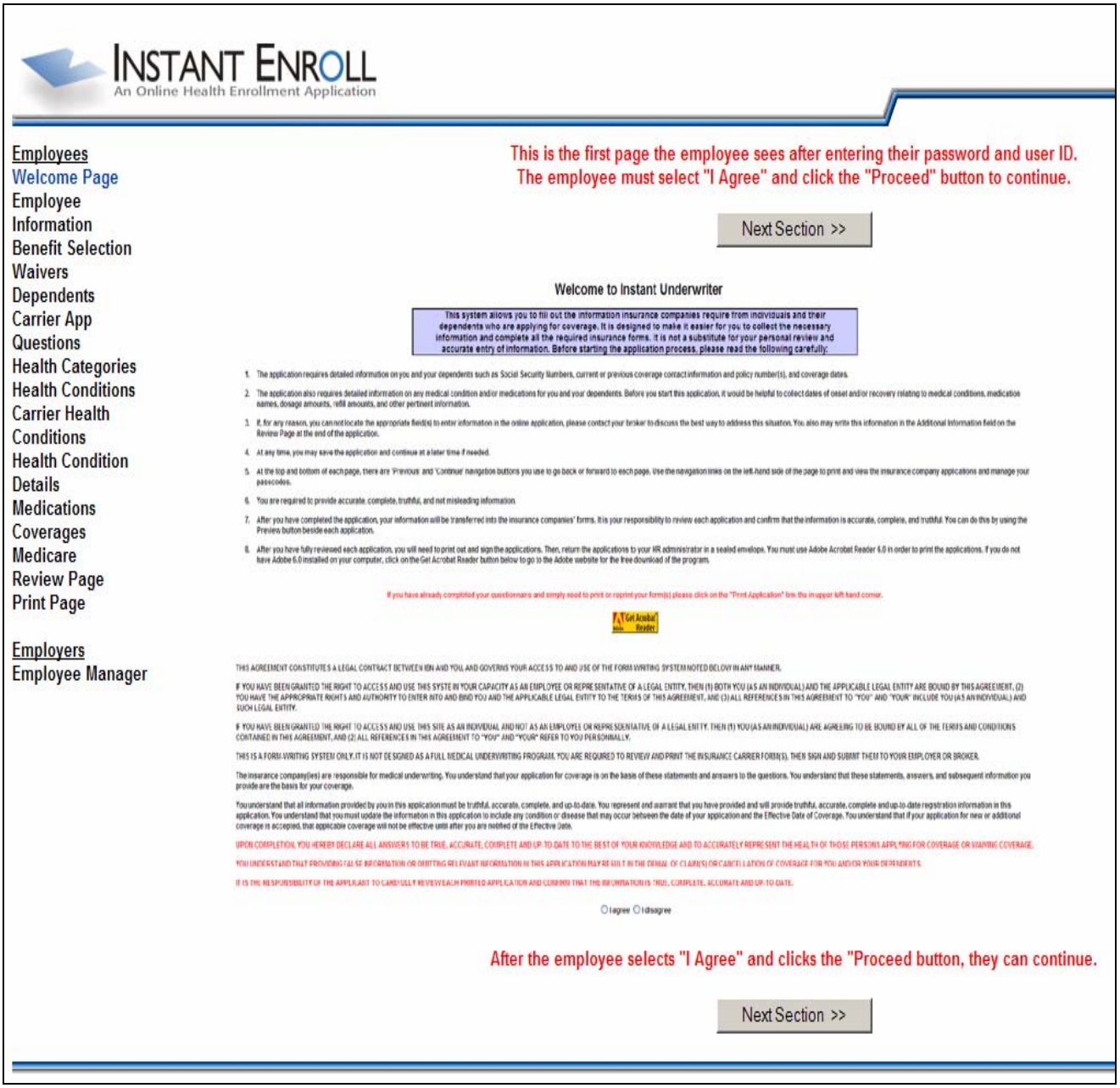
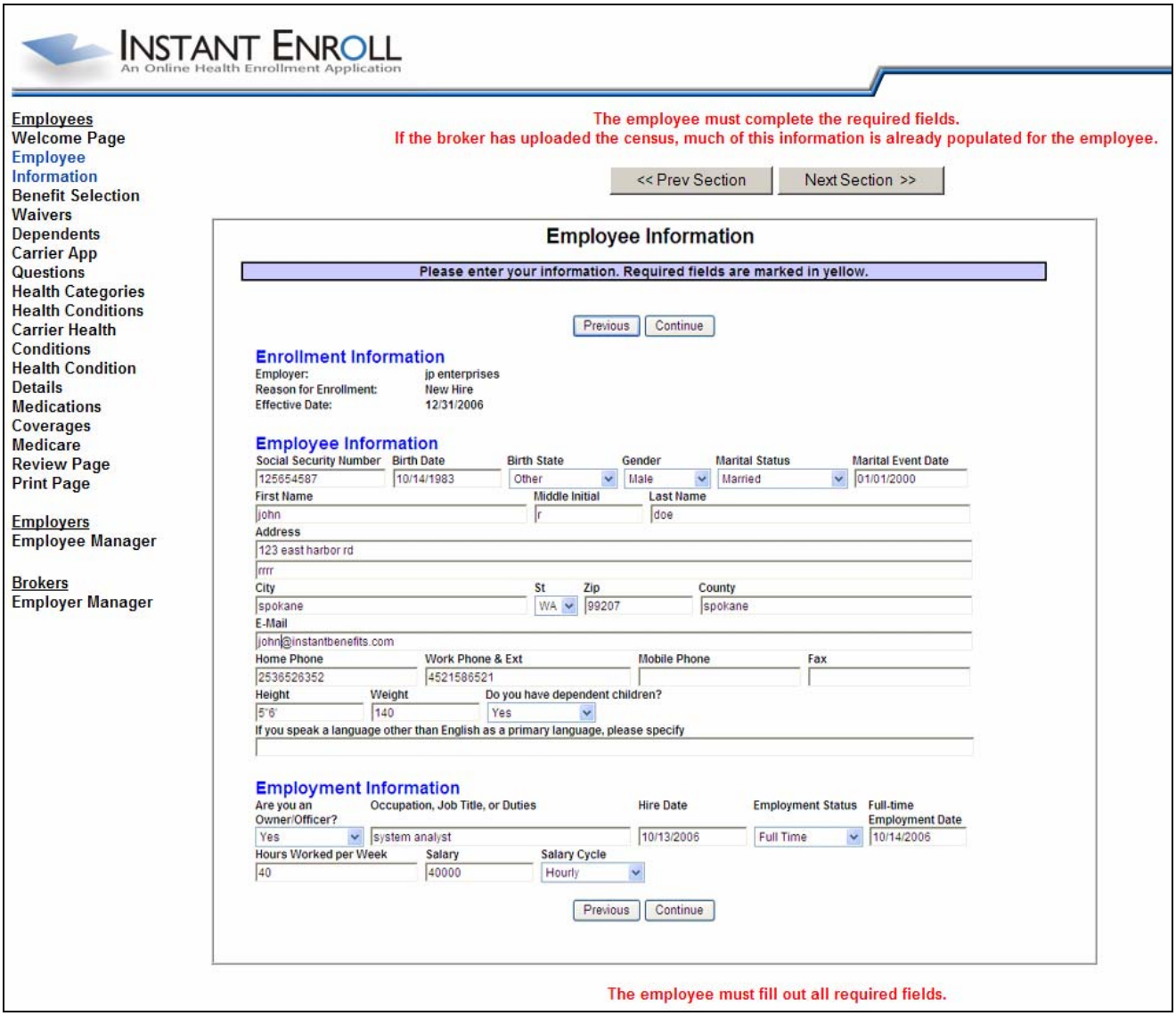
The following 18 pages provide an overview to www.InstantEnroll.com:

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Carrier App Questions
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Carrier Health Conditions
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Review Page
Print Page
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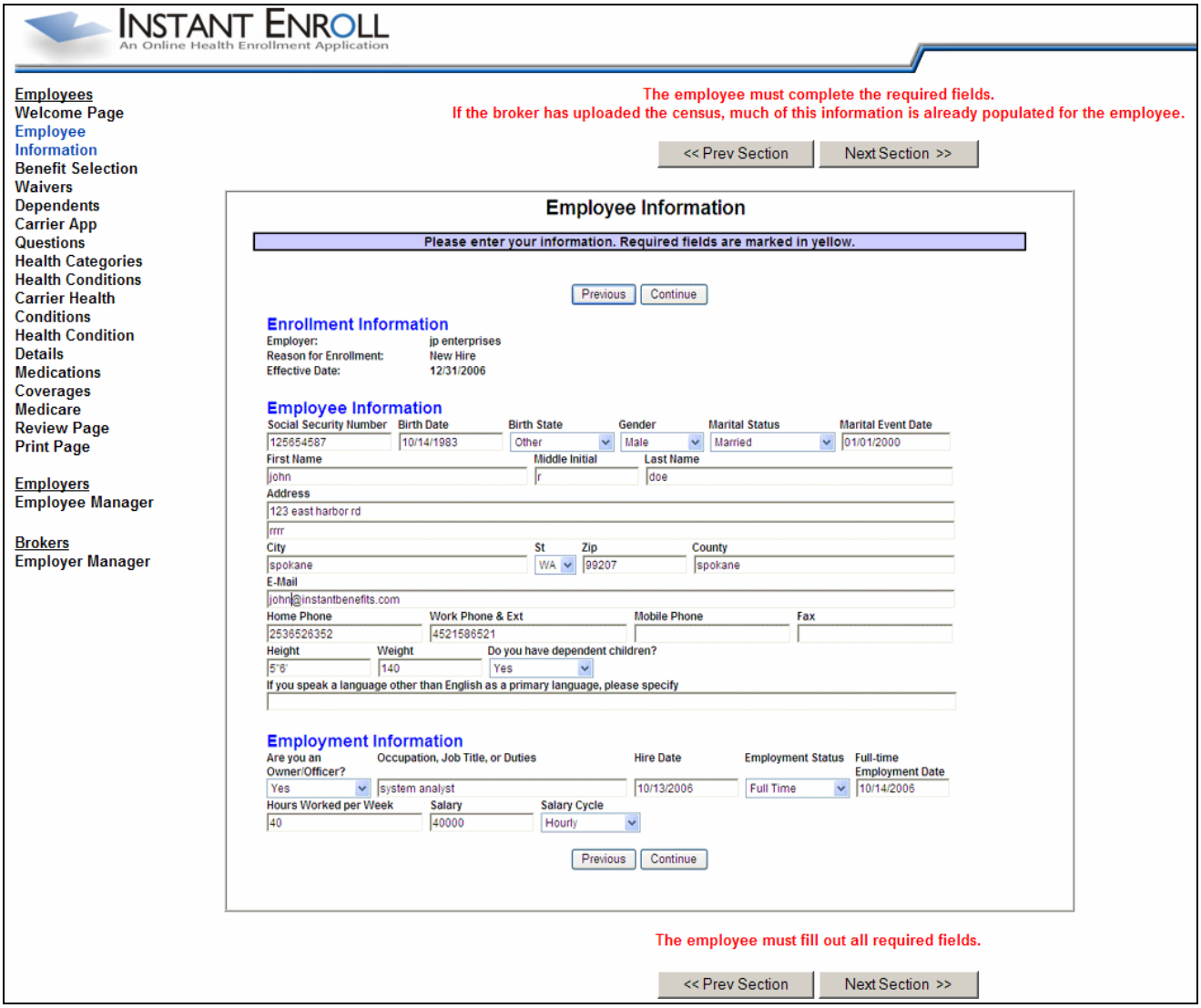
Brokers
Employer Manager
The employee must complete the required fields.
