

master group application

For 51+ eligible employees

Effective January 1, 2012

C14939 (8/11)

blue  of california

blueshieldca.com

Group submission checklist

The following is a checklist of what we need to enroll membership for your group in a timely and effective manner. Use this guide to assist in assembling your group and employee documents. Complete all steps, and it's ready to go!

For medical plan and specialty benefits combined membership enrollment.

Step 1. Complete the Master Group Application with employer and producer signatures. Please also:

- Provide your IRS-assigned Federal Employer Tax ID Number in Section 6.G of the application. If you have more than one entity associated with the group health plan, provide an Employer Tax ID Number for each entity on a separate attachment.
- If question number 13.E in the application is answered YES, provide a Medicare Part D application completed by each eligible member (form PDP00045).
- If you are a new 51 to 299 group, please submit a completed Employer Questionnaire (form A16419).
- Ensure benefit selections for any eligible dependents are clearly indicated.
- Include a business check in the amount of the first month's dues and an initial eligibility listing to support the dues amount paid.

Step 2. Collect completed Employee's Enrollment Applications (form C15390). Review the applications to verify:

- Each employee and covered dependent has listed their Social Security number.
- Employees enrolling in HMO or POS medical plans have listed a Personal Physician name, provider number, and IPA number for each enrolling employee and dependent.
- Employees enrolling in a dental HMO plan have listed a dental provider name and dental provider number for each enrolling employee and dependent.
- Retirees enrolling in a Blue Shield 65 Plus plan have completed their own enrollment application (form MG00001) and have provided their:
 - HICN (Medicare number)
 - Date of birth
 - Gender
 - Permanent physical home address (street, city, state, ZIP code – cannot contain a P.O. box)
 - Medicare Part A and Part B effective dates
 - Answers to questions related to ESRD and other prescription drug coverage
 - Personal Physician name, Medicare provider number
- Any applicable Declaration of Disability for Over-Age Dependent Child forms (form C3674) have been provided.
- COBRA applications (form C11825-RIM) are complete, including primary care provider name, IPA number, the qualifying event for the employee, and the date effective has been provided.

Step 3. Submit all completed Application, forms and documentation to Blue Shield.

Step 4. Collect and keep on file all Refusal of Coverage Forms for all eligible employees and eligible dependents who refuse coverage. These forms are to be provided to Blue Shield upon request.

Master Group Application (for 51+ 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 plans	Shield Savings Plus plans	Active Choice [®] plans*	Foundation group? <input type="checkbox"/> Yes <input type="checkbox"/> No (Local Foundation for Medical Care in Kern, Mendocino/Lake, and Tulare/Kings counties)
Access Baja [®] HMO plans	Access+ HMO SaveNet SM plans	Core Flex SM plans	Local Access+ HMO plans	Vision plans	Group term life/accidental death & dismemberment (AD&D) insurance
Out of Area (OOA) 100/50 PPO (Plan A or B – for 300+ employees only)	Blue Shield 65 Plus plans	Dental HMO plans	Dental PPO plans	[Dental INO plans]	Supplemental life/accidental death & dismemberment (AD&D) insurance

Please type or print clearly. Use black ink.

1 Check all boxes that apply: Medical plans (with or without dental coverage, life insurance, or vision coverage)
Specialty plans: Dental PPO plans Dental HMO plans Dental INO[†] plans Group term life/AD&D insurance
 Supplemental life/AD&D insurance Vision plans

2 How are members being enrolled: Paper enrollment Web Portal/Electronic Enrollment

3 Full legal business name _____ Effective date (month/day/year) _____

4 Billing address (if P.O. box, complete No. 4 below)

City _____ State _____ ZIP _____

5 Physical address of business (if different from above) _____ County _____

6	A. Group contact's full name	B. Title	C. Phone No.	D. Fax No.	E. E-mail address
		On-Line Administrator contact			
		Billing contact			
		EOC/COI contact			
		Legal Contact/Decision Maker			

G. Federal employer tax ID number _____ **Do you have multiple tax ID numbers?** Yes No

If Yes, provide the Federal Employer Tax ID number for the plan sponsor. _____

7 Legal entity: Corporation Partnership Sole proprietorship Other (specify) _____

8 Type of business (provide as much detail as possible):
Major industries and products/services of your business _____
Standard industry classification code(s) (SIC code) in which the business is classified _____

