

Master Group Application

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

For 2-50 employees

Effective July 1, 2007

Get on the fast track

This handy check list will make it easier for you to assemble all the information and forms we need to process your application package. Check all the boxes, and it's ready to go!

- | | |
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| <ul style="list-style-type: none"> <input type="checkbox"/> Master group application (form C15835) <input type="checkbox"/> Employees' enrollment applications (form C12914) <input type="checkbox"/> Health Statements (form C15825) are required for guaranteed issue groups of 2-14 enrolling employees and all non-guaranteed issue groups. <input type="checkbox"/> Employer Questionnaires (form C15146) are required for guaranteed issue groups of 15 or more eligible enrolling employees. These must be dated within 45 days of the requested effective date. <input type="checkbox"/> "Sole Proprietor, Partner, or Corporate Officer Statement" (form C15293) for all enrolling owners/officers. <input type="checkbox"/> Wage information for each enrolling employee will be required for eligibility verification as follows: <ul style="list-style-type: none"> • DE-6 for the previous quarter (notate updated employee status, i.e. part-time, full-time, or terminated). • All four DE-6s from the previous year if group eligibility is based on, or includes, part-time employees. • Payroll records (for employees hired after the DE-6 filing). • Proof of owner/employer's eligibility if the owner/employer is not listed on the DE-6 (same as noted under "Owner Only Groups" below). <input type="checkbox"/> Refusal of Coverage Forms for all eligible employees and any eligible dependents who refuse coverage. <input type="checkbox"/> A copy of the previous carrier's current billing statement (if applicable) | <ul style="list-style-type: none"> <input type="checkbox"/> Disability form (if applicable) <input type="checkbox"/> A business check in the amount of the first month's dues as a deposit. Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield Life) will refund the full deposit to the group if the group application is declined. <input type="checkbox"/> For groups that choose Blue Shield dental HMO or dental PPO, vision or life insurance with medical, only one binder check is required. Simply note the portion of each product's dues on the check, payable to Blue Shield. <input type="checkbox"/> Owner Only Groups will be required to submit documentation verifying that they are active businesses, employing permanent, full-time employees, including but not limited to the following documentation: <ul style="list-style-type: none"> • Sole Proprietorship: 1040 Schedule C for the preceding calendar year • Partnership: K-1 for the preceding year for each partner <p>Corporation: Articles of Incorporation (state seal affixed) including officers; K-1 or signed refusal for each officer eligible for coverage.</p> |
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Master Group Application (for 2-50 enrolling employees)

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Group billing unit

Do not write in shaded area

Access+ HMO [®] plans	Shield Spectrum PPO SM plans	Added Advantage POS SM plan	Shield Spectrum PPO SM Savings plans
Active Choice SM plans*	Access Baja [®] HMO plans	Dental HMO plans	Dental PPO plans
Other			

Please type or print clearly. Use black ink.

1 Full legal business name Effective date

2 Billing address: Number, street, city, state, ZIP (If P.O. Box, complete No. 3 below)

3 Physical address of business (if different from above) County

4 Group contact name/title

Phone number ()	Fax number ()
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E-mail address:

5 Legal entity Corporation Partnership Sole proprietorship Other (specify)

6 Type of business (provide as much detail as possible):

List the major industries and products/services of your business

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.....

Standard industry classification code(s) (SIC Code) in which the business is classified:

7 List subsidiary, or affiliated companies. Give name(s), address(es). Identify which subsidiaries should be included in the coverage.

.....

.....

If no subsidiary/affiliated companies apply, check "N/A" N/A

8 Prior group health carrier(s)	Do you offer other carriers' health plans to your employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, enter dates of open enrollment period From: _____ To: _____
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If other health carrier is offered (in addition to Blue Shield), list carrier name and number of employees covered by this carrier

Name: _____ No. of employees: _____

Are you planning to offer any type of self-funded wrap-around plan, in addition to your Blue Shield PSP 2250 plan? Yes No

Please note: The PSP 2250 (HSA-eligible) plan may be used in conjunction with any partially self-funded Section 105 wrap-around product.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