If the broker has uploaded the census, much of this information is already populated for the employee.
<< Prev Section
Next Section >>
Employee Information
Please enter your information. Required fields are marked in yellow.
Previous
Continue
Enrollment Information
Employer: jp enterprises
Reason for Enrollment: New Hire
Effective Date: 12/31/2006
Employee Information
Social Security Number 125654587
Birth Date 10/14/1983
Birth State Other
Gender Male
Marital Status Married
Marital Event Date 01/01/2000
First Name john
Middle Initial r
Last Name doe
Address 123 east harbor rd
rrrr
City spokane
St WA
Zip 99207
County spokane
E-Mail john@instantbenefits.com
Home Phone 2536526352
Work Phone & Ext 4521586521
Mobile Phone
Fax
Height 5'6
Weight 140
Do you have dependent children? Yes
If you speak a language other than English as a primary language, please specify
Employment Information
Are you an Owner/Officer? Yes
Occupation, Job Title, or Duties system analyst
Hire Date 10/13/2006
Employment Status Full Time
Full-time Employment Date 10/14/2006
Hours Worked per Week 40
Salary 40000
Salary Cycle Hourly
Previous
Continue
The employee must fill out all required fields.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The employee must complete the required fields.
If the broker has uploaded the census, much of this information is already populated for the employee.
<< Prev Section
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Please enter your information. Required fields are marked in yellow.
Previous
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Reason for Enrollment: New Hire
Effective Date: 12/31/2006
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Birth State Other
Gender Male
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Employment Information
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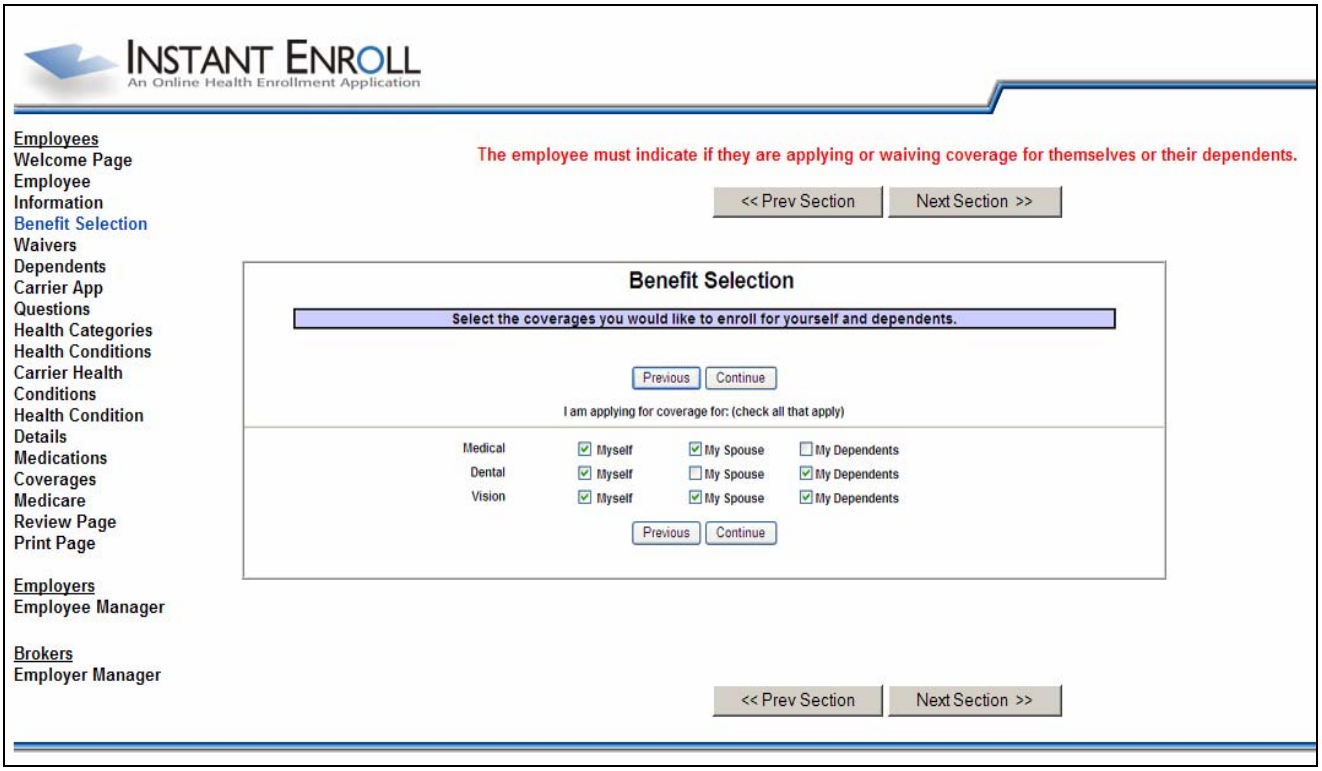
Hire Date 10/13/2006
Employment Status Full Time
Full-time Employment Date 10/14/2006
Hours Worked per Week 40
Salary 40000
Salary Cycle Hourly
Previous
Continue
The employee must fill out all required fields.
<< Prev Section
Next Section >>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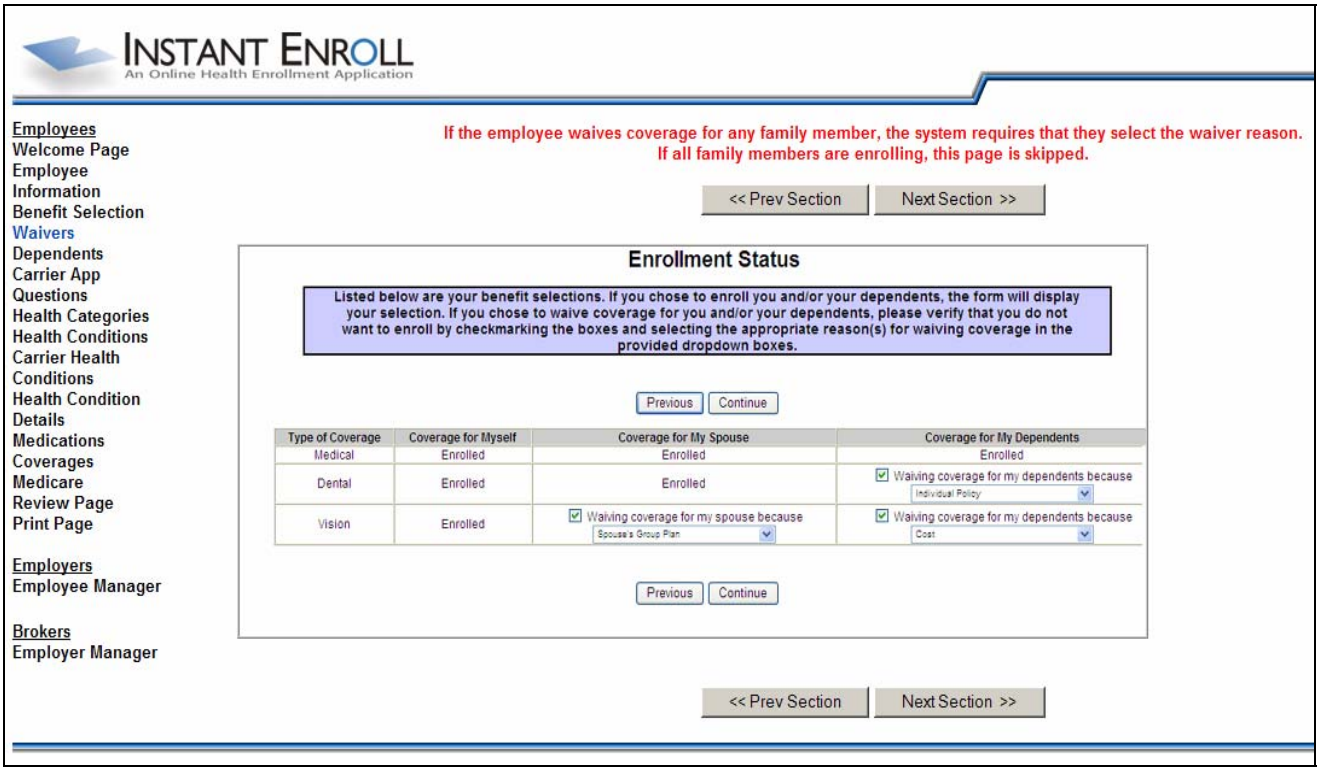
The employee must indicate if they are applying or waiving coverage for themselves or their dependents.
<< Prev Section
Next Section >>
Benefit Selection
Select the coverages you would like to enroll for yourself and dependents.
