REQUEST FOR AMENDMENT TO SALES AGREEMENT

SMALL GROUP

COMPLETE AND RETURN THIS FORM ONLY IF YOU ARE MAKING PLAN CHANGES. TO ASSIST IN COMPLETING THIS FORM PLEASE REFER TO THE INSTRUCTIONS ON THE BACK SIDE OF THIS FORM.

Group Name: _____ (hereinafter referred to as "Group")

Group Policy Number: _____

As an Authorized representative of the above named Group, I request that the Sales Agreement on the above referenced group policy number be amended with the following changes:

1. RATES ARE EFFECTIVE: __ __/__ __/__ __ __ __ through __ __/__ __/__ __ __ __

2. GROUP NUMBER(S)	**3.** KEY CODES **(A, D, R)**	**4.** PRODUCT NAME/DESCRIPTION *(*Vision: indicate Voluntary, non-Voluntary, or Contributory)*	**5.** MONTHLY PREMIUM			
			Enrollee Only	Enrollee & Spouse	Enrollee & Children	Enrollee, Spouse, & Children
			$	$	$	$
			$	$	$	$
			$	$	$	$

☐ By checking this box, Group attests that it has separately purchased a qualified dental plan certified by HealthSource RI.

*If Contributory Vision is purchased by Group, Group is required to make a minimum 50% contribution to Monthly Premium for its Vision coverage. If Group does not contribute at least 50%, Blue Cross & Blue Shield of Rhode Island (BCBSRI) may change the Monthly Premium rate for Vision coverage upon written notice to the GROUP.

I understand that this amendment will not become effective unless approved and issued by BCBSRI. I request that this amendment be approved by BCBSRI, subject to their usual underwriting guidelines and issued in their customary policy language. I request that this amendment, if approved and issued by BCBSRI, become effective by its terms without any further acceptance required by the Group, and that this REQUEST FOR AMENDMENT TO SALES AGREEMENT (SMALL GROUP) form be made the amendment and be attached to and made part of the Sales Agreement. This amendment may be executed and delivered by facsimile or e-mail, and such facsimile or e-mail delivery shall constitute the final agreement of the parties and conclusive proof of this amendment.

Blue Cross & Blue Shield of Rhode Island	**Group**
By: _____ Authorized Signature	By: _____ Authorized Signature
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Blue Cross Blue Shield of Rhode Island

Blue Cross & Blue Shield of Rhode Island is an independent license of the Blue Cross and Blue Shield Association

INSTRUCTIONS TO COMPLETE THE AMENDMENT FORM ENTITLED "REQUEST FOR AMENDMENT TO THE SALES AGREEMENT (SMALL GROUP)":

THE FOLLOWING INFORMATION MUST BE PROVIDED FOR EACH CHANGE IN ORDER FOR THE AMENDMENT TO BE PROCESSED.

THIS PAGE IS FOR INFORMATIONAL PURPOSES ONLY AND NOT DEEMED TO BE PART OF THE AMENDMENT FORM.
If you need assistance, please contact your General Agent, Broker, or Small Business Sales Representative.

	Group Policy Number	Insert the group policy number (nine (9) digit number found on your Sales Agreement).
1.	**RATES ARE EFFECTIVE**	Insert the requested effective dates.
2.	**GROUP NUMBER(S)**	Insert the group number(s)(eight (8) digit number found on your monthly bill)
3.	**KEY CODES**	Insert the appropriate code; use: • **"A"** to **Add** a new product. • "**D"** to **Delete** a current product. • **"R"** when Group has requested BCBSRI to recertify due to a change in the Group's demographics and the recertification result changed the monthly premium amount previously provided in the renewal packet. This **Rate Change** can only be effective on the group's renewal date.
4.	**PRODUCT NAME/DESCRIPTION**	Insert the product name and description (e.g. VantageBlue 100/80 $1,000, Group Plan 65, Blue Cross Dental, etc.) affected by this change. Please refer to your Renewal Packet.
5.	**MONTHLY PREMIUM**	Insert the applicable rates for dental and/or vision coverage. Attach Alternative Plan Benefits (Medical)/Small Group Rate Table form from BCBSRI Underwriting Department to indicate applicable rates for medical coverage. Please refer to your Renewal Packet.
6.	**QUALIFIED DENTAL PLAN CHECK BOX**	Under the Patient Protection and Affordable Care Act (ACA), Groups are responsible for offering their employees plans that cover certain pediatric dental services. If Group has selected a medical benefit plan that does not cover the required pediatric dental services, it must attest to BCBSRI that it has separately purchased a qualified dental plan certified by HealthSource RI.