

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, 2010

Get on the fast track

This handy checklist 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!

Please see important endnotes on page 8.

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Master group application (form C15385) <input type="checkbox"/> Verification and Statement of Understanding (C20283) <input type="checkbox"/> Employee enrollment application (form C12914) or Refusal for Coverage completed for each eligible employee. Please verify each employee and enrolling dependent has listed their Social Security number. <input type="checkbox"/> Health Statements (form C15825) are required for guaranteed-issue groups of 2 to 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 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 out of state employees and 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) | <ul style="list-style-type: none"> <input type="checkbox"/> Refusal of Coverage Forms for all eligible employees and any eligible dependents who refuse coverage. Applications for dental or life insurance only do not require Refusal of Coverage Forms. <input type="checkbox"/> A copy of the previous carrier's current billing statement (if applicable) <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 coverage, vision coverage, or life insurance with health coverage, 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 • Corporation: Articles of Incorporation (state seal affixed) including officers; K-1 or signed refusal for each officer eligible for coverage |
|---|--|

Master Group Application (for 2 to 50 eligible employees)

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

Effective July 1, 2010

Group billing unit

Do not write in shaded area

Access+ HMO [®] plans	Shield Spectrum PPO SM plans	Added Advantage POS SM plan	Shield Savings SM plans
Active Choice SM plans*	Access Baja [®] HMO plans	Dental HMO plans	Dental PPO plans
Local Access+ HMO [®] plans	Vision plans	Specialty Bundling Program	Other
Group term life/accidental death dismemberment (AD&D insurance) plans*			Parity benefits

Please type or print clearly. Use black ink. Please see important endnotes on page 8.

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)

Federal Tax Identification number:

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) and address(es). Identify which subsidiaries should be included in the coverage.

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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? <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: _____

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

9 The Shield SavingsSM 2250/4500, Shield SavingsSM 1800/3600 (both HSA-eligible), and the Shield Spectrum PPO Plan 3000 are the only Blue Shield plans, offered by either Blue Shield of California or Blue Shield of California Life & Health Insurance Company, that may be used with any form of an employer-sponsored wrap plan. Underwriting criteria prohibits pairing its other health plans with a wrap plan at any time, with the exception of a Health Savings Account (HSA) or employee-funded general purpose Flexible Spending Account (FSA).

If you have any questions about this policy, please contact Blue Shield prior to completing this section.

A. Do you offer, or are you planning to offer, any employer-sponsored wrap plan? Yes No

If yes, describe the type of wrap plan: _____

B. If "no" to (A) above, do you understand and acknowledge that, with the exception of an HSA or employee-funded general purpose FSA, if you pair an employer-sponsored wrap plan with any Blue Shield health plan other than the Shield SavingsSM 2250/4500, Shield SavingsSM 1800/3600, or Shield Spectrum PPO Plan 3000, your group contract/policy will be cancelled? Yes No

10 New employee waiting period: _____ months (minimum 0, maximum 6 months)

If the group has a special exception to waiting period of managerial/executive new hires, please indicate here (minimum 0, maximum of 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 8/1/09, and the group has a three-month waiting period – employee is eligible for enrollment effective 11/1/09. If hire date is 8/2/09, and the group has a three-month waiting period, employee is eligible for enrollment effective 12/1/09.

Will the waiting period be waived for current, actively at work employees? Yes No

11 Total No. of employees _____ Total No. of **eligible** employees _____

Total No. of **enrolled** employees: **Medical enrollment** _____ **Dental enrollment** _____ **Vision enrollment** _____ **Life enrollment** _____

Are you required to comply with the Federal Mental Health Parity and Addiction Equity Act of 2008 (HR1424)? Yes No

If yes, please provide at least two quarters DE6 from the prior calendar quarter showing more than 50 total employees

If you have any questions regarding this requirement, please contact your Producer for more information.

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 forms.

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) and copies of two quarters DE-6.

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

12 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

Employees working fewer than 30 hours must have been employed for at least 50% of the previous calendar quarter before they are eligible to enroll.

13 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).

14 Are all employees covered by workers' compensation to the extent required by law?

Yes Carrier name: _____

No If no, please explain: _____

15 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.

16 If existing Cal-COBRA/COBRA enrollees or those in the Cal-COBRA/COBRA election period are not disclosed at the time of the group's initial enrollment, the group may be re-rated.

A. Is your group subject to federal COBRA? Yes No

B. How many existing Cal-COBRA or COBRA participants do you have? _____

C. Existing Cal-COBRA or COBRA participants: Please complete for each employee or family member currently on Cal-COBRA or COBRA.

Name _____ Date of birth _____ Social Security number _____

Qualifying event description _____ Date _____

Name _____ Date of birth _____ Social Security number _____

Qualifying event description _____ Date _____

Name _____ Date of birth _____ Social Security number _____

Qualifying event description _____ Date _____

Name _____ Date of birth _____ Social Security number _____

Qualifying event description _____ Date _____

D. How many employees and/or family members are in a Cal-COBRA/COBRA eligibility/election period? _____

Please complete the following for each employee or family member that is currently in the eligibility/election period.