Previous
Continue
I am applying for coverage for: (check all that apply)
Medical Myself My Spouse My Dependents
Dental Myself My Spouse My Dependents
Vision Myself My Spouse My Dependents
Previous
Continue
<< Prev Section
Next Section >>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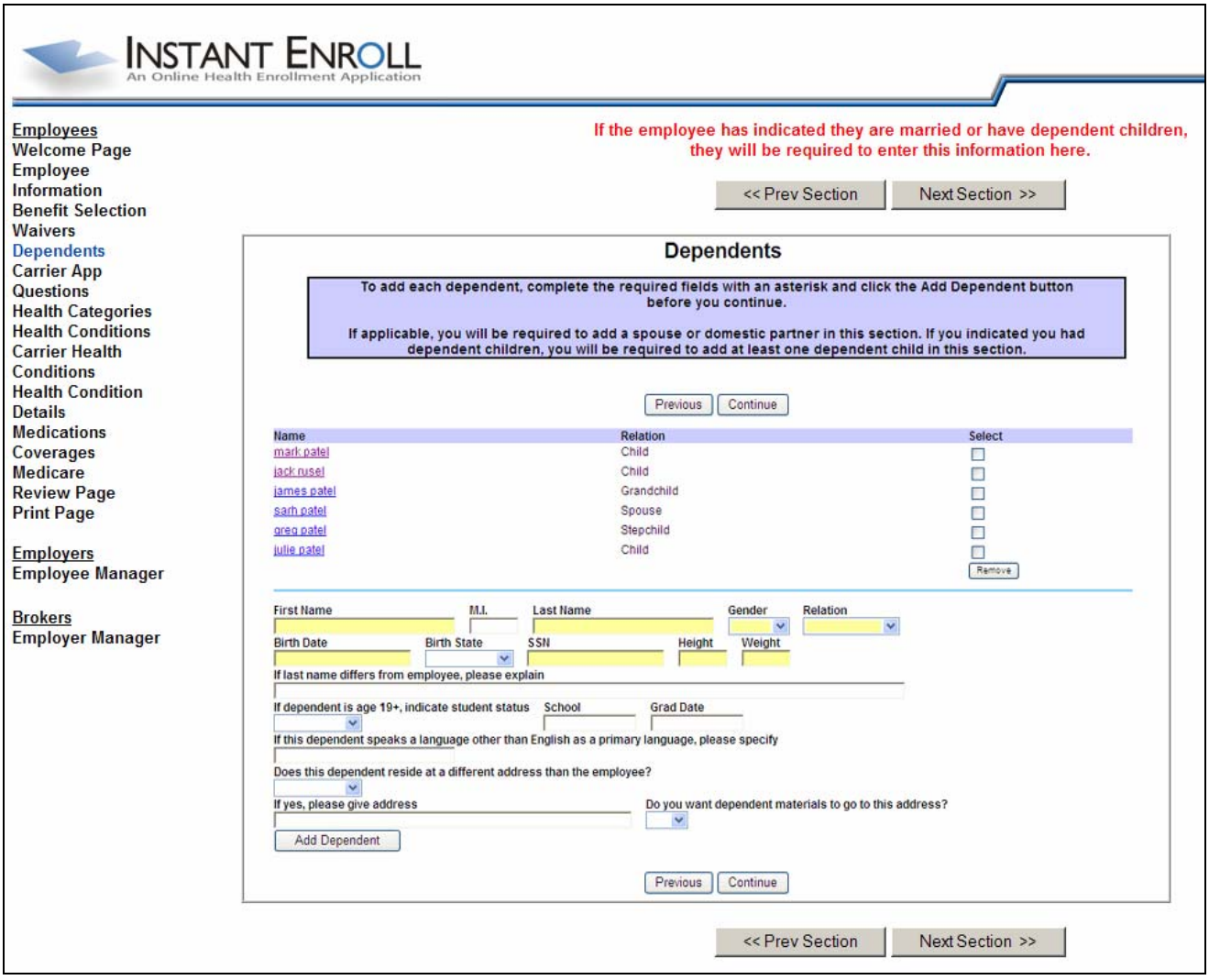
If the employee waives coverage for any family member, the system requires that they select the waiver reason.
If all family members are enrolling, this page is skipped.
<< Prev Section
Next Section >>
Enrollment Status
Listed below are your benefit selections. If you chose to enroll you and/or your dependents, the form will display your selection. If you chose to waive coverage for you and/or your dependents, please verify that you do not want to enroll by checkmarking the boxes and selecting the appropriate reason(s) for waiving coverage in the provided dropdown boxes.
Previous
Continue
Type of Coverage
Coverage for Myself
Coverage for My Spouse
Coverage for My Dependents
Medical
Enrolled
Enrolled
Enrolled
Dental
Enrolled
Enrolled
Waiving coverage for my dependents because
Individual Policy
Vision
Enrolled
Waiving coverage for my spouse because
Spouse's Group Plan
Waiving coverage for my dependents because
Cost
Previous
Continue
<< Prev Section
Next Section >>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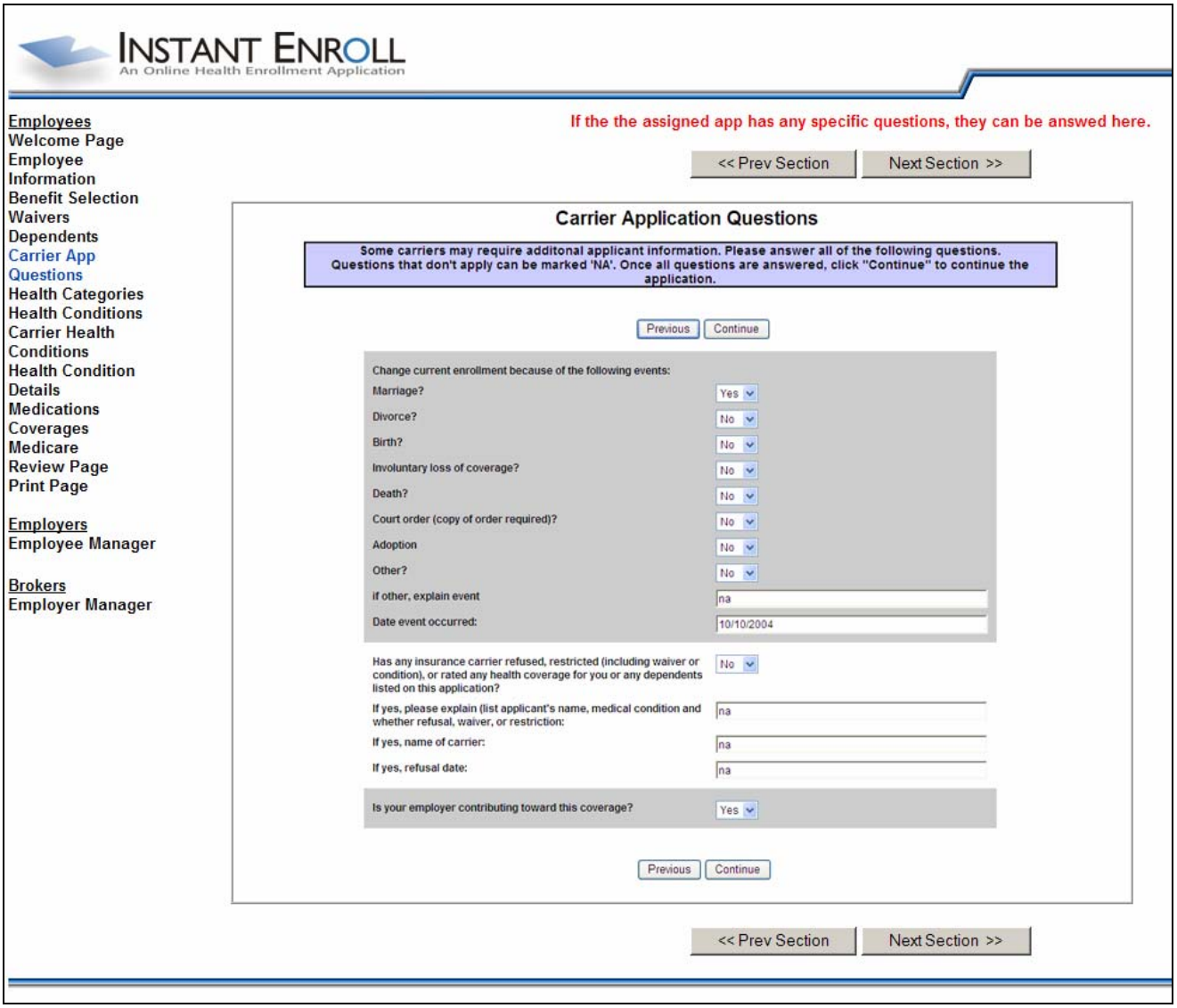
If the employee has indicated they are married or have dependent children, they will be required to enter this information here.
<< Prev Section
Next Section >>
Dependents
To add each dependent, complete the required fields with an asterisk and click the Add Dependent button before you continue.
If applicable, you will be required to add a spouse or domestic partner in this section. If you indicated you had dependent children, you will be required to add at least one dependent child in this section.
Previous
Continue
Name
Relation
Select
mark patel
Child
jack rusel
Child
james patel
Grandchild
sarh patel
Spouse
greg patel
Stepchild
julie patel
Child
Remove
First Name
M.I.
Last Name
Gender
Relation
Birth Date
Birth State
SSN
Height
Weight
If last name differs from employee, please explain
If dependent is age 19+, indicate student status
School
Grad Date
If this dependent speaks a language other than English as a primary language, please specify
Does this dependent reside at a different address than the employee?
If yes, please give address
Do you want dependent materials to go to this address?
