

Employer Questionnaire
FOR 51- 299 ELIGIBLE EMPLOYEES
PARTICIPATION AND ELIGIBILITY
REQUIREMENTS APPLY



Group Name: _____ Proposed Effective Date: _____

Address: _____

Type of Business (SIC): _____

Has the group been previously covered by Blue Shield, or have other coverage with Blue Shield? Yes No

If yes, explain: _____

Carrier History for the past 5 years: (Groups with more than 3 carriers in 5 years are ineligible)		
Carrier Name	Type of Coverage	Period Insured
Employee Eligibility Eligible employees are active full-time employees who work at least 20 hours per week (Retirees or 1099's are not eligible) How many employees do you employ? _____ How many employees are eligible for health benefits? _____ How many eligible employees are enrolling? _____ How many eligible employees are covered under a spouse's/domestic partner's plan? _____ How many eligible employees are covered under Kaiser? _____		Employer Contribution For Employees: _____% For Dependents: _____% (Minimum of 50 percent overall)
Please answer the following questions to the best of your knowledge for the persons to be insured (employees, dependents, partners). Provide details for any YES responses on a separate sheet of paper.		
1. In the past twelve months, has any person suffered a condition that resulted in expenses of \$25,000 or more?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you aware of any person that is disabled, or being treated for heart disease, stroke, cancer, kidney disorder, AIDS or AIDS related complex, chronic respiratory disease, or is currently hospitalized or has been told extensive medical treatment, surgery or hospitalization is required? Please note: California law prohibits an HIV test from being required or used by health care service plans or health insurance companies as a condition of obtaining health coverage.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are there any COBRA continues? If yes, how many? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Will an HRA or an HSA plan be offered? If yes, what will the employer contribution level be for? HRA Employee \$ _____ HSA Employee \$ _____ Family \$ _____ Family \$ _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
This document expires 60 days from the date of execution. The information provided by the employer group in this questionnaire is correct and true to the best of the employer group's knowledge and belief, and Blue Shield relies upon this information in issuing a quote. If errors or omissions are subsequently found, Blue Shield of California, and/or Blue Shield of California Life & Health Insurance Company as applicable, reserves the right to revise rates quoted or rescind the quote.		

Signature of Company Officer

Date

Print Name

Title

Signature of Broker/Consultant

Date

Print Name

Title



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 An Independent Member of the Blue Shield Association

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 An Independent Licensee of the Blue Shield Association

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