9 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

10 Prior group health carrier(s) (If prior carrier was Blue Shield, please note)	Do you offer other carriers' health plans to your employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list carrier name(s): _____	Employees to be effective on (month/day/year): _____
Prior dental carrier(s) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list carrier name(s): _____		

11 New employee waiting period (minimum 0, maximum 6 months): If there are multiple waiting periods based on classification, please indicate as appropriate:

Date of hire (Example: Employee hired 11/15/10 is effective 11/15/10)
 All employees
 Other (please describe): _____

1st of the month following date of hire (Example: Employee hired 11/15/10 is effective 12/1/10)
 All employees
 Other (please describe): _____

1st of the month following _____ days (Example: If 30-days, Employee hired 11/15/10 is effective 1/1/11)
 All employees
 Other (please describe): _____

1st of the month following _____ months (Example; If waiting period is 1 month, employee hired 11/1/10 is effective 12/1/10.)
 All employees
 Other (please describe): _____

Other: _____

Please explain any exceptions to the waiting period. (Example: Waiting period is waived for executives)

Will the waiting period be waived:

Yes No For current, actively at-work employees

Yes No For part-time employees upon attaining full-time status

Yes No For employees rehired within 6 months

_____ of their termination date

12 Total number of employees (full and part time) _____	Total number of eligible employees _____	Number of full-time employees in waiting period: _____ Number of employees who are declining coverage: _____
Are there any out-of-state employees? <input type="checkbox"/> Yes <input type="checkbox"/> No How many out-of-state employees do you have? _____ Do you wish to offer coverage to your out-of-state employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the state(s) employees reside in: _____		<p>Employer is responsible for collecting and retaining Refusal of Coverage Forms, and to provide to Blue Shield upon request. For dental, life insurance, and vision-only products, where no medical plan is also being offered, Refusal of Coverage Forms are not required.</p>

13 A. Are all full-time eligible employees being offered health coverage? Yes No If No, please explain: _____

B. 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: _____

C. Are you offering coverage to employees working at least 20 hours per week but fewer than 30 hours per week?
 Yes No

D. Are retirees eligible for benefits? Yes No
 If Yes, please check any that apply: Early retirees under age 65 Retirees 65 years and over
 Will you contribute to retiree coverage? Yes No (attach a copy of both Medicare Part A and B cards for installation. For paper applications only.)

E. Will you offer Medicare Part D options? Yes No If Yes, please check any that apply:
 Retirees only Actives and retirees Enhanced PDP Retiree drug subsidy Blue Shield 65 Plus

F. Definition of dependent children: Dependent children may be eligible, if less than 26 years of age. Dependent children over the age of 25 with a physical or mental disabling injury or illness are not subject to any age restrictions and will continue to be covered.

14 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).

15 A. For employer contribution – Enter percentage of dues paid by employer for employees and dependents. If 100%, all eligible employees must enroll.

Access+ HMO plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Active Choice plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Out of area 100/50 PPO A or B Active Choice plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Added Advantage POS plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%
Access+ HMO SaveNet plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Local Access+ HMO plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Shield Spectrum PPO Savings Plus plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Blue Shield 65 Plus plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%
Shield Spectrum PPO plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Shield Savings Plus plans For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Core Flex Basic Value For employees <u>100</u> % For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Core Flex 2200 For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%
Core Flex 1000 For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%	Dental plans with required employer contribution For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____% (For dental plans, minimum employer contribution of 50% toward employee's coverage is required. 75% of all eligible employees must enroll. Excludes voluntary coverage.)		

Vision plans
 For employees _____%
 For dependents _____%
 For retirees (if applicable) _____%
 For retirees' dependents (if applicable) _____%

(For vision plans, minimum employer contribution of 25% toward employee's coverage for all plans except voluntary plans is required. 75% of all eligible employees must enroll. Excludes voluntary coverage. Voluntary plan requires 10 employees with medical coverage or 25% without.)

Group term life and AD&D insurance

100% employer paid (100% of eligible employees must enroll)
 Under 100% employer paid
 For employees _____% (minimum of 25%)
 For dependents _____%

Supplemental life and AD&D Insurance

100% employer paid (100% of eligible employees must enroll)
 Under 100% employer paid
 For employees _____%
 For dependents _____%
 A minimum of 20% or 10 employees must enroll in supplemental insurance, whichever is greater.