Add Dependent
Previous
Continue
<< Prev Section
Next Section >>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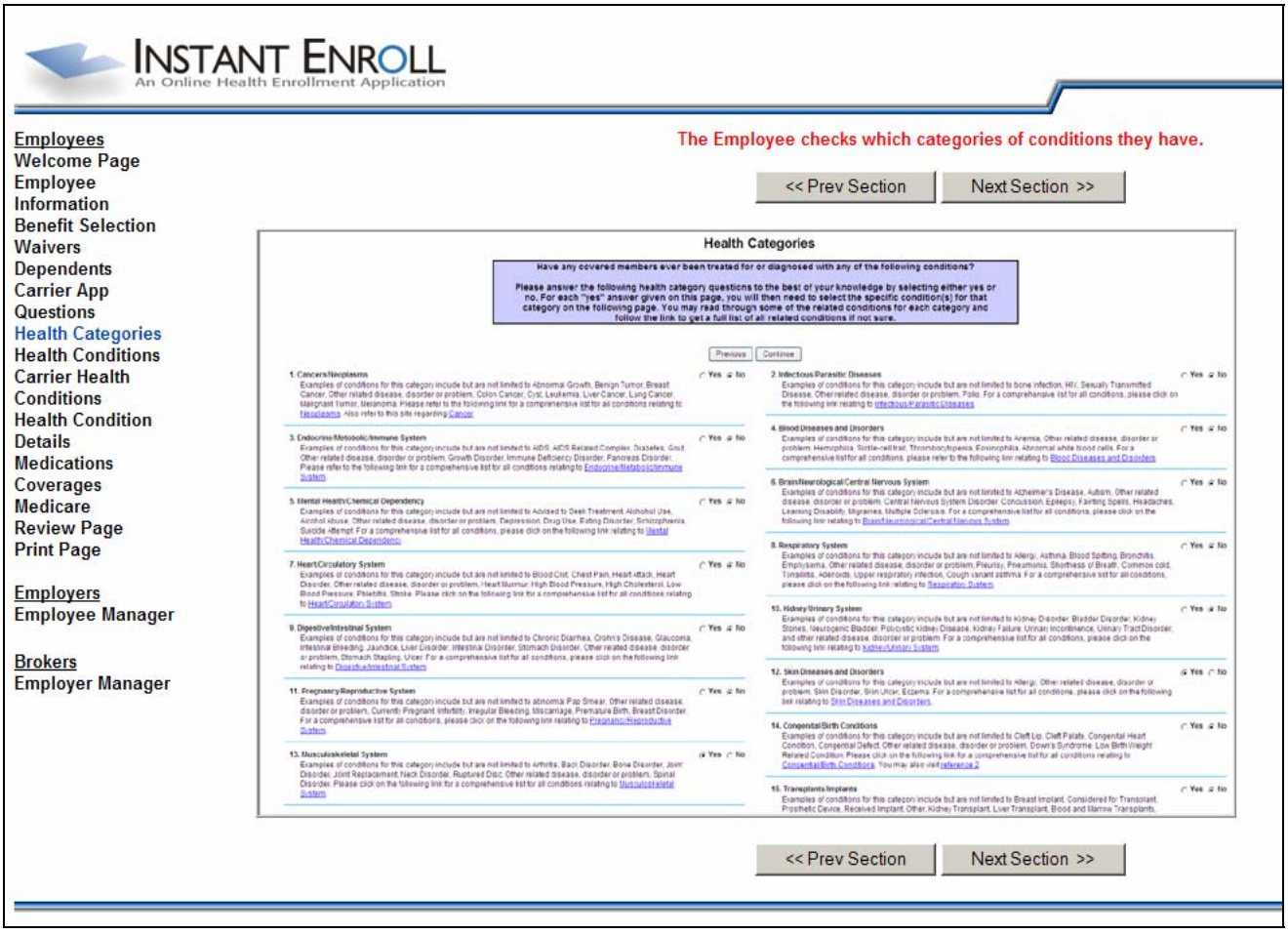
If the the assigned app has any specific questions, they can be answed here.
<< Prev Section
Next Section >>
Carrier Application Questions
Some carriers may require additonal applicant information. Please answer all of the following questions. Questions that don't apply can be marked 'NA'. Once all questions are answered, click "Continue" to continue the application.
Previous
Continue
Change current enrollment because of the following events:
Marriage? Yes
Divorce? No
Birth? No
Involuntary loss of coverage? No
Death? No
Court order (copy of order required)? No
Adoption No
Other? No
If other, explain event na
Date event occurred: 10/10/2004
Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? No
If yes, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction: na
If yes, name of carrier: na
If yes, refusal date: na
Is your employer contributing toward this coverage? Yes
Previous
Continue
<< Prev Section
Next Section >>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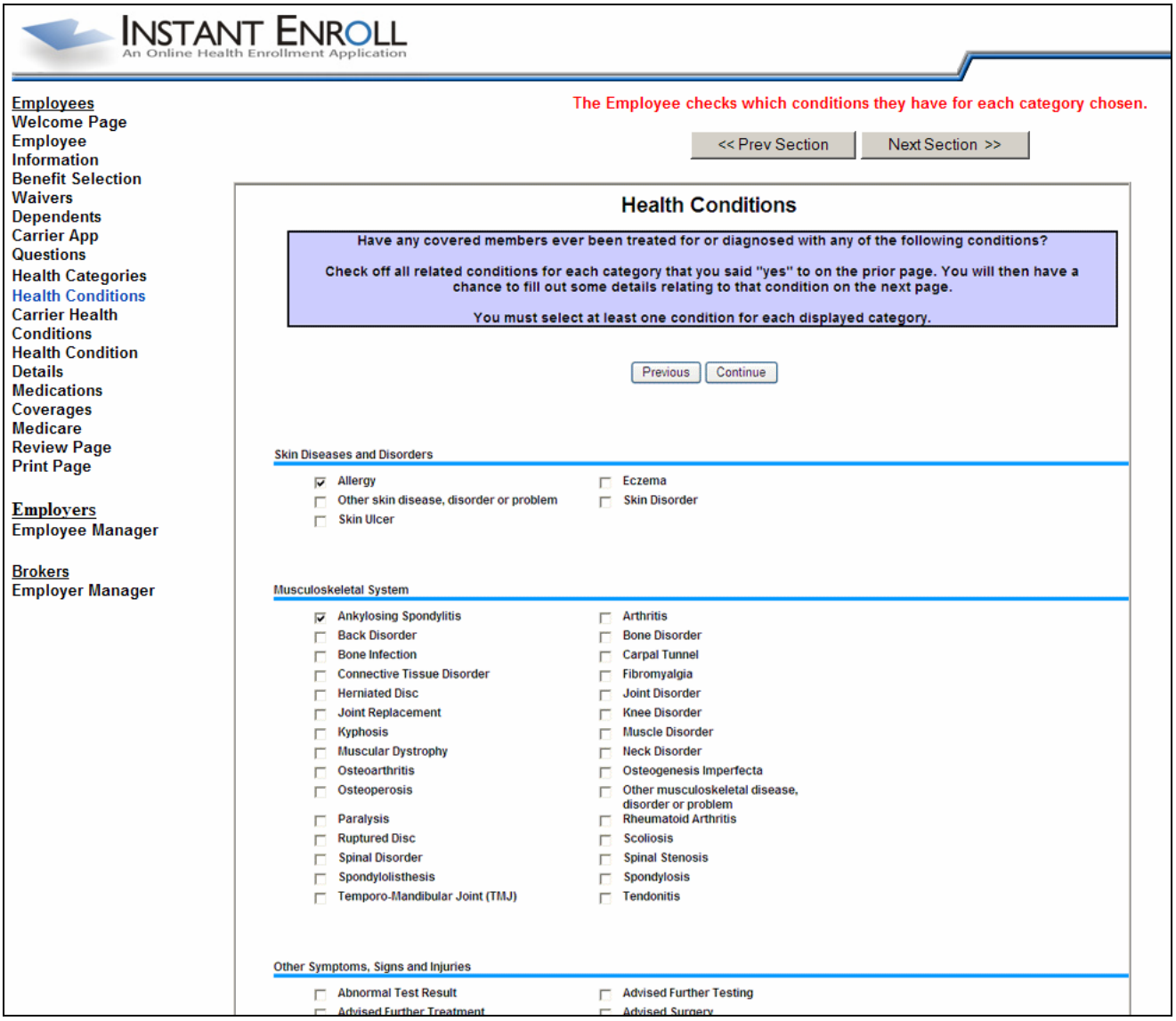
The Employee checks which categories of conditions they have.
<< Prev Section
Next Section >>
Health Categories
Have any covered members ever been treated for or diagnosed with any of the following conditions?
Please answer the following health category questions to the best of your knowledge by selecting either yes or no. For each "yes" answer given on this page, you will then need to select the specific condition(s) for that category on the following page. You may read through some of the related conditions for each category and follow the link to get a full list of all related conditions if not sure.
Previous
Continue
1. Cancers/Neoplasms
2. Infectious/Parasitic Diseases
3. Endocrine/Metabolic/Immune System
4. Blood Diseases and Disorders
5. Mental Health/Chemical Dependency
6. Brain/Neurological/Central Nervous System
7. Heart/Circulatory System
8. Respiratory System
9. Digestive/Intestinal System
10. Kidney/Urinary System
11. Pregnancy/Reproductive System
12. Skin Diseases and Disorders
13. Musculoskeletal System
14. Congenital/Birth Conditions
15. Transplants/Implants
<< Prev Section
Next Section >>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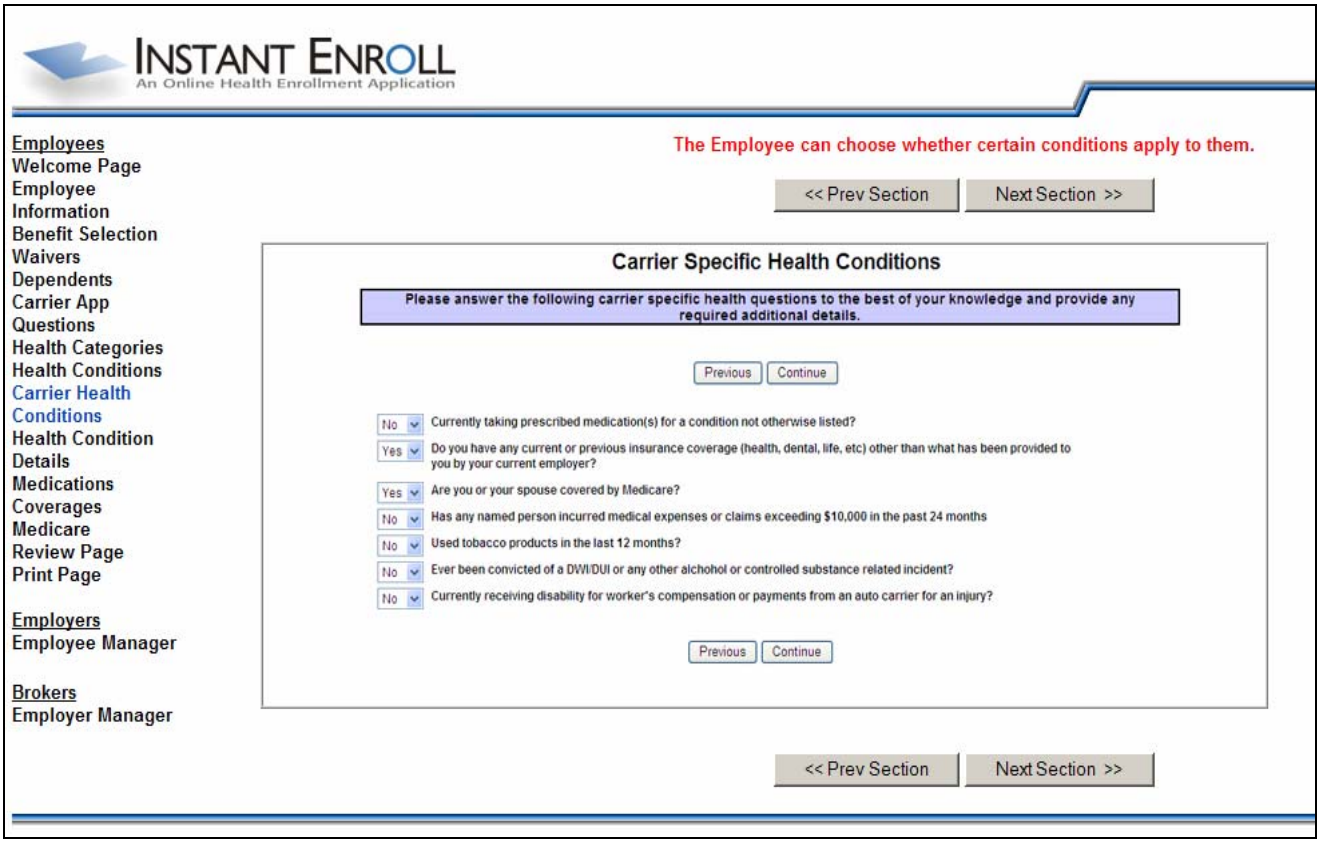
The Employee checks which conditions they have for each category chosen.
