

Employer Application



CaliforniaChoice 51+
Your Health. Your Choice.®

721 South Parker, Suite 200 • Orange, CA 92868
www.calchoiceplus.com

Please complete using black ink or typewriter. Return signed and completed application — and those of employees — to your broker.

Group # (for staff use only)

A. Employer Information

| | | | | | | | |
|--|--|---|-------|---|---------------------|----------------------------|---|
| 1. Legal Company Name: | | 2. Date Business Started: / / | | 3. CA Federal Tax ID # (9 digits)—NOT Social Security # - - - - - | | | |
| 4. DBA Name (Doing Business As): | | 5. Exact Nature of Business: | | 6. Owner/President Name: | | | |
| 7. Company Structure: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____ | | | | 8. Contact Name: | | | |
| 9. Contact Job Title: | | 10. Contact Phone: () () | | 11. Contact Fax: () () | | 12. Contact E-mail: | |
| 13. Billing Address Street: | | Suite/Unit #: | City: | | State: | Zip: | Check if Residence <input type="checkbox"/> |
| 14. Street Address (if different) (no P.O. Box) Street: | | Suite/Unit #: | City: | | State: CA | Zip: | Check if Residence <input type="checkbox"/> |
| 15. Workers' Comp Carrier Name: (not broker or agency name) | | 16. Policy #: | | 17. Future Renewal Date: (mo/day/year) / / | | | |

Note: Workers' Compensation Coverage must be effective on or prior to the effective date requested with CaliforniaChoice 51+

B. Enrollment & Eligibility Information

| | | | | |
|---|--|----------------------|------------------------------------|---------------------------------|
| 1. Requested effective date (mo/day/year) / 01 / | | | | |
| 2. Have you employed 20 or more employees during at least 50% of the preceding calendar year? (COBRA) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Total # of COBRA enrollees: | |
| 3. Have you employed 20 or more employees for 20 or more weeks during the current or preceding year? (TEFRA) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 4. Does your group currently have group medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Carrier Name: | Policy #: | Termination Date: / / |
| 5. All new employees and their dependents will be eligible for coverage the first of the month following a waiting period of: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days <i>(Other options are not available, please do not write in)</i> | | | | |
| 6. Waiting period applies to: <input type="checkbox"/> Future employees (hired after the effective date) <input type="checkbox"/> Current (hired on or prior to effective date) and future employees | | | # in waiting period | |
| 7. Total number of employees on payroll regardless of hours worked: _____ (including owners, seasonal, etc.) Total number of <u>active eligible</u> employees on payroll: _____ (including owners, seasonal, etc.) Total number of eligible employees <u>applying</u> for medical: _____ (including owners, seasonal, etc.) | | | | |
| 8. Number of employees waiving due to: A) Other Group Coverage _____ B) Other Individual Coverage _____ | | | | |
| 9. Total number of <u>ineligible</u> employees in each of the following categories: (write "0" if none) A) Union: _____ B) Part-time: _____ C) Seasonal: _____ D) Temporary: _____ E) Terminated: _____ | | | | |
| 10. Are all eligible employees covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 11. How many of the employees (including owners) enrolling are related by blood or marriage? _____ | | | | |

C. Network

Yes, I am electing to offer the Health Net Silver HMO Provider Network to my employees.

D. Premium Contribution Method

NOTE: Employer must pay for at least 50% of each employee's lowest cost premium. Dependent contributions are optional for Employer. Employer contribution cannot be applied toward the Salud HMO y Más.

PARTICIPATING HEALTH PLANS: HMO plans include Health Net of California Inc., Kaiser Permanente and Western Health Advantage. PPO plans include Health Net Life Insurance Company.

CHOOSE ONLY ONE OPTION BELOW:

OPTION 1 PERCENTAGE OF COST

STEP 1: Enter the percentage amount you will contribute toward:

Employee Premium: _____% (50% minimum) Dependent Premium: _____% (write 0 if none)

STEP 2: Apply contribution toward one HMO, PPO, HDHP or ANY Plan Option (A, B or C)

- A. HMO:**
- Lowest cost plan in HMO benefit level:
 - Highest cost plan in HMO benefit level:
 - All plans in HMO benefit level:

- 15 15 Value 20/\$500 Value
 25 25 Value 40 40 Value

- Specific Health Plan (select one from list):

| Carrier | HMO 15 | HMO 15 Value | HMO 20/\$500 Value | HMO 25 | HMO 25 Value | Elect Open Access | HMO 40 | HMO 40 Value | HDHP 1500* | HSA 1800 |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Health Net | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kaiser Permanente | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Western Health Advantage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*HSA-qualified High Deductible Health Plan

- B. PPO:** PPO 250 PPO 500 PPO 1000 PPO 1500
 HSA 1500 HSA 2000

**Underwritten by Health Net
Life Insurance Company**

- C. Any HMO or PPO plan selected by employee**

OPTION 2 EMPLOYER FIXED DOLLAR AMOUNT

Enter the dollar amount you will contribute which will be applied to any plan selected by employee:

\$ _____ for Employee

OR

\$ _____ Combined amount for Employee and Dependents

\$ _____ for Dependents

E. Medical Questionnaire

Please answer the following questions to the best of your knowledge regarding the eligible enrollees (employee, dependents, COBRA, proprietors and partners).