9 New employee waiting period: _____ months (minimum 0, maximum 6 months).
The employees effective date is the first bill date following their waiting period.
Examples: Employee hired 8/1/05 with a three-month waiting period will have an effective date of 11/1/05.
Employee hired on 8/2/05 with a three-month waiting period will have an effective date of 12/1/05.
Will the waiting period be waived: For current, actively at work employees Yes No

If the group has a special exception to waiting period of managerial/executive new hires, please indicate here (minimum 0, maximum of 6 months):

10 Total No. of employees _____ Total No. of **eligible** employees _____ Total No. of **enrolled** employees _____
For 2-50 enrolling employees, please have them complete the Employee Application (C12914). If you have 2-14 enrolling employees, they must also fill out the Health Statement (C15825).

Number of full-time employees in waiting period: _____ Number of employees who are declining coverage: _____

Employer is responsible for collecting refusal of coverage.

For employers of fewer than 20 employees:

Do you currently have an employee who is eligible for Blue Shield Medicare Primary Rates? Yes No

If yes, please provide a copy of qualifying Medicare card(s).

Are there any out-of-state employees? Yes No How many out-of-state employees do you have? _____

Do you wish to offer coverage to your out-of-state employees? Yes No

11 **Are all full-time eligible employees being offered health coverage?** Yes No If no, please explain:

Are all of the full-time eligible employees to whom you will be offering health coverage actively working at least 30 hours per week?

Yes No If no, please explain:

Do you wish to offer coverage for your permanent employees who work fewer than 30 but not fewer than 20 hours per week?

Yes No

12 **Domestic partner coverage** (check one) – Domestic partners in Options 1 and 2 must also meet Blue Shield’s dependent eligibility requirements as contractually defined.

1. Narrow coverage: California state registered (both partners have filed a Declaration of Domestic Partnership with the state of California. Both partners must be the same sex. Opposite sex partners allowed if one partner is at least 62 and eligible for Social Security)

2. Broad coverage: California state registration not required (both partners may be the same or opposite sex)

13 Are all employees covered by workers’ compensation to the extent required by law?

Yes Carrier name: _____

No If no, please explain:

14 Are any COBRA participants enrolling in a Blue Shield/Blue Shield Life plan disabled or hospitalized, or are any active employees currently not working, disabled, or hospitalized? Yes No If yes, complete Disability Addendum Form No. C11248.

15 Your group is subject to federal COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year.

A) Is your group currently subject to Cal-COBRA? (Employed 2-19 employees for at least 50% of the working days in the previous calendar year.) Yes No

B) Is your group subject to federal COBRA? (Employed 20 employees for at least 50% of the working days in the previous calendar year.) Yes No

C) How many existing COBRA or Cal-COBRA participants do you have? _____ How many in eligibility period? _____

Medical Benefits

16 Dual Choice Check this box for Dual Choice. (2+ employees) Choose one Access+ HMO plan and one other non-HMO plan

PlanSelectSM Packages Select the appropriate combination of plans except Access Baja plans.

Employers can offer Access Baja in addition to PlanSelect. (See Small Group UW Guidelines for requirements.)

5+ subscribers¹ All plans (available to groups with 5+ subscribers only)

Access+ HMO

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Access+ HMO Plan 5 | <input type="checkbox"/> Access+ HMO Plan 10 | <input type="checkbox"/> Access+ HMO Plan 15 | <input type="checkbox"/> Access+ HMO Plan 20 |
| <input type="checkbox"/> Access+ HMO Plan 30 | <input type="checkbox"/> Access+ HMO Plan 25 | <input type="checkbox"/> Access+ HMO Plan 40 | |