<< Prev Section
Next Section >>
Health Conditions
Have any covered members ever been treated for or diagnosed with any of the following conditions?
Check off all related conditions for each category that you said "yes" to on the prior page. You will then have a chance to fill out some details relating to that condition on the next page.
You must select at least one condition for each displayed category.
Previous
Continue
Skin Diseases and Disorders
Allergy
Eczema
Other skin disease, disorder or problem
Skin Disorder
Skin Ulcer
Musculoskeletal System
Ankylosing Spondylitis
Arthritis
Back Disorder
Bone Disorder
Bone Infection
Carpal Tunnel
Connective Tissue Disorder
Fibromyalgia
Herniated Disc
Joint Disorder
Joint Replacement
Knee Disorder
Kyphosis
Muscle Disorder
Muscular Dystrophy
Neck Disorder
Osteoarthritis
Osteogenesis Imperfecta
Osteoperosis
Other musculoskeletal disease, disorder or problem
Paralysis
Rheumatoid Arthritis
Ruptured Disc
Scoliosis
Spinal Disorder
Spinal Stenosis
Spondylolisthesis
Spondylosis
Temporo-Mandibular Joint (TMJ)
Tendonitis
Other Symptoms, Signs and Injuries
Abnormal Test Result
Advised Further Testing
Advised Further Treatment
Advised Surgery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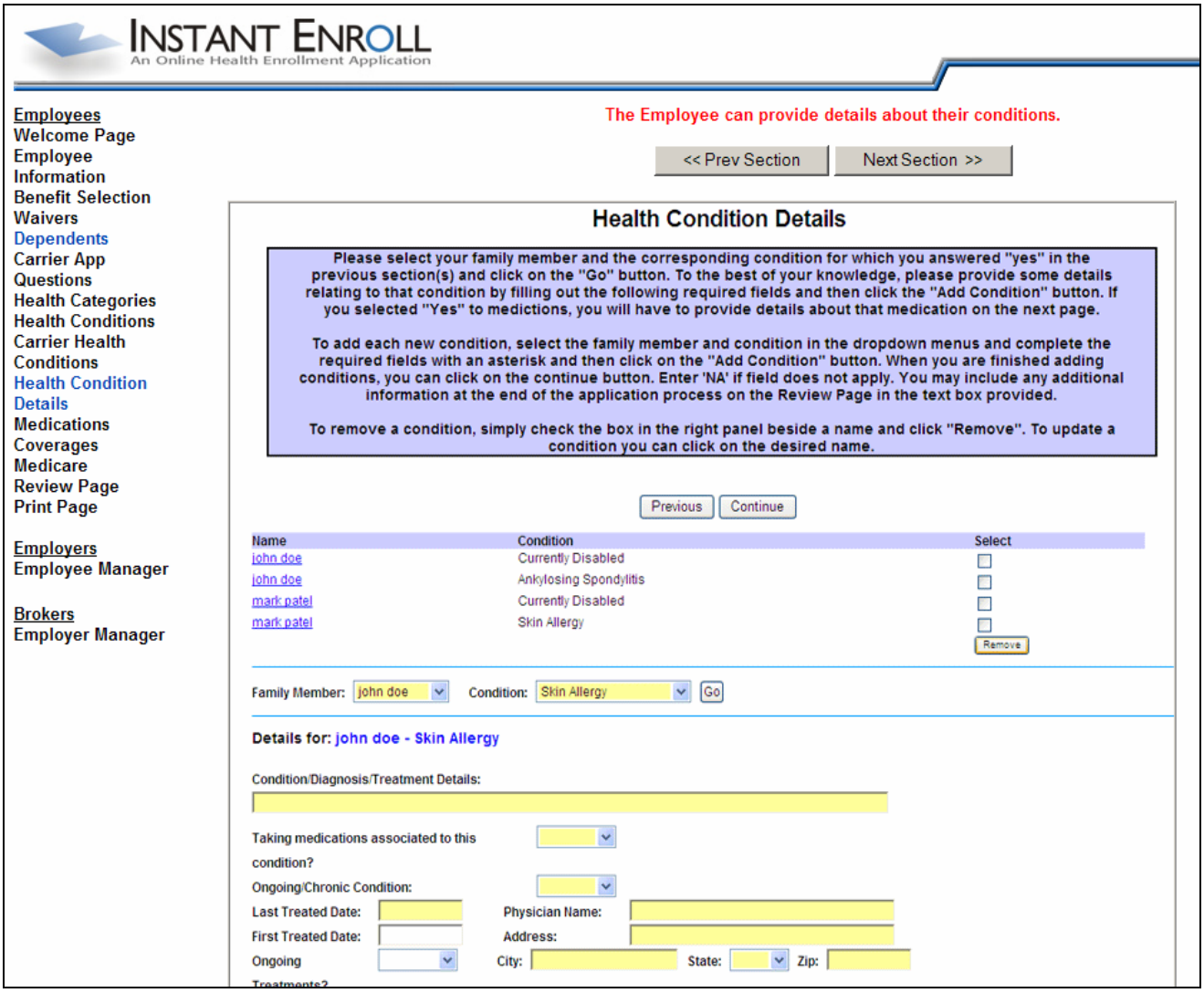
The Employee can choose whether certain conditions apply to them.
<< Prev Section
Next Section >>
Carrier Specific Health Conditions
Please answer the following carrier specific health questions to the best of your knowledge and provide any required additional details.
Previous
Continue
No Currently taking prescribed medication(s) for a condition not otherwise listed?
Yes Do you have any current or previous insurance coverage (health, dental, life, etc) other than what has been provided to you by your current employer?
Yes Are you or your spouse covered by Medicare?
No Has any named person incurred medical expenses or claims exceeding $10,000 in the past 24 months
No Used tobacco products in the last 12 months?
No Ever been convicted of a DWI/DUI or any other alchohol or controlled substance related incident?
No Currently receiving disability for worker's compensation or payments from an auto carrier for an injury?
Previous
Continue
<< Prev Section
Next Section >>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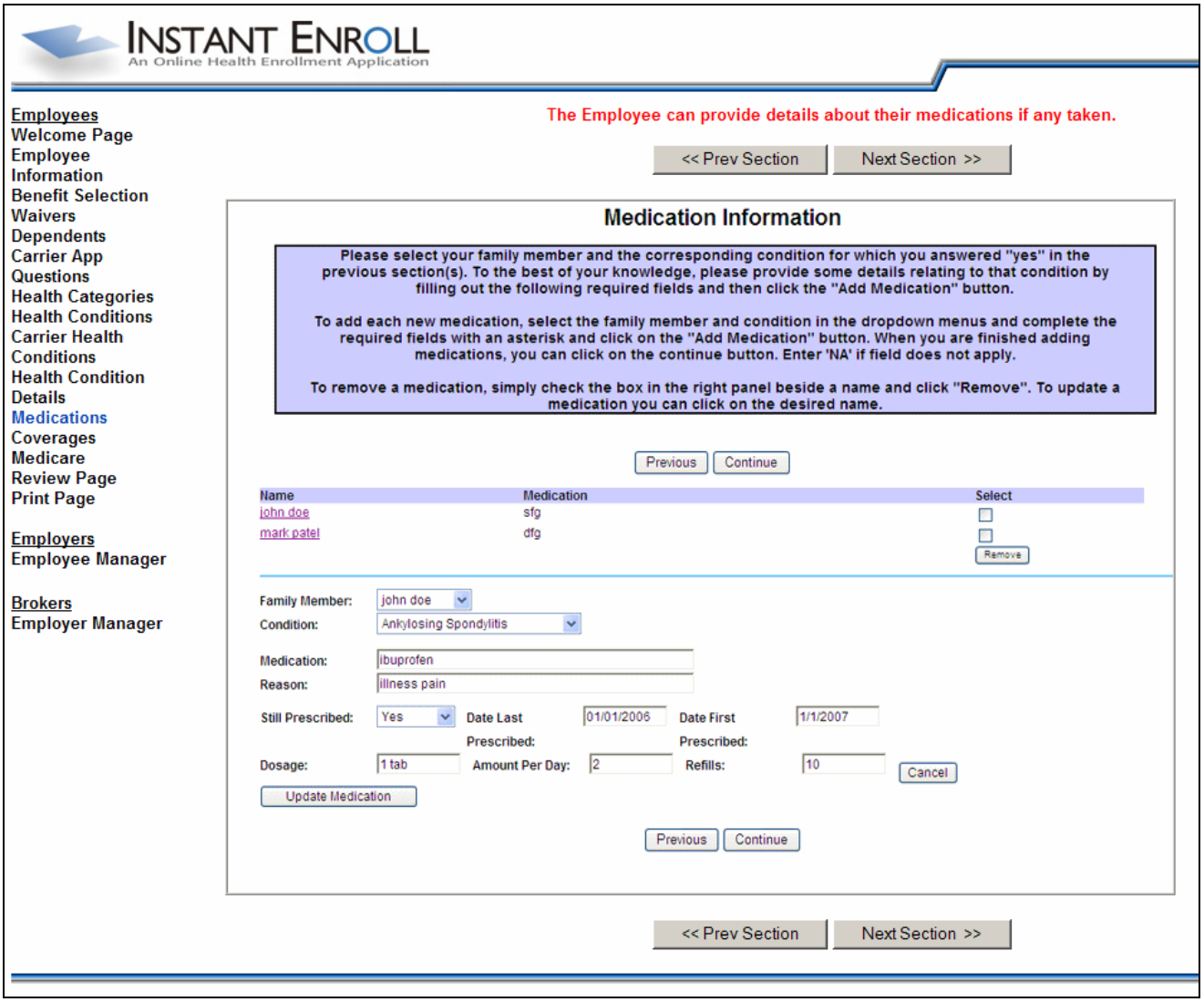
The Employee can provide details about their conditions.