Have any eligible enrollees:

1. Been hospitalized during the past 12 months? If yes, explain: _____ Yes No
2. Been diagnosed with or being treated for cancer, brain tumor, blood disease, heart disease or heart disorder, stroke, AIDS, AIDS related conditions, nervous system disorder, mental condition, liver/kidney disease, birth defect, transplant, or any other medical condition? If yes, circle condition(s) Yes No
3. Received medical benefits in excess of \$50,000 in the last 12 months? If yes, explain: _____ Yes No

Are any eligible enrollees:

4. Currently pregnant? If yes, provide total number of pregnancies: _____ Yes No
5. Currently expecting a multiple birth? If yes, provide total number of enrollees: _____ Yes No
6. Currently disabled? If yes, provide total number of disabled: _____ Yes No

Please be advised that Employee Enrollment Application forms are available in the following languages: Spanish, Vietnamese and Chinese - please contact your broker or CaliforniaChoice 51+. Some translations in these languages are also available to your employees on an on-going basis as well as interpretation services in 150 different languages. CaliforniaChoice 51+ would be glad to give you copies of the Employee Enrollment Application Form in the "threshold languages" of the Plan(s) your employees select. Please contact us or your broker to receive these.

F. Statement of Compliance

I hereby certify that all the information contained in the Employer and Employee applications are true and correct to the best of my knowledge. I have read and understand the following statements and confirm that my group complies with all the rules and regulations of the CaliforniaChoice 51+ Program. I understand that no coverage will become effective until notified by the CaliforniaChoice 51+ Underwriting Department.

- Our Home Office is located in California.
- I will maintain 70% participation of all eligible employees, excluding those with other "group" coverage, and a minimum of 40.
- CaliforniaChoice 51+ coverage will be offered to all eligible employees on a uniform basis for those working 30+ hours per week.

I understand that once CaliforniaChoice 51+ coverage is approved, group policy changes cannot be implemented until the next Renewal period. These changes shall include, but are not limited to COBRA provisions, new hire waiting period, and premium contribution amounts.

I understand that once membership information is transmitted to the elected health plans, our group coverage effective date cannot be changed nor can our coverage be terminated until after the first month of coverage.

I understand that no alterations can be made to this section and that it must be signed exactly as stated.

I understand that the above statements are subject to audit at any time.

I understand that the above qualifications must be maintained in order for my group to continue coverage through CaliforniaChoice 51+.

I agree to provide CaliforniaChoice 51+ with any and all information necessary to prove the above statements.

I understand that if I am unable to provide the requested information, all CaliforniaChoice 51+ benefits will terminate 15 days following notice of termination, and employees will be held responsible for all services and charges incurred through CaliforniaChoice 51+ program providers.

I understand that any persons, business, or health plan that suffers a loss because of false declarations contained in this Employer Application may have cause to bring civil action against our company to recover their losses.

I understand that premium payments are to be received by CaliforniaChoice 51+ by the statement due date and if payment is not received by the due date, my group will be subject to a 10% late fee.

I DECLARE UNDER THE PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining coverage.

My signature acknowledges my decision to contribute toward the medical coverages that I selected in Section D, and my decision to offer the Optional Benefits selected in Sections G, H, I, J & K.

Employer Signature

Print Name

Date

Company Name

Witness Signature or Broker Signature

Print Name

Date

Health Net of California Inc. offers the following products: ELECT Open Access, HMO. Health Net Life Insurance Company offers the following products: Flex Net, PPO

To be completed by BROKER:

General Agent/PPGA Name: (if applicable)

Broker name (please print): **Must be broker name—not agency**

Co-broker name: (please print)

Phone:

()

Fax:

()

Phone:

()

Fax:

()

Commissions payable to:

% Commissions if split:

Commissions payable to:

% Commissions if split:

I certify that the employer applying for coverage through the CaliforniaChoice 51+ Program has met the 70% participation requirement

Broker signature:

Co-broker signature:

Optional Benefits Application GROUP NAME: _____

| | |
|--|---|
| G. Dental Insurance | SmileSaverSM (Prepaid)/Ameritas Group (EPO & PPO) |
| <p>When electing dental coverage, the undersigned employer hereby applies for membership in the Bankers Life Nebraska Preferred Trust and agrees to be bound by all the terms and conditions of the Declaration of Trust.</p> <p>Select one plan offering:</p> <p><input type="checkbox"/> All buy-up dental plans: Prepaid 1000 & 3000, EPO 3000 & 3500, and PPO 4000 & 5000 WITHOUT Ortho</p> <p><input type="checkbox"/> All buy-up dental plans: Prepaid 1000 & 3000, EPO 3000 & 3500, and PPO 4000 & 5000 WITH Ortho</p> <p><input type="checkbox"/> AccessPlus Dental 100</p> | |
| <p>Groups electing EPO 3000, EPO 3500, PPO 4000 or PPO 5000 qualify for takeover benefits by submitting the following: 1) group's most recent dental billing statement; 2) statement from 12 months prior to effective date; 3) and 24 months prior showing Ortho for Ortho takeover.</p> | |
| Complete items 1-6: | |
| 1. Total number of employees applying for dental coverage: _____ | |
| 2. Total number of COBRA eligibles applying for dental coverage: _____ | |
| 3. Percentage of employee-only premium paid by Employer: _____ % <i>(Employer must pay a minimum of 50%)</i> | |
| 4. Percentage of dependent premium paid by Employer: _____ % <i>(write 0 if none)</i> | |
| 5. Employer contribution is based on plan: <i>(Check one box only)</i> | |
| <input type="checkbox"/> Prepaid 1000 <input type="checkbox"/> EPO 3000 <input type="checkbox"/> PPO 4000 <input type="checkbox"/> Prepaid 3000 <input type="checkbox"/> EPO 3500 <input type="checkbox"/> PPO 5000 | |
| 6. Does your group currently have dental? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, carrier name: _____ | |

