



Employer Application

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

Group #

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 (for CaliforniaChoice[®] 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											
18. <input type="checkbox"/> We are not covered by Workers' Compensation coverage due to legal exemption under the following checked condition:											
<input type="checkbox"/> Corporation: 100% owners/shareholders (Corporation must be closed and officers must be owners and own all stock)											
<input type="checkbox"/> LLC/Partnership: 100% owners/partners (General partnership must be set up as a Corporation with all partners as owners)											
<input type="checkbox"/> 100% family-related running business out of home (does not include domestic partners; family members must reside at the same residence)											

B. Enrollment & Eligibility Information

1. Requested effective date: (mo/day/year) / /				
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. If you answered YES to question #2, do you want your COBRA participants on your bill? (If yes, you must complete the "Group COBRA Direct Billing" contract) <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. 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				
5. Does your group currently have group medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Carrier Name:	Policy #:	Termination Date: / /
6. Eligible employees must work the following number of hours to qualify: <input type="checkbox"/> 20+ hours a week <input type="checkbox"/> 30+ hours a week				
7. 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 (Other options are not available, please do not write in)				
8. Waiting period applies to: <input type="checkbox"/> Future employees (hired after the effective date) <input type="checkbox"/> Current and future employees (Current=hired on or prior to effective date)			# in Waiting Period	
9. 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 and partners) Total number of eligible employees <u>applying</u> for medical: _____ (including owners and partners)				
10. Number of employees waiving due to: A) Other Group Coverage _____ B) Other Individual Coverage _____				
11. 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: _____				
12. How many of the employees (including owners) enrolling are related by blood or marriage? _____				

C. Network

Yes, I am electing to offer the Anthem Blue Cross Select HMO and Health Net Silver HMO Provider Networks 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 mas or Salud Mexico plan.

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 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 25 30 40
 25 Value 30 Value 40 Value

Carrier	HMO 15	HMO 25	HMO 25 Value	Elect Open Access	HMO 30	HMO 30 Value	HMO 40	HMO 40 Value
Anthem Blue Cross	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
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"/>
Sharp	<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"/>

B. PPO: 750 1000 3000 4000 HSA 1800* HSA 2500* *PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE*

*HSA-Qualified High Deductible Health Plan

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

Please be advised that Employee Enrollment Application forms are available in the following languages: Spanish, Chinese, Korean, Tagalog and Vietnamese - please contact your broker or CaliforniaChoice®. 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 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.

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:	% Commission if split:	Commissions payable to:	% Commission if split:
I certify that the employer applying for coverage through the CaliforniaChoice Program has met the 70% participation requirement			
Broker signature:		Co-broker signature:	

E. 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® Program. I understand that no coverage will become effective until notified by the CaliforniaChoice Underwriting Department.

- Our Home Office is located in California.
- A majority (51+%) of our eligible employees reside in California.
- I will maintain 70% participation including all eligible employees. (those working either 20+ or 30+ hours per week as checked in Section B).
- CaliforniaChoice coverage will be offered to all eligible employees on a uniform basis for those working either 20+ or 30+ hours per week as checked in Section B.
- All employees enrolling are currently working the minimum number of hours per week to be considered eligible (either 20+ or 30+ hours per week as checked in Section B) to enroll for CaliforniaChoice coverage.

I understand that once CaliforniaChoice coverage is approved, group policy changes cannot be implemented until the next Open Enrollment period. These changes shall include, but are not limited to COBRA provisions, new hire waiting period, minimum hours worked per week, 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.

I agree to provide CaliforniaChoice Benefit Administrators 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 benefits will terminate 15 days following notice of termination, and employees will be held responsible for all services and charges incurred through CaliforniaChoice 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 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.

Owner/Partner Signature

Witness Signature of Broker of Record

Print Name

Date

Print Name

Date

Company Name

F. Medical Questionnaire (15 or more medically enrolling employees*)

The employer must answer the following questions to the best of his/her knowledge for all eligible employees, proprietors, partners, corporate officers, COBRA participants and all eligible dependents, including spouses & domestic partners to be enrolled.