B. Tax savings options: Please indicate if you plan on offering any of the following options (check all that apply) and the administrator of each program. Also indicate any amount to be funded by employer contribution.

Program	Name of Administrator	Employer Contribution Amount Individual Coverage	Employer Contribution Amount Family Coverage
<input type="checkbox"/> Health Savings Account (HSA)			
<input type="checkbox"/> Health Reimbursement Arrangement (HRA)			
<input type="checkbox"/> Employer-funded or partially funded wraparound plan*			
<input type="checkbox"/> Flexible Spending Account (FSA)			
<input type="checkbox"/> Premium Only Plan (POP)			

Note: Blue Shield does not offer tax advice, nor do we offer HSAs, HRAs, or FSAs.

*A "wraparound plan" includes any employer-sponsored plan, that is:

(1) paid for or funded in whole or in part by the employer and/or the employee;

(2) (a) provides reimbursement for health plan deductibles, copayments, coinsurance, or medical expenses, or (b) provides for the payment of set amounts in the event of hospitalization.

Examples include: an employer-funded flexible spending account (FSA), a health reimbursement account (HRA), self-funding of the deductible, an IRS Section 105 plan, a medical expense reimbursement plan (MERP).

- 16** Are all employees covered by workers' compensation to the extent required by law?
 Yes Carrier name: _____
 No If No, please explain: _____
- 17** Are any COBRA participants enrolling in a Blue Shield of California/Blue Shield of California Life & Health Insurance Company (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 C11248).
 Name of COBRA Administrator: _____
- 18** 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.
 Note: The employer is solely responsible for all aspects of the administration of Title X, of the Consolidated Omnibus Budget Reconciliation Act (COBRA).
 How many existing COBRA or Cal-COBRA participants do you have? _____ How many in eligibility period? _____
- 19** Department Codes – Please list: _____

Medical plan benefits

20 Access+ HMO plans

- HMO 5-0 Inpatient
- HMO 10-0 Inpatient
- HMO 10-100/Day Inpatient
- HMO 10-200/Day Inpatient
- HMO 10-250/Admit Inpatient
- HMO 10-20%/Zero Facility Deductible
- HMO 15-500/Admit Inpatient
- HMO 15-500/Day Inpatient
- HMO 15-20%/Zero Facility Deductible
- HMO 15-10%/1500 Facility Deductible
- HMO 20-250/Admit Inpatient
- HMO 20-500/Admit Inpatient

- HMO 20-25%/Zero Facility Deductible
- HMO 20-20%/1000 Facility Deductible
- HMO 25-500/Admit Inpatient
- HMO 25-750/Day Inpatient
- HMO 30-20%/Zero Facility Deductible
- HMO 30-10%/1500 Facility Deductible
- HMO 40-1000/Day Inpatient
- HMO 40-40%/Zero Facility Deductible
- HMO 40-40%/1000 Facility Deductible
- HMO 45-50%/Zero Facility Deductible
- HMO 45-50%
- Custom plan (attach custom menu)

Access+ HMO SaveNet¹ plans

- Access+ HMO SaveNet 10-250/Admit Inpatient
- Access+ HMO SaveNet 15-500/Admit Inpatient
- Access+ HMO SaveNet 15-20%/Zero Facility Deductible
- Access+ HMO SaveNet 10-50%/Zero Facility Deductible

21 Local Access+ HMO plans⁴

- Local Access+ HMO 15-500/Admit Inpatient
- Local Access+ HMO 20-250/Admit Inpatient
- Local Access+ HMO 25-500/Admit Inpatient
- Local Access+ HMO 25-750/Day Inpatient

- Local Access+ HMO 40-1000/Day Inpatient
- Local Access+ HMO 15-10%/1500 Facility Deductible
- Local Access+ HMO 15-20%/Zero Facility Deductible
- Local Access+ HMO 30-20%/Zero Facility Deductible

- Local Access+ HMO 40-40%/Zero Facility Deductible
- Local Access+ HMO 45-50%/Zero Facility Deductible
- Other

22 Access Baja HMO plans

- Access Baja HMO Plan 5
- Access Baja HMO Plan 10
- Access Baja dependent only coverage (split contract option – special eligibility requirements apply)

Check this box for Dual Choice.
Choose one Access+ HMO plan and one other non-HMO plan