Shield Spectrum PPO

- | | | |
|---|---|--|
| <input type="checkbox"/> Shield Spectrum PPO Plan Zero Deductible | <input type="checkbox"/> Shield Spectrum PPO Plan 250 Premier | <input type="checkbox"/> Shield Spectrum PPO Plan 250 Standard |
| <input type="checkbox"/> Shield Spectrum PPO Plan 500 Premier | <input type="checkbox"/> Shield Spectrum PPO Plan 500 Standard* | <input type="checkbox"/> Shield Spectrum PPO Plan 500 Value* |
| <input type="checkbox"/> Shield Spectrum PPO Plan 750 Value* | <input type="checkbox"/> Shield Spectrum PPO Plan 1000 Value* | <input type="checkbox"/> Shield Spectrum PPO Plan 1500 Value* |
| <input type="checkbox"/> Shield Spectrum PPO Plan 1000 | <input type="checkbox"/> Shield Spectrum PPO Plan 3000* | |

Shield Spectrum PPO Savings²

- | | |
|---|--|
| <input type="checkbox"/> Shield Spectrum PPO Savings Plan 2250 | <input type="checkbox"/> Shield Spectrum PPO Savings Plan 2500* |
| <input type="checkbox"/> Shield Spectrum PPO Savings Plan 3400* | <input type="checkbox"/> Shield Spectrum PPO Savings Plan 4800 Individual/9600 Family* |

Added Advantage POS

- Added Advantage POS Plan

Active Choice Plan*

- Active Choice Plan 750 SG
 Active Choice Plan 500 SG

Access Baja HMO

- Access Baja HMO Plan 5
 Access Baja HMO Plan 10

Other

(Specify) _____

Foundation Group?

- Yes No (Local foundation for medical care in Kern county, Mendocino/Lake counties, and Tulare/Kings counties)

For PlanSelect packages only: The employer must contribute a defined contribution of \$100 per employee (or the cost of the total employee rates, whichever is less), or 50% of the total employee rates.

Indicate amount of defined contribution here: For employees ____% or \$ ____ For dependents ____% or \$ ____

For all other plan offerings:

For employer contribution, enter percent of dues paid (must be at least 50% of total employee rates) by employer for employees and dependents. If 100%, all eligible employees must enroll. (Does not apply to PlanSelect packages. See below for PlanSelect packages requirements.)

Access+ HMO Plans	Employees ____% Dependents ____%	Shield Spectrum PPO Plans	Employees ____% Dependents ____%	Dental PPO Plans	Employees ____% Dependents ____%
Added Advantage POS Plan	Employees ____% Dependents ____%	Shield Spectrum PPO Savings Plans	Employees ____% Dependents ____%	Dental HMO Plans	Employees ____% Dependents ____%
Active Choice Plans*	Employees ____% Dependents ____%				

Optional Benefits (cannot be purchased without a medical plan)

17 For Dual Choice and PlanSelect packages, each optional benefit must be purchased for all medical plans selected.

- | | | |
|--|--|--|
| <input type="checkbox"/> Inpatient substance abuse treatment | <input type="checkbox"/> Vision Basic 0/130 | <input type="checkbox"/> Flexible spending account: Flex 1-2-3 |
| <input type="checkbox"/> Infertility rider | <input type="checkbox"/> Vision Basic 10/130 | <input type="checkbox"/> Premium only plan (POP) |
| <input type="checkbox"/> Access+ HMO and/or POS chiropractic rider | <input type="checkbox"/> Vision Basic 0/100 | |
| <input type="checkbox"/> Access+ HMO and/or POS chiropractic/acupuncture rider | <input type="checkbox"/> Vision Basic 10/75 | |

¹ 75% participation in Blue Shield PlanSelect plans required with a minimum of 5 or more employees enrolled.

² HSA-eligible high-deductible health plan.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Shield Spectrum PPO Plan 750 Value, Plan 1000 Value, and Plan 1500 Value are pending regulatory review.

Dental Benefits (can be purchased with or without a medical plan)