<< Prev Section
Next Section >>
Health Condition Details
Please select your family member and the corresponding condition for which you answered "yes" in the previous section(s) and click on the "Go" button. To the best of your knowledge, please provide some details relating to that condition by filling out the following required fields and then click the "Add Condition" button. If you selected "Yes" to medictions, you will have to provide details about that medication on the next page.
To add each new condition, select the family member and condition in the dropdown menus and complete the required fields with an asterisk and then click on the "Add Condition" button. When you are finished adding conditions, you can click on the continue button. Enter 'NA' if field does not apply. You may include any additional information at the end of the application process on the Review Page in the text box provided.
To remove a condition, simply check the box in the right panel beside a name and click "Remove". To update a condition you can click on the desired name.
Previous
Continue
Name
Condition
Select
john doe
Currently Disabled
john doe
Ankylosing Spondylitis
mark patel
Currently Disabled
mark patel
Skin Allergy
Remove
Family Member: john doe
Condition: Skin Allergy
Go
Details for: john doe - Skin Allergy
Condition/Diagnosis/Treatment Details:
Taking medications associated to this condition?
Ongoing/Chronic Condition:
Last Treated Date:
Physician Name:
First Treated Date:
Address:
Ongoing Treatments?
City:
State:
Zip: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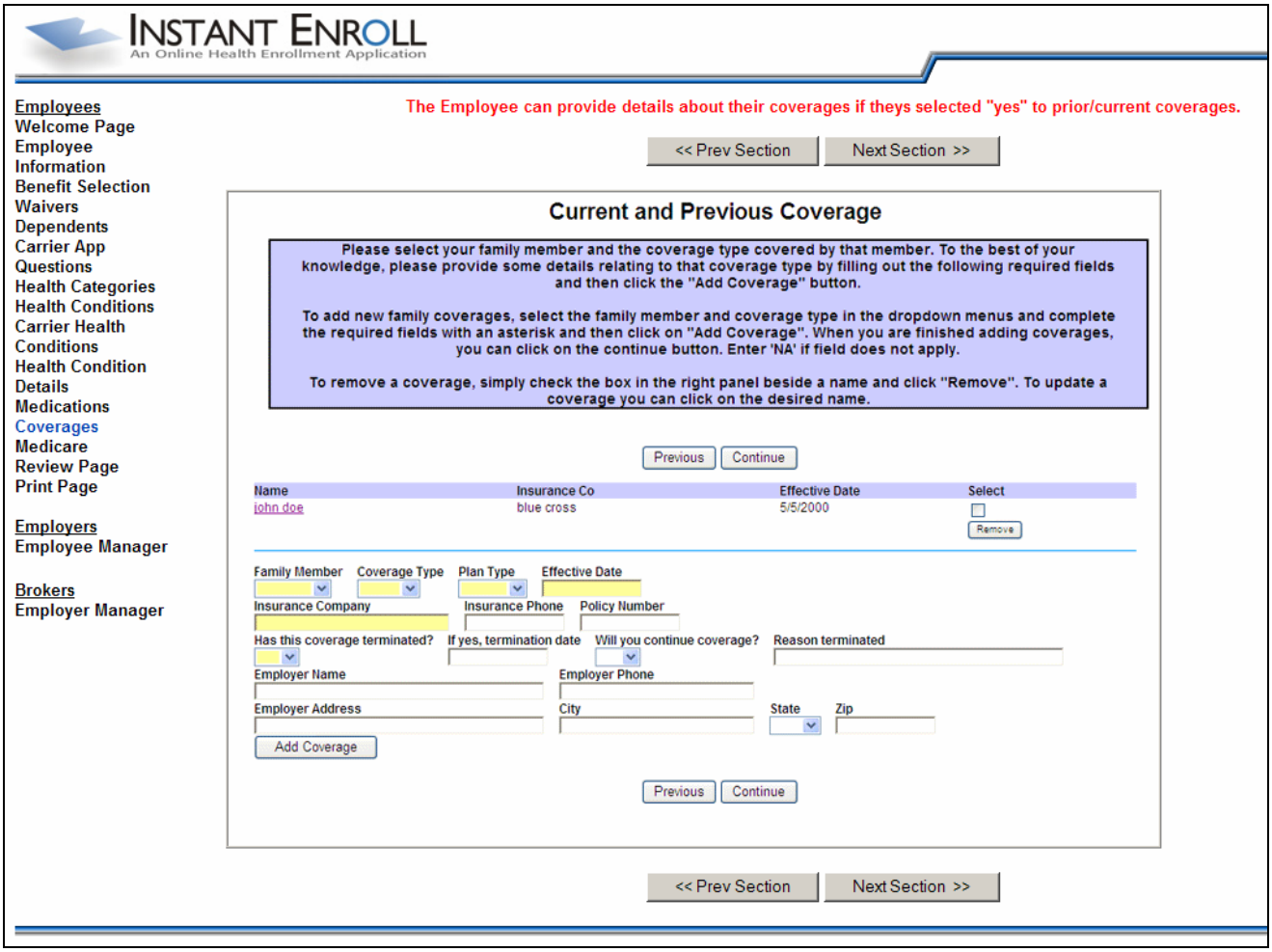
The Employee can provide details about their medications if any taken.
<< Prev Section
Next Section >>
Medication Information
Please select your family member and the corresponding condition for which you answered "yes" in the previous section(s). To the best of your knowledge, please provide some details relating to that condition by filling out the following required fields and then click the "Add Medication" button.
To add each new medication, select the family member and condition in the dropdown menus and complete the required fields with an asterisk and click on the "Add Medication" button. When you are finished adding medications, you can click on the continue button. Enter 'NA' if field does not apply.
To remove a medication, simply check the box in the right panel beside a name and click "Remove". To update a medication you can click on the desired name.
Previous
Continue
Name
Medication
Select
john doe
sfg
mark patel
dfg
Remove
Family Member:
john doe
Condition:
Ankylosing Spondylitis
Medication:
ibuprofen
Reason:
illness pain
Still Prescribed:
Yes
Date Last Prescribed:
01/01/2006
Date First Prescribed:
1/1/2007
Dosage:
1 tab
Amount Per Day:
2
Refills:
10
Cancel
Update Medication
Previous
Continue
<< Prev Section
Next Section >>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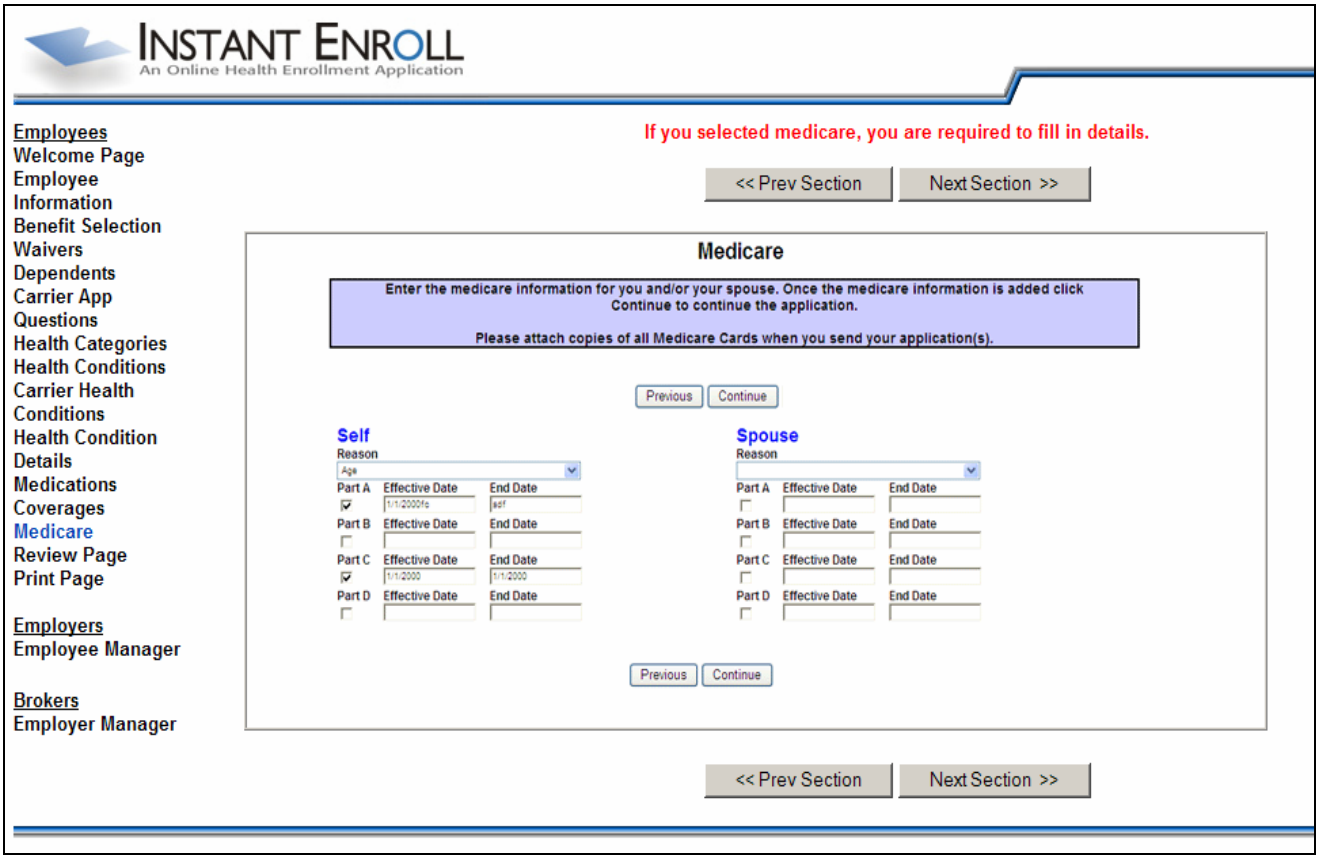
The Employee can provide details about their coverages if theys selected "yes" to prior/current coverages.
