

Small Business Group Application

Effective March 1, 2008

Source Code	Tracking #
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Important: Please Print or Type All Sections in Black Ink				
Legal Name of Group/DBA		Phone ()	Fax ()	E-mail Address
Address	City	County	State	ZIP
<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other:		Start Date of Business	Employer Tax ID#	
Executive/Employer Contact		Title	Phone ()	E-mail Address
Administrative/Service Contact		Title	Phone ()	E-mail Address
Billing Contact		Title	Phone ()	E-mail Address
Billing Address		City	State	ZIP
List Current Medical Carrier(s):			Years with Carrier:	
Are you subject to a local living wage law? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Did you have health care coverage for the employees under the local living wage law prior to January 1, 2003? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you subject to ERISA regulations? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you currently have a workers' compensation policy in force? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of Business	SIC Code	List current workers' compensation carrier:		
Are all employees covered under workers' compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, please state reason:		
Please list the name and job title of all individuals to be included for medical coverage not eligible for workers' compensation:				
Name		Title	E-mail Address	
Name		Title	E-mail Address	
Total number of eligible employees enrolling in PacifiCare:		Medical:	Dental:	Vision:
Number of eligible employees waiving medical coverage:	Number of permanent full-time (30+ hours per week) employees:	Number of permanent full-time (30+ hours per week) employees who work or reside outside of CA :		
Please complete if offering health care coverage to permanent part-time employees (at least 20 but less than 29 hours per week):		Number of permanent part-time employees:	Number of permanent part-time employees who work or reside outside of CA :	

Contribution		
Medical (Employer: 50% min.)	Dental (Employer: 50% min.)	Vision (Employer: 50% min.)
Employee _____ %	Employee _____ %	Employee _____ %
Dependents _____ %	Dependents _____ %	Dependents _____ %

Eligibility		
NOTE: Independent contractors whose income is reported on IRS Form 1099, part-time, seasonal and leased employees are ineligible. Eligible employees and rehires must be full-time permanent employees who work at least thirty (30) hours per week or permanent part-time employees who work at least twenty (20) hours per week but not more than twenty-nine (29) hours per week, and the employer offers employees health coverage under a health benefit plan to all similarly situated individuals. In addition, eligible employees must complete the employer's required waiting period of: _____ (max. 6 months).		
Rehire Eligibility: 1st of month following _____ months	Total employees in waiting period: _____	How long do you continue paying health care premiums for employees on leave of absence? (max. 6 months): _____

Continuation Coverage

Is your group subject to Federal COBRA (20 or more total employees during at least 50% of the working days in the previous Calendar Year) or Cal-Cobra (less than 20 Eligible Employees during at least 50% of the working days in the previous Calendar Year or previous calendar quarter)?
 Federal COBRA Cal-COBRA

Please provide details on ALL COBRA participants below. In addition, please provide a list of AB1401 COBRA, Cal-COBRA and/or Senior COBRA enrollees from your current carrier.

Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date

If AB1401 COBRA, Cal-COBRA and/or Senior COBRA enrollees are added after the initial group enrollment, the group may be subject to re-rate.

Plan Coverage

Requested effective date: (coverage must begin 1st of the month) *Note: PacifiCare SignatureEliteSM plans are underwritten by PacifiCare Life and Health Insurance Company.*

Medical Plans

Select one or more plans, up to a maximum of four. Plans indicated with an asterisk (*) are only available on a Stand Alone basis. Groups must have at least five eligible employees enrolling with PacifiCare to purchase more than one plan. PacifiCare SignatureValue plans may not be offered alongside PacifiCare SignatureValue Advantage plans.	PacifiCare SignatureValue[®] (HMO) and PacifiCare SignatureValue[®] Advantage (HMO)		PacifiCare SignatureElite[®] (PPO)
	HMO	HMO Advantage	<input type="checkbox"/> 15/90-50/250 <input type="checkbox"/> 20/80-60/250 <input type="checkbox"/> 30/70-50/250 <input type="checkbox"/> 35/80-60/500 <input type="checkbox"/> 35/70-50/1000 <input type="checkbox"/> 35/50-50/1000 <input type="checkbox"/> 70-50/2000* <input type="checkbox"/> 70-50/3500*
	PacifiCare SignaturePOS[®] (POS)		
	<input type="checkbox"/> 15/80-60*		

Please answer the following question:
 Will you self-fund any portion of your employees' cost-sharing by offering a wrap-around plan, such as a Health Reimbursement Account (HRA), in addition to your PacifiCare Small Group plan? Yes No
 If **No**, and a group does not indicate they have an HRA or adds one after the initial group enrollment, the group may be subject to re-rate.

