Pocket Max
☐ K. HSA 3.0 − $2,500 Ind / $5,000 Fam Ded, 80/60 Coins, $5,000 Ind / $10,000 Fam Out of Pocket Max
☐ L. HSA 3.0 − $5,000 Ind / $10,000 Fam Ded, 100/80 Coins, $5,000 Ind / $10,000 Fam Out of Pocket Max
☐ M. HSA 3.0 − $3,000 Ind / $7,000 Fam Ded, 80/60 Coins, $5,000 Ind / $10,000 Fam Out of Pocket Max
☐ L. HSA 3.0 − $5,000 Ind / $10,000 Fam Ded, 100/80 Coins, $5,000 Ind / $10,000 Fam Out of Pocket Max

I acknowledge all selected benefit plans and networks have been indicated on this form. Each medical plan chosen will be offered with every selected network. Rates associated with these benefits are detailed on the rate sheets in quote #_____. I understand any options not specifically checked have not been selected and will not be included in the policy. I agree to the effective date of coverage as indicated in this document.

Group Authorized Signature: _____

Official Title: _____ Date: _____

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Group Name: Effective Date:

Agent:

Employee Choice Enrollment Form Groups 51-99

Important note: If a new employee is enrolling or an existing employee is making any change to enrollment such as adding a spouse/dependent, waiving an already enrolled spouse/dependent, or termination of coverage, this form cannot be used. An Application for Enrollment/Change form must be submitted.

Employee's Name	Network Choice (1–4)	Plan Choice (A–M)	Employee's Name	Network Choice (1–4)	Plan Choice (A–M)
1.			26.		
2.			27.		
3.			28.		
4.			29.		
5.			30.		
6.			31.		
7.			32.		
8.			33.		
9.			34.		
10.			35.		
11.			36.		
12.			37.		
13.			38.		
14.			39.		
15.			40.		
16.			41.		
17.			42.		
18.			43.		
19.			44.		
20.			45.		
21.			46.		
22.			47.		
23.			48.		
24.			49.		
25.			50.		