Other
 Specify: _____

23 Shield Spectrum PPO plans

- Choose deductible and copayment:
- Shield Spectrum PPO 0/500-90/70 Standard
 - Shield Spectrum PPO 0/500-100/50
 - Shield Spectrum PPO 250-80/60 Standard
 - Shield Spectrum PPO 250-90/70 Premier

- Shield Spectrum PPO 250-90/70 Standard
- Shield Spectrum PPO 250-90/70 Value
- Shield Spectrum PPO 250-80/60
- Shield Spectrum PPO 500-90/70
- Shield Spectrum PPO 500-80/60
- Shield Spectrum PPO 750-80/60
- Shield Spectrum PPO 1000-80/50
- Shield Spectrum PPO 1000-80/60 Premier*

- Shield Spectrum PPO 1000-90/70
- Shield Spectrum PPO 2500-80/60
- Shield Spectrum PPO 3500-80/60
- Shield Spectrum PPO 3000-80/60*
- Custom plan (attach custom menu)

24 Shield Savings Plus² plans

- Shield Savings Plus 1500 Individual/3000 Family*
- Shield Savings Plus 1800 Individual /3600 Family*
- Shield Savings Plus 2400
- Shield Savings Plus 2250 Individual/4500 Family

- Shield Savings Plus 2600
- Shield Savings Plus 3000
- Shield Savings Plus 3500
- Shield Savings Plus 4000*

25 Core Flex Value package³

- Check this box to offer the Core Flex Value package listed below:
 Core Flex Basic Value²
 Core Flex 2200²
 Core Flex 1000

Choose from the Core Flex Value package Rx Options below:
 Core Flex Basic Value (RX embedded)
 Core Flex 2250 (RX embedded)
 Core Flex 1000: 5/40/50% (\$50 Min-\$100 Max) -10/80/50% (\$100 min-\$200 Max)

26 Added Advantage POS plans (continued)

- Added Advantage POS 250-100/80/50
- Added Advantage POS 300-100/90/70 Premier
- Added Advantage POS 300-100/90/70 Standard
- Added Advantage POS 300-100/70

- Added Advantage POS 300-100/80/60
- Added Advantage POS 500-100/80/60
- Custom plan (attach custom menu)

27 Active Choice* plans

- Active Choice Plan 750*
- Active Choice Plan 750 70/50*
- Active Choice Plan 750 1000 Deductible*

- Active Choice Plan 500 1500 Deductible*
- Active Choice Plan 500*
- Custom plan (attach custom menu)

28 Blue Shield 65 Plus plans

- Custom Plan (attach custom menu)

29 Foundation plans (Available in Kern, Mendocino/Lake, and Tulare/Kings counties)

- Shield Spectrum PPO 0/500 90/70 Standard Foundation*
- Shield Spectrum PPO 250 70/50 Foundation*
- Shield Spectrum PPO 250-90/70 Value Foundation*
- Shield Spectrum PPO 500-80/60 Foundation*

- Shield Spectrum PPO 1000-80/60 Premier Foundation*
- Active Choice® 750 Foundation*
- Active Choice Plan 750 70/50 Foundation*
- Active Choice Plan 750 1000 Deductible Foundation*
- Active Choice Plan 500 1500 Deductible Foundation *

- Shield Savings Plus 1800 Individual/3600 Family Foundation*.2
- Shield Savings Plus 2400 Foundation*.2
- Shield Savings Plus 4000*.2
- Custom Plan (attach custom menu)

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

- 1 Access+ HMO SaveNet products are only available alongside our Access+ HMO products in designated Southern California counties: Orange, San Luis Obispo, and portions of Los Angeles, San Diego, San Bernardino, and Riverside.
- 2 These high-deductible health plans are HSA-compatible.
- 3 The Core Flex Value plan package can only be sold as a package. The Core Flex Value package cannot be offered with any competitive plan. For additional competitive option information, please contact your broker or Blue Shield sales representative. You can also purchase alternative dental and/or vision plans with your Core Flex medical package. They will be subject to our usual dental and/or vision underwriting guidelines.
- 4 Local Access+ HMO products are only available in designated counties: San Luis Obispo and portions of Los Angeles, Orange, San Diego, San Bernardino, Riverside, Kern, Sacramento, San Mateo, Santa Clara, Santa Cruz, Ventura, Yolo, San Francisco and portions of Contra Costa County.