<< Prev Section
Next Section >>
Current and Previous Coverage
Please select your family member and the coverage type covered by that member. To the best of your knowledge, please provide some details relating to that coverage type by filling out the following required fields and then click the "Add Coverage" button.
To add new family coverages, select the family member and coverage type in the dropdown menus and complete the required fields with an asterisk and then click on "Add Coverage". When you are finished adding coverages, you can click on the continue button. Enter 'NA' if field does not apply.
To remove a coverage, simply check the box in the right panel beside a name and click "Remove". To update a coverage you can click on the desired name.
Previous
Continue
Name
Insurance Co
Effective Date
Select
john doe
blue cross
5/5/2000
Remove
Family Member
Coverage Type
Plan Type
Effective Date
Insurance Company
Insurance Phone
Policy Number
Has this coverage terminated?
If yes, termination date
Will you continue coverage?
Reason terminated
Employer Name
Employer Phone
Employer Address
City
State
Zip
Add Coverage
Previous
Continue
<< Prev Section
Next Section >>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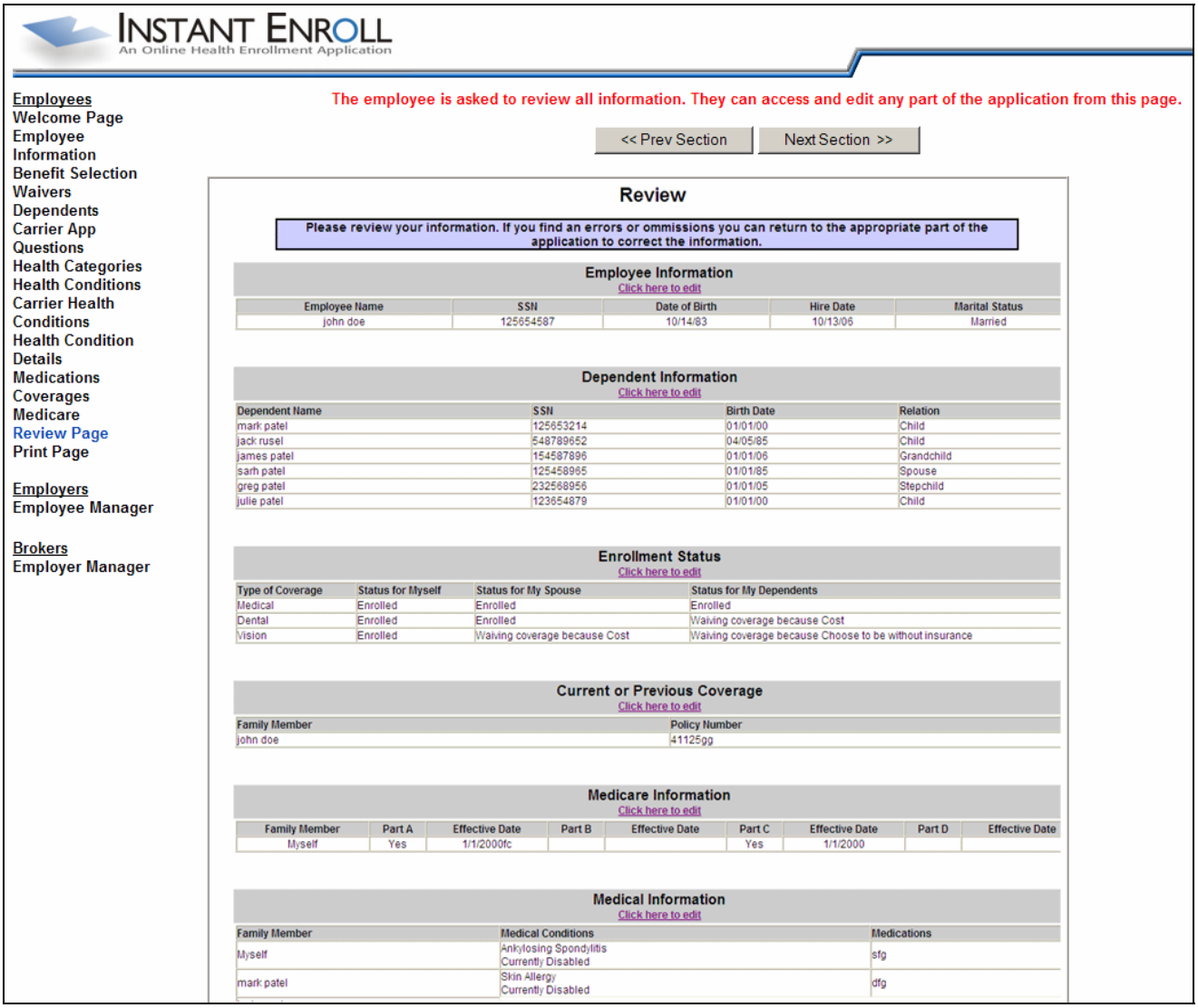
If you selected medicare, you are required to fill in details.
<< Prev Section
Next Section >>
Medicare
Enter the medicare information for you and/or your spouse. Once the medicare information is added click Continue to continue the application.
Please attach copies of all Medicare Cards when you send your application(s).
Previous
Continue
Self
Reason
Age
Part A Effective Date End Date
Part B Effective Date End Date
Part C Effective Date End Date
Part D Effective Date End Date
Spouse
Reason
Part A Effective Date End Date
Part B Effective Date End Date
Part C Effective Date End Date
Part D Effective Date End Date
Previous
Continue
<< Prev Section
Next Section >>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The employee is asked to review all information. They can access and edit any part of the application from this page.
<< Prev Section
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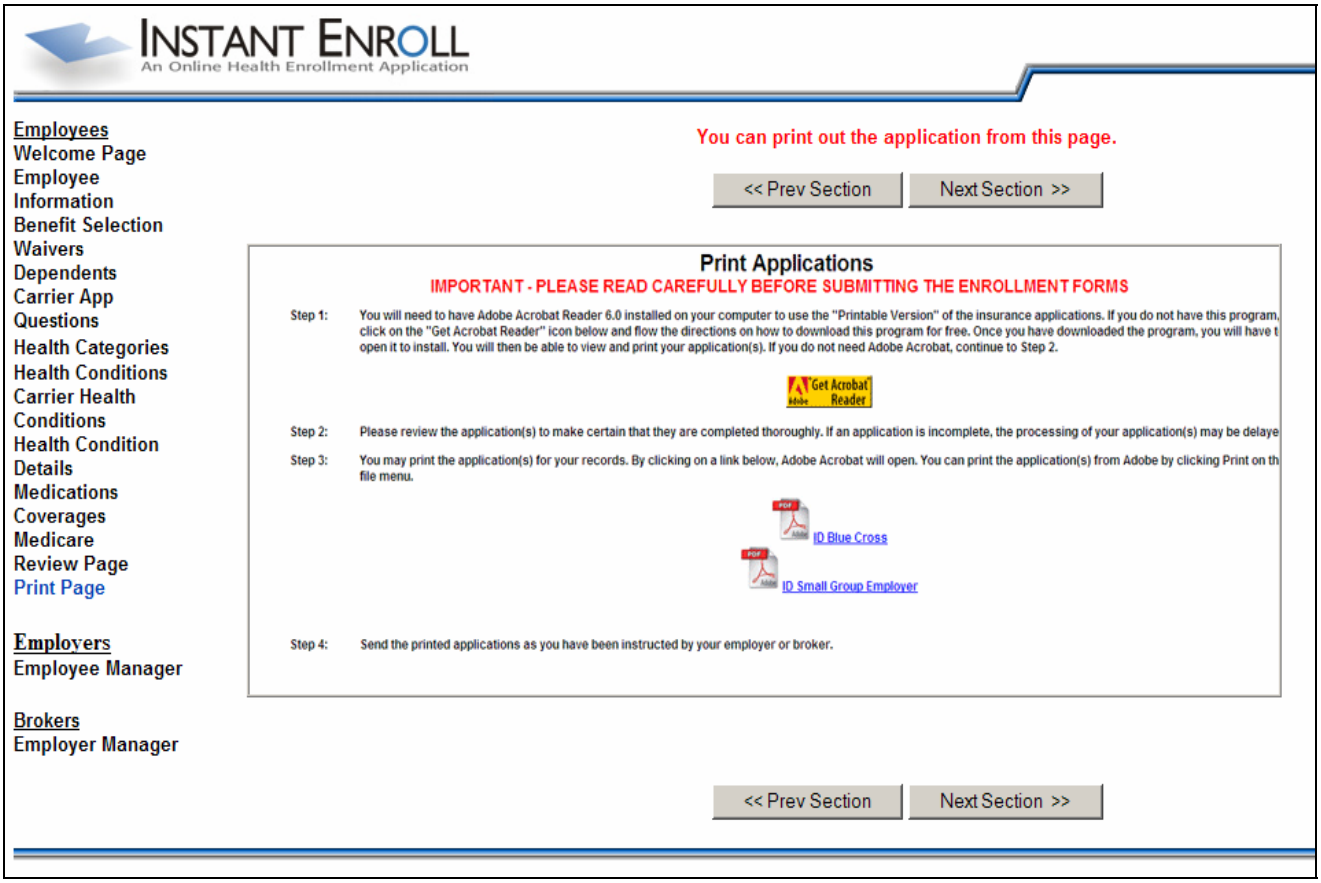
Review
Please review your information. If you find an errors or ommissions you can return to the appropriate part of the application to correct the information.
Employee Information
Click here to edit
Employee Name | SSN | Date of Birth | Hire Date | Marital Status
john doe | 125654587 | 10/14/83 | 10/13/06 | Married
Dependent Information
Click here to edit
Dependent Name | SSN | Birth Date | Relation
mark patel | 125653214 | 01/01/00 | Child
jack rusel | 548789652 | 04/05/85 | Child
james patel | 154587896 | 01/01/06 | Grandchild
sarh patel | 125458965 | 01/01/85 | Spouse
greg patel | 232568956 | 01/01/05 | Stepchild
julie patel | 123654879 | 01/01/00 | Child
Enrollment Status
Click here to edit
Type of Coverage | Status for Myself | Status for My Spouse | Status for My Dependents
Medical | Enrolled | Enrolled | Enrolled
Dental | Enrolled | Enrolled | Waiving coverage because Cost
Vision | Enrolled | Waiving coverage because Cost | Waiving coverage because Choose to be without insurance
Current or Previous Coverage
Click here to edit
Family Member | Policy Number
john doe | 41125gg
Medicare Information
Click here to edit
Family Member | Part A | Effective Date | Part B | Effective Date | Part C | Effective Date | Part D | Effective Date
Myself | Yes | 1/1/2000fc | | | Yes | 1/1/2000 | |
Medical Information
Click here to edit
Family Member | Medical Conditions | Medications
Myself | Ankylosing Spondylitis Currently Disabled | sfg
mark patel | Skin Allergy Currently Disabled | dfg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You can print out the application from this page.
