



# 2-50 Small Group Employer Application

www.bluecrossca.com

Blue Cross Dental Net and Blue Cross Dental SelectHMO, and all medical products except Blue Cross Basic PPO, Blue Cross Saver PPO and Advantage PPO offered by Blue Cross of California. Blue Cross PPO and FFS Dental, Blue Cross Basic PPO, Blue Cross Saver PPO, Advantage PPO, Life and AD&D products offered by BC Life & Health Insurance Company.



## 1. EMPLOYER INFORMATION

Company Name		Group No. (For existing groups)	
Street Address	City	State	ZIP Code
Billing Address	City	State	ZIP Code
Employer is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Other (Explain):		Type of Business (Be specific)	
Date Business Established (Mo/Yr)	Company Contact Person	Phone No. ( )	Fax No. ( )
Has company been insured by Blue Cross in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior Blue Cross coverage terminated:		E-mail Address	

## 2. EMPLOYER MEDICAL CONTRIBUTION OPTION

Check one:

Defined Contribution 100\*

Defined Contribution 80\*\*

Defined Contribution Select\*\*\* \$ \_\_\_\_\_

Traditional Contribution: \*\*\*\*  
Employee: \_\_\_\_\_% Dependent: \_\_\_\_\_%

\* Employer contributes \$100 per employee per month.  
\*\* Employer contributes \$80 per employee per month.  
\*\*\* Employer selects contribution amount over \$100 per employee per month.  
\*\*\*\* Employer selects contribution amount of 50% or more per employee per month.

## 2a. MEDICAL COVERAGE SELECTION – EmployeeElect Plus

All plans \*

OR, designate specific plan option(s) (Check as many as apply.)

<input type="checkbox"/> Basic PPO*	<input type="checkbox"/> Premier PPO \$20 Copay**
<input type="checkbox"/> Saver PPO	<input type="checkbox"/> Premier PPO \$10 Copay**
<input type="checkbox"/> PPO \$40 Copay	<input type="checkbox"/> High Deductible EPO
<input type="checkbox"/> PPO \$30 Copay	<input type="checkbox"/> Saver HMO
<input type="checkbox"/> Advantage PPO \$25 Copay	<input type="checkbox"/> HMO 100%**
<input type="checkbox"/> Other _____	

\* Basic PPO is included in the "all plans" option or can be selected in combination with one or more additional PPO/EPO only to groups uninsured for 30 or more days.  
\*\* Premier PPO \$20 Copay, Premier PPO \$10 Copay, and HMO 100% are not available with Defined Contribution 80 Option.

## 3. EMPLOYER DENTAL CONTRIBUTION OPTION

Check one:

Defined Contribution 15\*

Defined Contribution Select\*\* \$ \_\_\_\_\_

Traditional Contribution \*\*\* \_\_\_\_\_%

\* Employer contributes \$15 per employee per month.  
\*\* Employer selects contribution amount over \$15 per employee per month.  
\*\*\* Employer selects contribution amount of 50% or more per employee per month.

## 3a. DENTAL COVERAGE SELECTION – EmployeeElect Plus

All plans

OR, designate specific plan option(s) (Check as many as apply.)

<input type="checkbox"/> High Option PPO*	<input type="checkbox"/> Dental Net
<input type="checkbox"/> Standard Option PPO*	<input type="checkbox"/> Blue Cross Dental SelectHMO
<input type="checkbox"/> Basic Option PPO*	<input type="checkbox"/> Other _____

\* Fee-for-service dental coverage will be substituted if the member is outside of PPO dental service area.

## 4. LIFE BENEFIT SELECTION

Choose one schedule only:

Employer Contribution: \_\_\_\_\_ Employee Life Premium: \_\_\_\_\_% Dependent Life Premium: \_\_\_\_\_%

Schedule A – Any amounts between \$15,000 and \$250,000 in \$1,000 increments for all employees (specify): \$ \_\_\_\_\_

Schedule B – Benefits by job title – Any amounts between \$15,000 and \$250,000 in \$1,000 increments.  
Benefit amount for Class I cannot exceed 2.5 times benefit amount for Class II.  
Class I – Officers, managers, supervisors – (specify) \$ \_\_\_\_\_ Class II – All other employees – (specify) \$ \_\_\_\_\_

Schedule C – Salary Based Life Insurance  
All employees in Salary Based Life Insurance must have the same salary schedule.  
Indicate maximum benefit up to \$250,000.  
 1 times employee's annual salary – Max. benefit: \$ \_\_\_\_\_ OR  2 times employee's annual salary – Max. benefit: \$ \_\_\_\_\_  
If you choose Schedule C, please provide list of employees and annual base salary.

Dependent Life option:

\$10,000 spouse, \$10,000 children six months to 19 years (age 24 if full-time student), \$1,000 for children under six months of age.  
**This option only available if employee life benefit is \$20,000 or more.**

\$5,000 spouse, \$5,000 children six months to 19 years (age 24 if full-time student), \$500 for children under six months of age.