Optional benefits (cannot be purchased without a medical plan)

30 For Dual Choice packages, the same optional benefits must be purchased for all the plans selected

- Substance abuse treatment
Select plan option(s):
 - HMO
 - PPO
 - POS
 - PSP
 - Active Choice
 - Core Flex
 - Foundation
- Infertility rider
Select plan option(s):
 - HMO
 - PPO
 - POS
 - PSP
 - Active Choice
 - Core Flex
 - Foundation

- Access+ HMO and/or POS chiropractic rider
- Access+ HMO and/or POS chiropractic/acupuncture rider
- Hearing-aid rider
Select plan option(s):
 - PPO
 - Active Choice
 - Foundation
- Vision plan options
 - Vision Basic 0/25/100
 - Vision Basic 0/15/120
 - Vision Basic 0/0/130
 - Vision Basic Plus 0/15/120
 - Eye Exam Only

- Other

Blue Shield Life Rx options

(available for: Active Choice 500, 750, 750 70/50, 750 1000 and 500 1500, PPO 1000-80/60 Premier, PPO 3000-80/60, and PPO/Active Choice Foundation plans)

Choose one calendar-year brand-name deductible option below:

- \$0 per person
- \$150 per person
- \$250 per person
- \$500 per person

Choose one of the Rx drug plan options below:*

- \$0 (generic formulary)/\$20 (brand-name formulary)/40 (brand-name non-formulary) Rx drug plan
- \$3/\$20/\$40 Rx drug plan
- \$5/\$10/\$25 Rx drug plan
- \$5/\$40/50% \$50 min \$100 max Rx drug plan
- \$10/\$15/\$30 Rx drug plan

- \$10/\$20/\$35 Rx drug plan
- \$10/\$25/\$40 Rx drug plan
- \$10/\$30/\$50 Rx drug plan
- \$15/\$30/\$45 Rx drug plan
- \$10/\$30/greater of \$45 or 50% Rx drug plan
- \$15/\$30/50% \$45 min \$100 max Rx drug plan

* Specialty Drugs 30% up to a \$150 maximum

<p>Blue Shield of California Rx options (available for PPO plans) Choose one calendar-year brand-name deductible option below:</p> <p><input type="checkbox"/> \$0 per person <input type="checkbox"/> \$150 per person <input type="checkbox"/> \$250 per person</p>	<p>Choose one of the Rx drug plan options below:*</p> <p><input type="checkbox"/> PPO \$0 (generic formulary)/\$20 (brand-name formulary)/\$40 (brand-name non-formulary) Rx drug plan <input type="checkbox"/> PPO \$3/\$20/\$40 Rx drug plan <input type="checkbox"/> PPO \$5/\$10/\$25 Rx drug plan <input type="checkbox"/> PPO \$5/\$40/50% \$50 min \$100 max Rx drug plan <input type="checkbox"/> PPO \$10/\$15/\$30 Rx drug plan <input type="checkbox"/> PPO \$10/\$20/\$35 Rx drug plan</p>	<p><input type="checkbox"/> PPO \$10/\$25/\$40 Rx drug plan <input type="checkbox"/> PPO \$10/\$30/\$50 Rx drug plan <input type="checkbox"/> PPO \$10/\$30/ 50% \$45 min \$100 max Rx drug plan <input type="checkbox"/> PPO \$15/\$30/\$45 Rx drug plan <input type="checkbox"/> PPO \$15/\$30/ 50% \$45 min \$100 max Rx drug plan</p> <p>* Specialty Drugs 30% up to a \$150 maximum</p>
<p>Blue Shield of California Rx options (available for HMO/POS and Blue Shield 65 Plus plans) Choose one calendar-year brand-name deductible option below:</p> <p><input type="checkbox"/> \$0 per person <input type="checkbox"/> \$150 per person <input type="checkbox"/> \$250 per person</p> <p>Choose one of the two-tier Rx drug plan options below:†</p> <p><input type="checkbox"/> HMO/POS \$5 (generic formulary)/\$10 (brand-name formulary) Rx drug plan (closed formulary) <input type="checkbox"/> HMO/POS \$5/\$15 Rx drug plan</p>	<p><input type="checkbox"/> HMO/POS \$10/\$15 Rx drug plan <input type="checkbox"/> HMO/POS \$10/\$20 Rx drug plan <input type="checkbox"/> HMO/POS \$10/\$25 Rx drug plan <input type="checkbox"/> HMO/POS \$15/\$25 Rx drug plan <input type="checkbox"/> HMO/POS \$15/\$30 Rx drug plan</p> <p>† Specialty Drugs 20% up to a \$100 maximum</p> <p>Choose one of the three-tier Rx drug plan options below:†</p> <p><input type="checkbox"/> HMO/POS \$0 (generic formulary)/\$20 (brand-name formulary)/\$40 (brand-name non-formulary) Rx drug plan <input type="checkbox"/> HMO/POS \$3/\$20/\$40 Rx drug plan</p>	<p><input type="checkbox"/> HMO/POS \$5/\$10/\$25 Rx drug plan <input type="checkbox"/> \$5/\$40/50% \$50 min \$100 max Rx drug plan <input type="checkbox"/> HMO/POS \$10/\$15/\$30 Rx drug plan <input type="checkbox"/> HMO/POS \$10/\$20/\$35 Rx drug plan <input type="checkbox"/> HMO/POS \$10/\$25/\$40 Rx drug plan <input type="checkbox"/> HMO/POS \$10/\$30/\$50 Rx drug plan <input type="checkbox"/> HMO/POS \$10/\$30/50% \$45 min \$100 max Rx drug plan <input type="checkbox"/> HMO/POS \$15/\$30/\$45 Rx drug plan <input type="checkbox"/> HMO/POS \$15/\$30/50% \$45 min \$100 max Rx drug plan</p> <p>† Specialty Drugs 20% up to a \$100 maximum</p>