Name _____ Date of birth _____ Social Security number _____

Qualifying event description _____ Date _____

Please list any health conditions you are aware of for the employee and/or family member(s) _____

Name _____ Date of birth _____ Social Security number _____

Qualifying event description _____ Date _____

Please list any health conditions you are aware of for the employee and/or family member(s) _____

Name _____ Date of birth _____ Social Security number _____

Qualifying event description _____ Date _____

Please list any health conditions you are aware of for the employee and/or family member(s) _____

Medical benefits plan

17 Dual Choice¹ Check this box for Dual Choice (2+ eligible employees). Choose one Access+ HMO plan or Local Access+ HMO^{8,9} 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.

Shield Spectrum PPO	Shield Savings ^{SM5}	Access+ HMO
Shield Spectrum PPO Plan 500 Standard*	Shield Savings SM 2000/4000* [†]	Access+ HMO Plan 20 Value
Shield Spectrum PPO Plan 500 Value*	Shield Savings SM 3000/6000*	Access+ HMO Plan 30
Shield Spectrum PPO Plan 1000 Value* [†]	Shield Savings SM QS 2000/4000	OR
Shield Spectrum PPO Plan 1500 Value* [†]	Shield Savings SM QS 3000/6000	Local Access+ HMO Plan 20 Value
Shield Spectrum PPO Plan 2000 Value* ^{6,†}		Local Access+ HMO Plan 30

Employers in certain Southern California counties and cities: If you are a Southern California employer whose eligible employees live and/or work in the Local Access+ HMO service area⁸ you have the option of choosing the Suite Deal medical plan package with either the Access+ HMO plans or the Local Access+ HMO plans but not both. The Local Access+ HMO plans have the same benefits as our Access+ HMO plans, at a reduced rate.

One HMO plan option must be selected; both options are not available to combine.

Access+ HMO Plan 20 Value and Access+ HMO Plan 30 **OR** Local Access+ HMO Plan 20 Value and Local Access+ HMO Plan 30

PlanSelectSM Packages^{3,4} Groups with 2 to 50 enrolled employees, select between 2 and up to 32 plans, not including Access Baja or Local Access+ HMO^{8,9} plans. Employers can offer Access Baja in addition to PlanSelect.

All plans All plans (except SS1800/SS2250/PP03000)

Selected plans (choose at least two plans from below when not offering all plans)

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

Local Access+ HMO^{8,9}

Local Access+ HMO Plan 20 Value Local Access+ HMO Plan 30

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 Plan 2000 Value*^{6,†}

Shield Savings^{SM5}

Shield SavingsSM 1800/3600*[†] Shield SavingsSM 2000/4000*[†] Shield SavingsSM 2250/4500
 Shield SavingsSM QS 2000/4000 Shield SavingsSM 3000/6000* Shield SavingsSM 2500*
 Shield SavingsSM 4800*⁷ Shield SavingsSM QS 3000/6000 Shield SavingsSM QS 4800*

Added Advantage POS

Added Advantage POS Plan

Active Choice Plan⁷

Active Choice Plan 750 SG
 Active Choice Plan 500 SG

Access Baja HMO

Access Baja HMO Plan 5
 Access Baja HMO Plan 10

Other _____

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

† Shield Spectrum PPO Plan 750 Value, Shield Spectrum PPO Plan 1000 Value, Shield Spectrum PPO Plan 1500 Value, Shield Spectrum PPO Plan 2000 Value, Shield SavingsSM 1800/3600, and Shield SavingsSM 2000/4000 are pending regulatory approval.

Optional benefits (cannot be purchased without a medical plan)

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

<input type="checkbox"/> Inpatient substance abuse treatment ^Δ	<input type="checkbox"/> Vision Basic 0/25/100 ^Δ	<input type="checkbox"/> Flexible Spending Account: Flex 123
<input type="checkbox"/> Infertility rider ^Δ	<input type="checkbox"/> Vision Basic 0/15/120 ^Δ	<input type="checkbox"/> Premium Only Plan (POP)
<input type="checkbox"/> Local Access+ HMO and Access+ HMO and/or POS chiropractic rider	<input type="checkbox"/> Vision Basic 0/0/130 ^Δ	
<input type="checkbox"/> Local Access+ HMO and Access+ HMO and/or POS chiropractic/acupuncture rider	<input type="checkbox"/> Vision Basic Plus 0/15/120 ^Δ	

Dental benefit plans¹⁰

19 Suite Deal Dental Package¹¹ 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 option³ Check this box for Dual Option (2+ enrolling employees). Choose any two dental plans below.