**2-50 Small Group Employer Application (Continued)**

**5. SUPPLEMENTAL LIFE BENEFIT SELECTION AND/OR VOLUNTARY DENTAL COVERAGE**

- A.  Check if you are offering Supplemental Life coverage to your employees. The Supplemental Life premium may be 100% employee paid.
- B.  Check if you are offering Voluntary Dental coverage to your employees. Voluntary Dental premium may be 100% employee paid.

**6. SECTION 125 PREMIUM ONLY PLAN (P.O.P.) OPTION**

- Check if you would like to enroll in P.O.P. (You must fully read the P.O.P. application booklet, complete the application form, and submit the completed form, and separate enrollment check if applicable, along with this Employer Application.)

**7. EMPLOYEE ELIGIBILITY**

- A. Total No. employees (including owners/officers): \_\_\_\_\_
- B. No. of eligible full-time employees (min. 30 hrs. weekly): \_\_\_\_\_
- C. Are part-time employees (20-29 hours weekly) to be covered? .....  Yes  No
- D. Are all eligible employees subject to withholding as on a W-2 Form?.....  Yes  No  
If no, please explain: \_\_\_\_\_
- E. Total No. of eligible **ENROLLING** employees: \_\_\_\_\_
- F. Total No. of Cal-COBRA/COBRA/FMLA applicants: \_\_\_\_\_
- G. No. of eligible employees **DECLINING** coverage: \_\_\_\_\_
- H. No. of **INELIGIBLE** employees: \_\_\_\_\_ Reason for **ineligibility**: \_\_\_\_\_
- I. If this group is a class carve-out (i.e., management only), please identify the class of employees to be covered: \_\_\_\_\_
- J. Do you wish to offer coverage for domestic partners? .....  Yes  No
- K. Probationary period/waiting period for employees:  
 1st of month following date of hire  1 month  2 months  3 months  4 months  5 months  6 months
- L. Under TEFRA/DEFRA, Medicare is primary coverage for groups of less than 20 employees, and Blue Cross is primary coverage for groups of 20 or more employees. **This is based upon the total number of employees during 50% of working days in the previous calendar year.** Please check the box that applies to your group.  
 Medicare is primary (less than 20 employees)  Blue Cross is primary (more than 20 employees)

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>M. Is your group currently subject to Cal-COBRA? (employed 2-19 full-time employees on at least 50% of the working days in the previous calendar year or if not, in business during any part of the previous calendar, previous quarter, and are not subject to COBRA.)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>N. Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year and are not subject to Cal-COBRA.) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>O. Is your group subject to the Family Medical Leave Act of 1993? (50 or more total employees.)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> | <p><b>If yes, please complete the Cal-COBRA/COBRA/ FMLA questionnaire.</b></p> |
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**8. EFFECTIVE DATE**

Requested Effective Date: \_\_\_ / \_\_\_ / \_\_\_ Actual effective date will be assigned if application is accepted.

**9. CURRENT CARRIER**

Has this employer group had group health coverage within 30 days of the signature date of this application?  Yes  No

Is this plan intended to replace any existing group coverage?	Name of Group Carrier	Proposed Termination Date
Health: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No		



**2-50 Small Group Employer Application (Continued)**

**10. LEAVE OF ABSENCE**

Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence. (Maximum 3 months)  None  1 month  2 months  3 months

Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence. (Maximum 6 months)  None  1 month  2 months  3 months  4 months  5 months  6 months

**11. MEDICAL INFORMATION**

To your knowledge, is any person to be covered unable to work due to injury or illness? .....  Yes  No

To your knowledge, is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? .....  Yes  No

Provide name(s), date(s) and degree of recovery for any "Yes" answers: \_\_\_\_\_

**12. WORKERS' COMPENSATION**

Current Workers' Compensation carrier: \_\_\_\_\_ Next Renewal Date: (mm/dd/yy) \_\_\_\_\_

List name and job title of any person to be included as a subscriber under the Blue Cross coverage who is not an employee, for the purpose of Workers' Compensation law or similar legislation. Please note that under California Labor Code Section 3351, partners and corporate officers, or members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances. In order for individuals holding the above-mentioned positions to fall outside the Workers' Compensation laws, they must be shareholders of the corporation, and all stock of the corporation must be held by persons who are either officers or members of the board of directors of the corporation.

**List all medically enrolling employees NOT covered by Workers' Compensation:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Exempt according to above requirements?  Yes  No

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Exempt according to above requirements?  Yes  No

**13. SIGNATURE**

Check the box that applies:

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employment Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employment Retirement Income Security Act), and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Blue Cross/BC Life & Health may rely on this application in deciding whether to provide coverage. If the application is not complete, Blue Cross reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Blue Cross and only if we have paid our first month's contribution and this application is accepted, that we should keep prior coverage in force until notified of acceptance in writing by Blue Cross/BC Life & Health and that no agent or broker has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Blue Cross/BC Life & Health.

Coverage may be rescinded if there are misstatements in this application. We have provided the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, with an explicit written notice specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of twelve (12) months as well as a six-month preexisting condition exclusion, and we have received signed acknowledgment.