Dental benefits (with or without a medical plan)

31 Dental HMO plans

- SmileSM Basic
- Smile Plus
- Smile Deluxe

Dental HMO Voluntary Plans

- Smile Basic Voluntary
- Smile Plus Voluntary
- Smile Deluxe Voluntary
- Custom plan: _____

32 Dental PPO plans

- SmileSM Basic 75/1000/No Ortho/MAC
- Smile Basic Voluntary 75/1000/No Ortho/MAC
- Smile Spectrum 50/1000/Ortho/U90
- Smile Spectrum 50/1000/No Ortho/MAC
- Smile Spectrum 50/1500/Ortho/U90
- Smile Spectrum 50/1500/Ortho/MAC
- Smile Spectrum 50/1500/No Ortho/U90
- Smile Spectrum 50/1500/No Ortho/MAC

- Smile Spectrum Premier 50/1500/Ortho/U90
- Smile Spectrum Premier 50/1500/Ortho/MAC
- Smile Spectrum Premier 50/1500/No Ortho/U90
- Smile Spectrum Premier 50/1500/No Ortho/MAC
- Smile Spectrum Premier 50/2000/Ortho/U90
- Smile Spectrum Premier 50/2000/Ortho/MAC

- Smile Spectrum Premier 50/2000/No Ortho/U90
- Smile Spectrum Premier 50/2000/No Ortho/MAC
- Smile Spectrum Premier Plus 50/1500/Ortho/U90
- Smile Spectrum Premier Plus 50/1500/No Ortho/U90
- Custom plan: _____

33 Dental INO[†] plans

- SmileSM In-Network Only Dental Plan
- 50/2500/Endo-Perio Basic/No Ortho
 - 50/2500/Endo-Perio Basic/Ortho
 - 50/2500/Endo-Perio Plus/No Ortho
 - 50/2500/Endo-Perio Plus/Ortho
- [†Pending regulatory approval.]

Dental INO[†] Voluntary plans

- 50/2500/Endo-Perio Basic/No Ortho
- 50/2500/Endo-Perio Basic/Ortho
- 50/2500/Endo-Perio Plus/No Ortho
- 50/2500/Endo-Perio Plus/Ortho
- Custom plan: _____

Form of Member Evidence of Coverage/Certificate of Insurance Booklets

36 For groups of 51 to 2,999 eligible employees

You are responsible for the distribution of the *Evidence of Coverage/Certificate of Insurance* booklets to your covered employees. Electronic versions will be distributed via Blue Shield employer web site. Blue Shield will notify the individual responsible for Evidence of Coverage/Certificate of Insurance (EOC/COI) distribution, identified in Part 5 above, by Email when the EOC/COI is ready for distribution. Employer is responsible for distributing these documents using one of the following methods; (1) posting on the company intranet for employee access, (2) emailing these documents directly to their employees, or (3) providing employees with instructions from Blue Shield about how to electronically retrieve the documents from the Blue Shield website. Printed versions will only be mailed to the employer directly upon request. Employers requesting printed copies will receive up to 10% of the total subscriber count at no additional cost to distribute to employees.