18 Dual Option Check this box for Dual Option (2+ employees). Choose any two dental plans.

- | | |
|--|--|
| <input type="checkbox"/> Dental PPO – Smile SM Basic 75/1000/No Ortho/MAC | <input type="checkbox"/> Dental PPO – Smile Deluxe Plus 2000 50/2000/Ortho/MAC |
| <input type="checkbox"/> Dental PPO – Smile Value 50/1500/No Ortho/MAC | <input type="checkbox"/> Dental PPO – Smile Deluxe Gold 50/1500/Ortho/U85 |
| <input type="checkbox"/> Dental PPO – Smile 50/1500/No Ortho/MAC | <input type="checkbox"/> Dental PPO – Smile Basic Voluntary 75/1000/No Ortho/MAC |
| <input type="checkbox"/> Dental PPO – Smile Plus 50/1500/Ortho/MAC | <input type="checkbox"/> Dental HMO Basic |
| <input type="checkbox"/> Dental PPO – Smile Plus Gold 50/1500/Ortho/U85 | <input type="checkbox"/> Dental HMO Voluntary |
| <input type="checkbox"/> Dental PPO – Smile Deluxe 2000 50/2000/No Ortho/MAC | <input type="checkbox"/> Dental HMO Plus |
| <input type="checkbox"/> Dental PPO – Smile Deluxe 50/1500/Ortho/MAC | <input type="checkbox"/> Dental HMO Deluxe |
| | <input type="checkbox"/> Other Dental (specify) _____ |

Group Term Life AD&D Insurance

19 Employee Life: minimum benefit \$15,000. If choosing graded, include class description.

- Flat \$ _____ Multiple of salary _____ times salary, maximum \$ _____
- Graded \$ _____, _____; \$ _____, _____; \$ _____, _____
- Class description Class description Class description

- 100% employer paid Contributory: Employer pays _____% for employees (minimum 25%, _____% for dependents)

Eligibility: All full-time employees Only those employees enrolled in the Blue Shield/Blue Shield Life Medical Plan

Dependent life: \$ _____ spouse/domestic partner/child(ren) (min. \$1,000/max. \$5,000, in \$1,000 increments; spouse/ domestic partner benefit must equal child benefit). To be eligible for life coverage, applicants must be actively at work for a minimum of 20 hours per week and cannot be enrolling in the Access Baja plans.

Authorization the following authorization section must be signed

(Blue Shield of California/Blue Shield Life requires an original copy of this legal document with original signature)

20 This is an application for coverage only. No contract for coverage will exist until Blue Shield/Blue Shield Life has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted and a group health service contract/group policy will be issued. I certify to the best of my knowledge and belief, all of the responses given are true, correct, and complete. I understand that if I have misrepresented or omitted any material fact, any coverage approved by Blue Shield/Blue Shield Life may be cancelled, the Health Service Contract/Insurance policy rescinded, or the applicable dues/rates adjusted.

Authorized Signature

Name and title (please print)

Date

NOTE: Blue Shield Life does not offer life insurance coverage to employers of under 10 employees due to state law. However, by applying to become a participating employer in the Small Employer Group Trust, this coverage may be obtained. Employer understands that the Small Employer Group Trust and its underwriting company may rely on this application and any individual applications, deciding whether to allow Employer to participate in the Small Employer Group Trust. Employer understands and agrees that no coverage shall be effective: 1) before the date determined by the Small Employer Group Trust and its underwriting company; and 2) before Employer has paid for the first month's premium. Employer understands and agrees that the Employer will receive a Small Employer Group Trust Participation Amendment and such Participation Amendment shall be incorporated into and become a part of the Small Employer Group Trust group life insurance policy. Employer understands and agrees that the Small Employer Group Trust shall provide Employer with a copy of such Small Employer Group Trust group life insurance policy, and that all communications regarding such policy shall be addressed to and handled directly by the Small Employer Group Trust and its underwriting company.

Producer Information (to be completed by producer or general agent)

21 Producer name		Producer e-mail	
Phone number ()		Fax number ()	
Producer street address (P.O. Box not acceptable)			
City		State	ZIP
General Agent Tax ID number		Producer Tax ID number (Commissions will be reported under this number)	
Department of Insurance license number		Region	Code number
Is this a split commission? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of second producer and percentage	
General agent name		General agent e-mail	
Would you prefer to be contacted by fax or e-mail?			
Today's date (required) ____ / ____ / ____	Producer signature (required) X_____	Print name _____	

I certify to the best of my knowledge and belief, all responses given above are true and correct and complete.

Blue Shield account executive	Phone number	Fax number	Office number
Sales representative and region		Account manager/service representative (if applicable)	