Master group application

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

For 2 to 50 eligible employees

Effective July 1, 2008

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!

- ☐ Master group application (form C15385)
- ☐ Employee enrollment applications (form C12914)
- ☐ Health Statements (form C15825) are required for guaranteed-issue groups of 2 to 14 enrolling employees and all non-guaranteed-issue groups.
- ☐ Employer Questionnaires (form C15146) are required for guaranteed-issue groups of 15 or more enrolling employees. These must be dated within 45 days of the requested effective date.
- ☐ "Sole Proprietor, Partner, or Corporate Officer Statement" (form C15293) for all enrolling owners/officers.
- ☐ Wage information for each enrolling employee will be required for eligibility verification as follows:
  - 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).
- ☐ Refusal of Coverage Forms for all eligible employees and any eligible dependents who refuse coverage. Refusal of Coverage Forms are not required for dental or life insurance only applications.
- ☐ A copy of the previous carrier's current billing statement (if applicable)
- ☐ Disability form (if applicable)
- ☐ 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.
- ☐ 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.
- ☐ 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:
  - Sole Proprietorship: 1040 Schedule C for the preceding calendar year
  - Partnership: K-1 for the preceding year for each partner
  - Corporation: Articles of Incorporation (state seal affixed) including officers; K-1 or signed refusal for each officer eligible for coverage.

An Independent Member of the Blue Shield Association

Master Group Application (for 2 to 50 eligible 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℠ plans	Added Advantage POS℠ plan	Shield Spectrum PPO℠ Savings plans
Active Choice℠ 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 ( )

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

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

7 List subsidiary or affiliated companies. Give name(s) and 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)

Begin date End date

Do you offer other carriers' health plans to your employees? ☐ Yes ☐ No

If yes, enter dates of open enrollment period From:__________ To:___________

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 2250/4500 plan? ☐ Yes ☐ No
Please note: The PSP 2250/4500 (HSA-eligible) plan is the only available plan to 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).

New employees are eligible for enrollment the first billing date following completion of the group's waiting period.

Example: Employee hire date is 8/1/07, and the group has a three-month waiting period – employee is eligible for enrollment effective 11/1/07. If hire date is 8/2/07, and the group has a three-month waiting period, employee is eligible for enrollment effective 12/1/07.

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 to 50 enrolling employees, please have them complete the Employee Application (C12914). If you have 2 to 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 enrolled in Medicare? ☐ 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 A) Is your group subject to federal COBRA? ☐ Yes ☐ No

B) How many existing COBRA or Cal-COBRA participants do you have? ______________ How many in eligibility period? ___________

Medical benefits

16 **Dual Choice[1]** ☐ Check this box for Dual Choice (2+ enrolling employees). Choose one Access+ HMO plan and one other non-HMO plan.

Suite Deal Package[1, 2] ☐ Check this box to offer all of the specified plans listed below (2+ enrolling employees). Employers can offer Access Baja® HMO in addition to the Suite Deal Package.

Access+ HMO	Shield Spectrum PPO	Shield Spectrum PPO Savings[5]
Access+ HMO Plan 20 Value	Shield Spectrum PPO Plan 500 Value*	Shield Spectrum PPO Savings Plan 1800/3600*
Access+ HMO Plan 30	Shield Spectrum PPO Plan 1000 Value*	Shield Spectrum PPO Savings Plan 3000/6000*
	Shield Spectrum PPO Plan 1500 Value*	

PlanSelect[SM] Packages[3,4] Groups with 2 to 50 enrolled employees, select between 2 and up to 27 plans, not including Access Baja plans. Employers can offer Access Baja in addition to PlanSelect.

☐ **All plans** ☐ **Selected plans (choose from below)**

Access+ HMO

☐ Access+ HMO Plan 5	☐ Access+ HMO Plan 10	☐ Access+ HMO Plan 15	☐ Access+ HMO Plan 20
☐ Access+ HMO Plan 20 Value	☐ Access+ HMO Plan 30	☐ Access+ HMO Plan 25	☐ Access+ HMO Plan 40

Shield Spectrum PPO

☐ Shield Spectrum PPO Plan, Zero Deductible	☐ Shield Spectrum PPO Plan 250 Premier	☐ Shield Spectrum PPO Plan 250 Standard
☐ Shield Spectrum PPO Plan 500 Premier	☐ Shield Spectrum PPO Plan 500 Standard*	☐ Shield Spectrum PPO Plan 1000
☐ Shield Spectrum PPO Plan 500 Value*	☐ Shield Spectrum PPO Plan 750 Value*	☐ Shield Spectrum PPO Plan 3000*
☐ Shield Spectrum PPO Plan 1000 Value*	☐ Shield Spectrum PPO Plan 1500 Value*	

Shield Spectrum PPO Savings[5]