<< Prev Section
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Print Applications
IMPORTANT - PLEASE READ CAREFULLY BEFORE SUBMITTING THE ENROLLMENT FORMS
Step 1: You will need to have Adobe Acrobat Reader 6.0 installed on your computer to use the "Printable Version" of the insurance applications. If you do not have this program, click on the "Get Acrobat Reader" icon below and flow the directions on how to download this program for free. Once you have downloaded the program, you will have t open it to install. You will then be able to view and print your application(s). If you do not need Adobe Acrobat, continue to Step 2.
Get Acrobat Reader
Step 2: Please review the application(s) to make certain that they are completed thoroughly. If an application is incomplete, the processing of your application(s) may be delaye
Step 3: You may print the application(s) for your records. By clicking on a link below, Adobe Acrobat will open. You can print the application(s) from Adobe by clicking Print on th file menu.
ID Blue Cross
ID Small Group Employer
Step 4: Send the printed applications as you have been instructed by your employer or broker.
<< Prev Section
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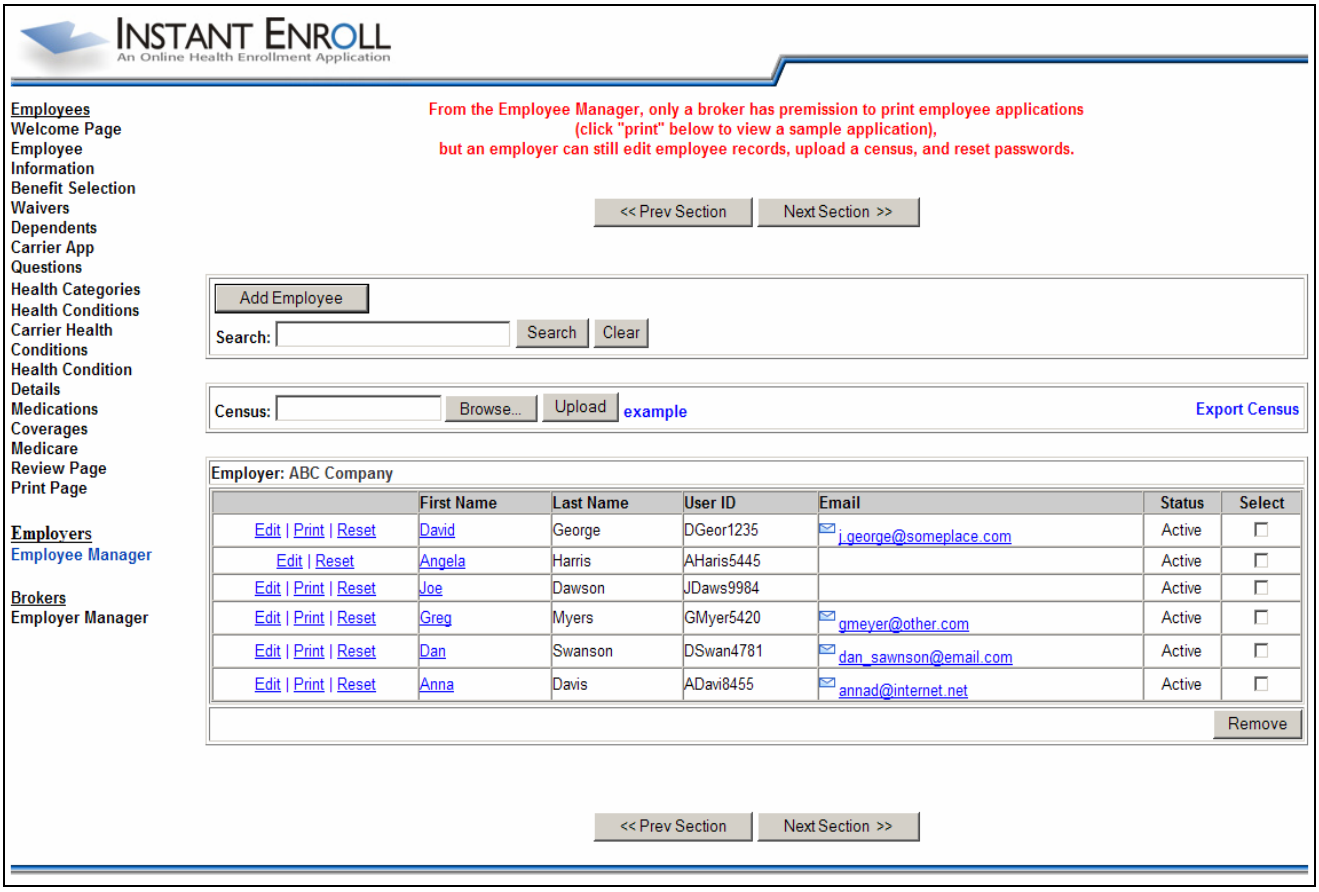
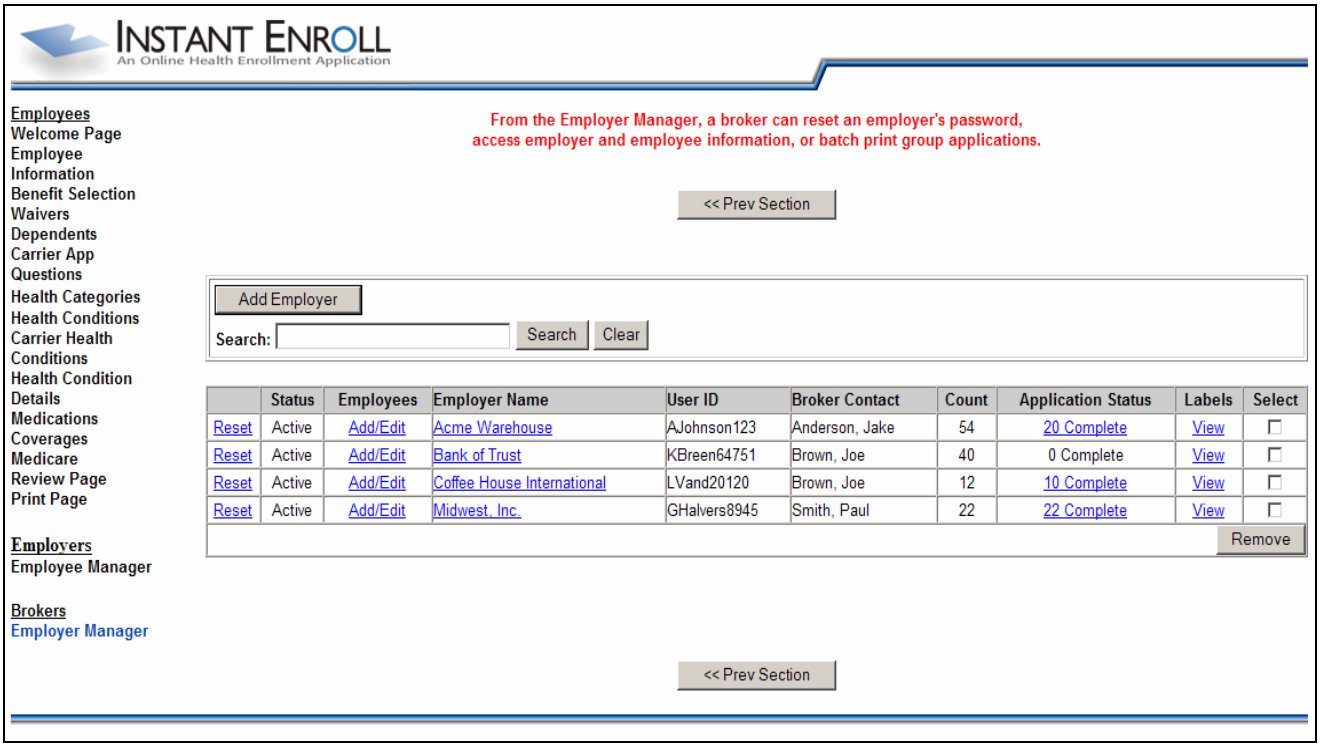

INSTANT ENROLL
An Online Health Enrollment Application
Employees
Welcome Page
Employee Information
Benefit Selection
Waivers
Dependents
Carrier App Questions
Health Categories
Health Conditions
Carrier Health Conditions
Health Condition Details
Medications
Coverages
Medicare
Review Page
Print Page
Employers
Employee Manager
Brokers
Employer Manager
From the Employee Manager, only a broker has premission to print employee applications
(click "print" below to view a sample application),
but an employer can still edit employee records, upload a census, and reset passwords.
<< Prev Section
Next Section >>
Add Employee
Search:
Search
Clear
Census:
Browse...
Upload
example
Export Census
Employer: ABC Company
First Name
Last Name
User ID
Email
Status
Select
Edit | Print | Reset
David
George
DGeor1235
j.george@someplace.com
Active
Edit | Reset
Angela
Harris
AHaris5445
Active
Edit | Print | Reset
Joe
Dawson
JDaws9984
Active
Edit | Print | Reset
Greg
Myers
GMyer5420
gmeyer@other.com
Active
Edit | Print | Reset
Dan
Swanson
DSwan4781
dan_sawnson@email.com
Active
Edit | Print | Reset
Anna
Davis
ADavi8455
annad@internet.net
Active
Remove
<< Prev Section
Next Section >>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Employers
Employee Manager
Brokers
Employer Manager
From the Employer Manager, a broker can reset an employer's password, access employer and employee information, or batch print group applications.
<< Prev Section
Add Employer
Search:
Search
Clear
Status
Employees
Employer Name
User ID
Broker Contact
Count
Application Status
Labels
Select
Reset Active Add/Edit Acme Warehouse AJohnson123 Anderson, Jake 54 20 Complete View
Reset Active Add/Edit Bank of Trust KBreen64751 Brown, Joe 40 0 Complete View
Reset Active Add/Edit Coffee House International LVand20120 Brown, Joe 12 10 Complete View
Reset Active Add/Edit Midwest, Inc. GHalvers8945 Smith, Paul 22 22 Complete View
Remove
<< Prev Section