¹ By selecting this plan, the Group has chosen not to offer Infertility Services to its employees. The Group understands that PacifiCare covers Infertility Services in other Small Business plans.

Supplemental Benefits		Other Coverage (required)
<input type="checkbox"/> Group Term Life (Separate Group Application required)	<input type="checkbox"/> Chiropractic/Acupuncture Supplemental Chiropractic/ Acupuncture through an arrangement with ACN Group of California, Inc. (for PacifiCare SignatureValue, PacifiCare SignatureValue Advantage and PacifiCare SignaturePOS only)	Domestic Partners Coverage All PacifiCare plans include Domestic Partner coverage as required by state law.

Dental and Vision Plans	
PacifiCare SignatureValue [®] (HMO)	PacifiCare SignatureOptions [®] (PPO)
Contributory	Contributory
<input type="checkbox"/> Dental 140 <input type="checkbox"/> Dental 142 <input type="checkbox"/> Dental 144 <input type="checkbox"/> Dental 146	<input type="checkbox"/> Vision 480 <input type="checkbox"/> Vision 490 Please choose: Material Deductible <input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$20

Signature Required for Terms and Conditions and Arbitration Disclosure

Terms and Conditions

I hereby certify that all statements on this document are complete and true to the best of my knowledge and belief, and I understand that PacifiCare will rely on these statements and this information as the basis for approving this Application. I have read and understand the information herein. Further, the authorized person agrees to PacifiCare's payment terms and conditions. Undersigned represents that he/she is an authorized person of the small employer group applying for the coverage indicated above and is authorized to enter into a PacifiCare Health Plan Medical and Hospital Group Subscriber Agreement and/or PacifiCare Life and Health Insurance Co. Group Policy on the small employer group's behalf. It is understood for the purposes of compliance with ERISA, the undersigned employer is to be named fiduciary of the employee benefit plan covered under this policy.

Arbitration Disclosure

EMPLOYER AGREES AND UNDERSTANDS THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, INC., OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Authorized Signature	Date
Print Name	Title

Check here if you do not have a broker of record. If you do, please complete the information below:

PacifiCare compensates Agents/Brokers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use an Agent/Broker. Please contact your Agent/Broker, if applicable, regarding the amount of compensation. In addition, you may request information regarding broker commissions attributable to your policy by contacting PacifiCare Membership Accounting.

Broker Information				
(Signature above acknowledges broker assignment) If a split commission, please attach payee information including percentages for each payee.				
Agent Name	Firm Name	Phone ()	E-mail Address	
Address	City	State	ZIP	Fax ()
Payee: <input type="checkbox"/> Agent or <input type="checkbox"/> Firm				
Payee's SS# or Tax ID #:		Payee's California License #:		Expiration Date
Broker Signature				

General Agent Information				
General Agent Name		Phone ()		
Address	City	State	ZIP	TIN #

FOR INTERNAL USE ONLY:

G.A. #	A.P. #	MKTG. #	G.C. #
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PacifiCare products and services are offered by one or more of the following PacifiCare family of companies: Health plan products and services are offered by PacifiCare of California, PacifiCare Behavioral Health of California, Inc., and PacifiCare Dental (in California). Indemnity insurance products (including PPO products) are underwritten by PacifiCare Life and Health Insurance Company. Other products and services are offered by PacifiCare Health Plan Administrators, Inc., RxSolutions, Inc., and PacifiCare Behavioral Health, Inc. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

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Dental & Vision Administrators Employer Agreement

Small employer groups who are electing dental and/or vision coverage

- I understand the pre-existing conditions limitations of the insurance plan and understand that coverage is renewable at the option of the Underwriting Company.
- I understand the underwriting and participation requirements and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The Open Enrollment period shall be during group's 11th month of annual continuous coverage.
- The PacifiCare SignatureOptions vision plans are underwritten by PacifiCare Life and Health Insurance Company.
- The PacifiCare SignatureValue dental plans are offered by PacifiCare Dental.

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge. I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Signature of Authorized Person for Employer Date Signed

Broker or General Agent Signature Date Signed

For Case Submission instructions, please contact your PacifiCare Sales Representative at 1-866-288-4993.

Customer Service:

- PacifiCare SignatureValue® (HMO): 1-800-624-8822 or 1-800-442-8833 (TDHI)
- PacifiCare SignaturePOS® (POS): 1-800-913-9133 or 1-800-442-8833 (TDHI)
- PacifiCare SignatureEliteSM (PPO): 1-866-316-9776 or 1-866-816-2018 (TDHI)
- PacifiCare Dental and Vision Administrators: 1-800-228-3384



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