PPO Smile plans

<input type="checkbox"/> Dental PPO – Smile SM Basic 75/1000/No Ortho/MAC	<input type="checkbox"/> Dental PPO – Smile Deluxe 2000 50/2000/No Ortho/MAC
<input type="checkbox"/> Dental PPO – Smile Basic Voluntary ¹²	<input type="checkbox"/> Dental PPO – Smile Deluxe 50/1500/Ortho/MAC
<input type="checkbox"/> Dental PPO – Smile Value 50/1500/No Ortho/MAC	<input type="checkbox"/> Dental PPO – Smile Deluxe Plus 2000 50/2000/Ortho/MAC
<input type="checkbox"/> Dental PPO – Smile 50/1500/No Ortho/MAC	<input type="checkbox"/> Dental PPO – Smile Deluxe Gold 50/1500/Ortho/U85
<input type="checkbox"/> Dental PPO – Smile Plus 50/1500/Ortho/MAC	
<input type="checkbox"/> Dental PPO – Smile Plus Gold 50/1500/Ortho/U85	

Dental HMO plans

<input type="checkbox"/> Dental HMO Basic	<input type="checkbox"/> Other dental (specify) _____
<input type="checkbox"/> Dental HMO Plus	
<input type="checkbox"/> Dental HMO Deluxe	
<input type="checkbox"/> Dental HMO Voluntary ¹²	

Vision coverage* (can be purchased with or without a medical plan)

20 Vision Standard (12/24/24)	Vision Plus (12/12/24)	Vision Deluxe (12/12/12)
<input type="checkbox"/> Vision Standard 0/25/100	<input type="checkbox"/> Vision Plus 0/25/100	<input type="checkbox"/> Vision Deluxe 0/25/100
<input type="checkbox"/> Vision Standard 0/15/120	<input type="checkbox"/> Vision Plus 0/15/120	<input type="checkbox"/> Vision Deluxe 0/15/120
<input type="checkbox"/> Vision Standard 0/25/130	<input type="checkbox"/> Vision Plus 0/25/130	<input type="checkbox"/> Vision Deluxe 0/25/130
<input type="checkbox"/> Vision Standard 0/0/130	<input type="checkbox"/> Vision Plus 0/0/130	<input type="checkbox"/> Vision Deluxe 0/0/130
<input type="checkbox"/> Vision Standard 0/25/120 Voluntary**		

^Δ Cannot be purchased without a medical plan. Blue Shield of California Vision Basic plans, infertility and substance abuse riders can be sold only with a medical plan underwritten by Blue Shield of California. Blue Shield of California Life & Health Insurance Company Vision Basic plans, infertility and substance abuse riders can be sold only with a medical plan underwritten by Blue Shield of California Life & Health Insurance Company.

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

** A voluntary vision plan requires a minimum of 10 enrolling employees.

Group Term Life and AD&D Insurance* (can be purchased with or without a medical plan)

21 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 Class description

- Eligibility:** All full-time employees Part-time employees _____ Minimum hours
 Only those employees enrolled in the Blue Shield/Blue Shield Life Medical Plan
- Dependent life insurance (available only with employee life/AD&D 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.

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

Employer contribution

22 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 ____%

Vision contribution – For employer contribution, enter percent of dues paid (must be at least 50% of total employee rates for a Vision Basic plan and 25% for all other plans except voluntary) by employer for employees and dependents. If 100%, all eligible employees must enroll.

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

Life insurance contribution

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

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)

23 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.

NOTE: Blue Shield Life does not offer life insurance coverage to employers of under ten employees. 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.

Authorized signature

Name and title (please print)

Date

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

24 Producer name		Producer e-mail	
Producer contact name/e-mail address	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	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)	

Endnotes:

- 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 five 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 five enrolled employees or 75% of the total number of enrolled employees.
- 5 HSA-eligible high-deductible health plan.
- 6 Prescription drug coverage for this plan only provides coverage for generic drugs and specifically excludes coverage for brand name prescriptions.
- 7 When either an Active Choice plan or the Shield SavingsSM 4800 is offered as a standalone Blue Shield Life offering alongside another carrier's HMO plan: Minimum Blue Shield Life enrollment is the greater of five active employees or 20% of overall enrolled employees
- 8 Local Access+ HMO products are only available in designated Southern California counties: portions of Orange, Los Angeles, San Diego, San Bernardino, and Riverside, as well as San Luis Obispo County. Please review the *Benefit Summary Guide* (form A16609) for detailed information regarding the Local Access+ provider network and service area.
- 9 Local Access+ HMO products are not available as part of the PlanSelect Package and may not be offered alongside any other full network HMO product (except Access Baja HMO).
- 10 If dental coverage is a rider to health coverage, the participation guidelines for health coverage apply (except for Suite Deal Dental package).
- 11 65% participation in the Suite Deal Dental package is required.
- 12 When a non-voluntary plan is combined with a voluntary plan, 75% participation of eligible employees is required. A 25% participation with a minimum of 5 eligible employees enrolled for voluntary dental plans are required.