☐ Shield Spectrum PPO Savings Plan 1800/3600*	☐ Shield Spectrum PPO Savings Plan 2250/4500
☐ Shield Spectrum PPO Savings Plan 2500*	☐ Shield Spectrum PPO Savings Plan 3000/6000*
☐ Shield Spectrum PPO Savings Plan 4800*	

Added Advantage POS	Active Choice Plan[6,*]	Access Baja HMO
☐ Added Advantage POS Plan	☐ Active Choice Plan 750 SG	☐ Access Baja HMO Plan 5
	☐ Active Choice Plan 500 SG	☐ Access Baja HMO Plan 10

Optional benefits (cannot be purchased without a medical plan)

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

☐ Inpatient substance abuse treatment	☐ Vision Basic 0/130	☐ Flexible spending account: Flex 123
☐ Infertility rider	☐ Vision Basic 10/130	☐ Premium Only Plan (POP)
☐ Access+ HMO and/or POS chiropractic rider	☐ Vision Basic 0/100	
☐ Access+ HMO and/or POS chiropractic/acupuncture rider	☐ Vision Basic 10/75	

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1 If offered with an HMO plan from another company, a minimum participation in the combined Blue Shield plans must be equal to the greater of 5 enrolled employees or 50% of the total number of enrolled employees.

2 65% participation in Suite Deal Package required.

3 75% participation in Blue Shield PlanSelect plans required.

4 If offered with an HMO plan from another company, a minimum participation in the combined Blue Shield plans must be equal to the greater of 5 enrolled employees or 75% of the total number of enrolled employees.

5 HSA-eligible high-deductible health plan.

6 When Active Choice is offered as a stand-alone Blue Shield Life offering alongside another carrier's HMO plan: Minimum Blue Shield Life enrollment is five active employees or 20% of overall enrolled employees (whichever is greater).

Dental benefits[1]

18 **Suite Deal Dental Package[2]** ☐ Check this box to offer all five of the specified plans listed below (2+ enrolling employees).

Dental PPO – Smile Basic 75/1000/No Ortho/MAC	Dental HMO Basic
Dental PPO – Smile Value 50/1500/No Ortho/MAC	Dental HMO Plus
Dental PPO – Smile Deluxe Plus 2000 50/2000/Ortho/MAC	

Dual option[3] ☐ Check this box for Dual Option (2+ enrolling employees). Choose any two dental plans below.

PPO Smile plans

☐ Dental PPO – Smile℠ Basic 75/1000/No Ortho/MAC	☐ Smile Deluxe 2000 50/2000/No Ortho/MAC
☐ Dental PPO – Smile Value 50/1500/No Ortho/MAC	☐ Smile Deluxe 50/1500/Ortho/MAC
☐ Dental PPO – Smile 50/1500/No Ortho/MAC	☐ Smile Deluxe Plus 2000 50/2000/Ortho/MAC
☐ Dental PPO – Smile Plus 50/1500/Ortho/MAC	☐ Smile Deluxe Gold 50/1500/Ortho/U85
☐ Dental PPO – Smile Plus Gold 50/1500/Ortho/U85	

Dental HMO plans

☐ Dental HMO Basic	☐ Other dental (specify) ________________
☐ Dental HMO Plus	________________
☐ Dental HMO Deluxe	________________

Voluntary dental plans[4]

☐ Dental PPO – Smile Basic Voluntary75/1000/No Ortho/MAC	☐ Dental HMO Voluntary

Employer contribution

19 **Medical contribution –** The employer must contribute either (1) a defined contribution of a minimum $100 per employee (or the cost of the total employee rates, whichever is less), or (2) a minimum of 50% of the total employee rates.

Indicate contribution amount here: For employees _____% or $ _________ For dependents _____% or $_________

If the employer contributes 100% of employee rates, all employees eligible for a group health plan must enroll in coverage offered by the group from any carrier or health plan.

Dental contribution – 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.

Indicate contribution amount here: For employees _____% For dependents _____%

Group term life AD&D insurance

20 **Employee life insurance:** 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 insurance: $ _____________ 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 insurance coverage, applicants must be actively at work for a minimum of 20 hours per week and cannot be enrolling in the Access Baja plans.

1 If dental coverage is a rider to medical coverage, the participation guidelines for medical coverage apply (except for voluntary or Suite Deal Dental package).

2 65% participation in the Suite Deal Dental package is required.

3 75% participation is required if one or both plans are non-voluntary plans.

4 When a non-voluntary plan is combined with a voluntary plan, 75% participation of eligible employees is required. When one or two voluntary plans are offered, there are no employee participation requirements.

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.)

21 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)

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Producer name		Producer e-mail	
Contact name	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? ☐ Yes ☐ No	If yes, define split ______ % / ______ %	Name of second writing agent	
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
Account executive and region		Account manager/service representative (if applicable)	