Please note: Electronic distribution will not apply to life insurance certificates. Printed versions of life insurance certificates will be mailed directly to employees.

- I elect to receive printed, not electronic, EOC/COI booklets. I understand that I am responsible for distributing the documents to my covered employees and understand that the dues/premiums charged for the coverage will include cost to print the documents.

For groups of 3,000 or more eligible employees

Please note: Available only for custom groups, or groups who enroll in vision benefits, or group term life and AD&D insurance benefits without a medical plan.

- Electronic format only: Documents will be distributed to the employer via CD-ROM. Employer is responsible for posting these documents on the company intranet for employee access.
- Electronic and printed format: Electronic versions will be distributed via CD-ROM. Employer is responsible for posting these documents on the company intranet for employee access. Printed versions will be mailed to the employer directly. Employers will receive 10% of the total subscriber count to distribute to employees.
- Printed format only: Printed versions will be mailed to the employer directly. Employers will receive the total subscriber count to distribute to employees.

Payment (deposit check amount – this amount will be applied to the first month's premium)

- 37** The group herewith tenders the amount of \$ _____ and, in consideration of approval of the application it will make and in event of such approval, promises to pay this company as appropriate any balance necessary to constitute the full initial payment for the group benefits herein identified on the checklist. It is understood that the rates will be determined from the initial enrollment data. It is understood that coverage will not commence until the application has been approved and the conditions of coverage are accepted by the employer.

Please note that depositing the group's check does not constitute approval of the group's application. 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.

Detail of how deposit check amount should be applied:

\$ _____ applied to medical	\$ _____ applied to vision
\$ _____ applied to dental PPO	\$ _____ applied to life insurance
\$ _____ applied to dental HMO	\$ _____ other, please indicate:
\$ _____ applied to dental INO	

Agreement

- 38** The group hereby applies for the group products selected on this application, as those benefit plans are outlined in the benefit summary(ies), with the understanding and agreement that:
- Group benefits will not become effective, unless:
 - Blue Shield receives and approves the application at its home office in San Francisco, California; and
 - The group meets Blue Shield's underwriting requirements, including minimum participation and contribution requirements.
 - The group agrees to pay the required monthly dues/premium to Blue Shield in a timely manner.
 - The group agrees to:
 - Enroll all employees as they become eligible, if the Group Policy is issued on a non-contributory basis; or
 - Give all eligible employees an opportunity to apply for such group benefits, if the Health Service Agreement/Group Policy is issued on a contributory basis.
 - No waiver or requested change in coverage will become effective unless agreed to and signed by an officer of Blue Shield.
 - For life insurance/AD&D products only: enrolling employees must be actively at work or meet the active employment provisions for coverage before coverage may become effective. Coverage for any person not meeting these provisions on the effective date of the Health Service Agreement/Group Policy, or any increase in coverage for any person not meeting these provisions on the effective date of such increase in coverage, will be deferred until the person returns to work or active employment.
 - I consent to and authorize Blue Shield to send all business correspondence through electronic communications. Blue Shield will notify the individuals identified in Part I above by Email. Other forms of contact will only be made upon direct request. Employers requesting mail correspondence may incur an additional cost.
- I elect to receive non-electronic correspondence. I understand that the dues/premiums charged for the coverage will include cost related to non-electronic communications. phone fax mail

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).

39 This is an application for coverage only. No contract for coverage will exist until Blue Shield of California/Blue Shield Life has completed its review and communicated to the applicant or the applicant's producer 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 committed fraud or made an intentional misrepresentation of any material fact, any coverage approved by Blue Shield of California/Blue Shield Life may, at the sole discretion of Blue Shield of California/Blue Shield Life be cancelled or, following notice, the Health Service Contract/Group Policy may be rescinded, or the applicable dues/premiums may be adjusted.

Authorized signature	Name and title (please print)	Date
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Producer information (to be completed by producer or general agent)

40 Producer name	Phone number	Fax number
Producer address (P.O. box not acceptable)		
City	State	ZIP
Producer e-mail	Producer tax ID number (commissions will be reported under this number)	
General agent tax ID number	Department of Insurance license number	
General agent name	General agent e-mail	
Region	Code number	
Today's date (required)	Producer signature (required)	Print name

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

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