| | | |
|----------------------------|---|--|
| H. Voluntary Vision | <input type="checkbox"/> Check this box if you would like to offer Voluntary Vision at an additional charge to your employees | Combined Insurance Company of America |
|----------------------------|---|--|

| | |
|---|----------------------------|
| I. ChiroPlus | Landmark Healthcare |
| CHOOSE <u>ONE</u> PLAN ONLY: <input type="checkbox"/> Chiropractic Only <input type="checkbox"/> Chiropractic & Acupuncture | |

| J. Life Insurance (choose one option) | Assurity Life Insurance Company | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|----------|--------------------|----------|---------|----------|----------|----------|-------|----------|----------|----------|----------|-----------|---------|----------|-----------|---------|----------|-----------|--|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> OPTION 1: Flat Amount Select a Flat amount for all employees: 1. Amount \$: _____ 2. # of eligible employees: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> OPTION 2: Scheduled Amount Select up to 6 amounts. The highest amount cannot be more than 5 times that of the lowest amount and each class cannot be more than 2.5 times the next lower class | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1" style="width:100%; border-collapse: collapse; font-size: small;"> <thead> <tr> <th colspan="3" style="text-align: center;">Guaranteed Issue Amounts available for both options</th> </tr> <tr> <th style="text-align: center;">Eligible Employees</th> <th style="text-align: center;">Minimum</th> <th style="text-align: center;">Maximum</th> </tr> </thead> <tbody> <tr><td style="text-align: center;">51-74</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$50,000</td></tr> <tr><td style="text-align: center;">75-99</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$75,000</td></tr> <tr><td style="text-align: center;">100-124</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$100,000</td></tr> <tr><td style="text-align: center;">125-149</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$125,000</td></tr> <tr><td style="text-align: center;">150-199</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$200,000</td></tr> <tr> <th colspan="3" style="text-align: center;">Amounts in between available in increments of \$5000</th> </tr> <tr> <td colspan="3">100% of all eligible employees (whether enrolling or waiving medical) must enroll for life coverage.</td> </tr> <tr> <td colspan="3">*Employees must fall under classification to qualify for specified amount</td> </tr> </tbody> </table> | Guaranteed Issue Amounts available for both options | | | Eligible Employees | Minimum | Maximum | 51-74 | \$10,000 | \$50,000 | 75-99 | \$10,000 | \$75,000 | 100-124 | \$10,000 | \$100,000 | 125-149 | \$10,000 | \$125,000 | 150-199 | \$10,000 | \$200,000 | Amounts in between available in increments of \$5000 | | | 100% of all eligible employees (whether enrolling or waiving medical) must enroll for life coverage. | | | *Employees must fall under classification to qualify for specified amount | | |
| Guaranteed Issue Amounts available for both options | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eligible Employees | Minimum | Maximum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 51-74 | \$10,000 | \$50,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 75-99 | \$10,000 | \$75,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 100-124 | \$10,000 | \$100,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 125-149 | \$10,000 | \$125,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 150-199 | \$10,000 | \$200,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Amounts in between available in increments of \$5000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Life Amount | Employee Classification* (i.e. management, executives, etc.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \$ _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \$ _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \$ _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \$ _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \$ _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \$ _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | |
|--|---------------------------------------|
| K. Section 125—Premium Only Plan | CONEXIS Benefit Administrators |
| * A one time \$100 Enrollment Fee must be submitted with the premium deposit | |
| 1. Name of Company President, Principal, or Partners: _____ | |
| 2. Name of Corporate Secretary: (if applicable) _____ | |
| 3. Plan Number: (usually 501) <i>(If not indicated, 501 will be used)</i> _____ | |
| 4. State of Incorporation (if applicable): _____ | |
| 5. Company Structure: | |
| <input type="checkbox"/> Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Other: _____ | |
| 6. Premium payments may be elected for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other: _____ | |
| 7. Last day of first plan year: ____/____/____ <i>(If not indicated, last day of medical plan year will be used)</i> Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date. | |
| Participation Limitations —Section 125 Premium Only Plan rules require that all participants be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore, are ineligible to participate. IMPORTANT —Read the information provided in the CaliforniaChoice 51+ Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences. | |