1. Is any employee to be covered not actively at work performing his or her full-time duties or missed five or more days in the last two months due to injury or illness? YES NO

Provide name(s) of employee(s) not actively at work: _____
(write "NA" if none) _____

2. Has anyone been treated for a serious illness, been hospitalized, had surgery or incurred medical expenses in excess of \$5000 during the past 5 years? YES NO

If "yes" please enter reason: _____

3. Is anyone currently being treated or been advised to seek treatment for cancer, chest pain, heart disease, stroke, high blood pressure, kidney disorder, liver disease, birth defects, transplants, brain tumor, nervous system disorders, diabetes, AIDS, AIDS Related Complex, Chronic respiratory disease, alcoholism, chemical dependency, mental disorder, depression or any other serious conditions? If "yes" please circle condition(s) YES NO

4. Is anyone currently pregnant? YES NO

If "yes" how many?

*** IMPORTANT:** Employees must complete an individual Health Questionnaire if less than 15 employees are medically enrolled. (COBRA participants are not counted as employees.)

Optional Benefits Application GROUP NAME: _____

G. Dental Insurance

SmileSaverSM (Prepaid)/Ameritas Group (EPO & PPO)

When electing dental coverage, the undersigned employer hereby applies for membership in the Bakers Life Nebraska Preferred Trust and agrees to be bound by all the terms and conditions of the Declaration of Trust.

Step 1: Select one plan offering:

- All buy-up dental plans: Prepaid 1000 & 3000, EPO 3500, and PPO 4000 & 5000 WITHOUT Ortho
- All buy-up dental plans: Prepaid 1000 & 3000, EPO 3500*, and PPO 4000* & 5000* WITH Ortho*
- Voluntary 3000 and FDH Access 100
- FDH Access 100 only

**PPO plans with Ortho are only available to groups with 5 or more eligible employees*

Groups electing 3500, 4000 or 5000 with 10 or more employees qualify for takeover benefits by submitting the following: 1) Group's most recent prior dental billing statement; 2) Statement from 12 months prior to effective date; 3) and 24 months prior showing Ortho for Ortho takeover

Step 2: Complete numbers 1-6 below for buy up dental plans only:

(Do not complete for Voluntary 3000 or FDH 100)

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: _____ % *(Employer must pay a minimum of 50%)*
4. Percentage of dependent premium paid by Employer: _____ % *(write 0 if none)*
5. Employer contribution is based on plan: 1000 3000 3500 4000 5000 *(Check one box only.)*
6. Does your group currently have dental? Yes No If yes, carrier name: _____

H. Voluntary Vision

Check this box if you would like to offer Voluntary Vision at an additional charge to your employees

Combined Insurance Company of America

I. Chiro Plus

Landmark Healthcare, Inc.

CHOOSE ONE PLAN ONLY: Chiropractic Only Chiropractic & Acupuncture

J. Life Insurance

CHOOSE ONE OPTION ONLY ↓

Assurity Life Insurance Company

OPTION 1: Flat Amount
Select a Flat amount for all employees:

- 1.. Amount \$:
2. # of eligible employees:

Guaranteed Issue Amounts available for both Options

Eligible Employees	Minimum	Maximum
2-10	\$10,000	\$25,000
11-25	\$10,000	\$50,000
26-50	\$10,000	\$75,000

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 →**

OPTION 2: Scheduled Amount
Select up to 4 amounts with the **highest being NO MORE THAN 2.5 X the lowest.**
(highest amount ok in increments of \$500)

Life Amount	Employee Classification* <i>(i.e. management, executives, etc.)</i>
\$ _____	_____
\$ _____	_____
\$ _____	_____
\$ _____	_____

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)
4. State of Incorporation (if applicable): _____
5. Company Structure:
 - Corporation S Corporation Partnership Sole Proprietorship LLC Other _____
6. Premium payments may be elected for: Medical Dental Vision Other: _____
7. Last day of first Plan year: ____/____/____
Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date.

Participation Limitations

P.O.P. rules require that all participants in the plan 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 in the P.O.P.

IMPORTANT: Read the information provided in the CaliforniaChoice Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Employer Signature:
(4 of 4)

Print Name

Date