For BC Life & Health insurance coverages, we, the employer, apply to become a participating employer in the Small Group Trust to obtain the coverages indicated. We understand that the Small Group Trust and the underwriting companies may rely on the application, deciding whether to allow us to participate in the Small Group Trust. We hereby acknowledge receipt of BC Life & Health's benefit description attached to and made a part hereof. We understand and agree that: 1) no coverage will be effective before the date determined by the Small Group Trust and the underwriting companies and only if: a) we have paid for the first month's contribution; and b) this application, and any individual applications have been approved by the Small Group Trust and the underwriting companies; 2) this application, if accepted, and any subsequent amendments become our participation agreement with the Small Group Trust, and 3) the trust agreement and contracts under which we elected coverage are incorporated in and are made a part of the participation agreement. The employer agrees to comply with all provisions of the Small Group Trust. I understand and agree to all of the above. I understand that it is required to submit a DECLINATION of coverage any time that an employee and/or dependent is/or becomes eligible for coverage, but does NOT enroll.

Continued on next page.



**2-50 Small Group Employer Application (Continued)**

**13. SIGNATURE (Continued)**

**For employers offering a Medical Savings Account (MSA) compatible EPO Plan:** We, the employer, understand that the MSA compatible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. We understand that having this coverage does not establish an MSA.

The MSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the MSA tax benefits. The IRS has not yet issued MSA or high deductible health plan regulations or determined that Blue Cross of California/BC Life & Health high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

**Arbitration Agreement:** We understand that any and all disputes, between us and Blue Cross of California/BC Life & Health, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, Blue Cross/BC Life & Health and we are giving up the right to pursue on a class basis any claim or controversy against each other.

If we are enrolled as an administrator of an Employee Welfare Benefit Plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) we understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, we further understand that any dispute we may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process has been completed.

Name of Company Officer <i>(Please print)</i>	Title of Company Officer
Signature of Company Officer <b>X</b>	Date <i>(Month/Day/Year)</i>

**14. AGENT'S CERTIFICATION**

**I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk.**

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notification from Blue Cross for itself and BC Life & Health that the coverage being applied for by this application is accepted.

Name of Writing Agent <i>(Print or type)</i>		%	Agent I.D. No.
Agent Address		City/State/ZIP Code	
Phone No. ( )	Fax No. ( )	Writing Agent's Signature <b>X</b>	Date
Name of Second Writing Agent <i>(Print or type)</i>		%	Agent I.D. No.
Phone No. ( )		Second Agent's Signature <b>X</b>	Date
<b>For General Agent Use Only</b>	Name of General Agent	Agent I.D. No.	
	Street Address	City/State/ZIP Code	

Send Administration Kit to:  Agent  Group





# Cal-COBRA/COBRA/FMLA Questionnaire

## CAL-COBRA

California law SB719 requires employers with 2-19 eligible (AB 1672-qualified) employees to extend health coverage programs to former employees.

## COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers, with 20 or more total employees, to extend health coverage programs to former employees, spouses (widowed or divorced), and their dependents when a qualifying event occurs.

### I. Complete for each employee or family member currently on Cal-COBRA or COBRA.

1. Name	Date of Birth	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Social Security No.
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Date of Qualifying Event | Qualifying Event

2. Name	Date of Birth	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Social Security No.
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Date of Qualifying Event | Qualifying Event

3. Name	Date of Birth	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Social Security No.
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Date of Qualifying Event | Qualifying Event

### II. For COBRA Applicants: Complete for each employee terminated in the last 90 days who has experienced a qualifying event. For Cal-COBRA Applicants: Complete for each employee terminated in the last 60 days who has experienced a qualifying event.

1. Name	Date of Termination	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Social Security No.
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Qualifying Event

To the best of your knowledge, will this employee/dependent(s) exercise their Cal-COBRA/COBRA option?.....  Yes  No  
If yes, is this employee/dependent(s) presently disabled? .....  Yes  No  
If yes, disabling condition: \_\_\_\_\_

2. Name	Date of Termination	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Social Security No.
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Qualifying Event

To the best of your knowledge, will this employee/dependent(s) exercise their Cal-COBRA/COBRA option?.....  Yes  No  
If yes, is this employee/dependent(s) presently disabled? .....  Yes  No  
If yes, disabling condition: \_\_\_\_\_

## FMLA

The Family and Medical Leave Act of 1993 requires groups with 50 or more employees to provide up to 12 weeks of unpaid, job-protected leave to be "eligible" employees for certain family and medical reasons.

### For FMLA Applicants: Complete for each employee on family or medical leave.

1. Name	Beginning Date of Leave	Social Security No.
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To the best of your knowledge, will this employee return to work?.....  Yes  No  
If no, is this employee presently disabled? .....  Yes  No  
If yes, disabling condition: \_\_\_\_\_

To the best of your knowledge, will this employee/dependent(s) exercise their COBRA option? .....  Yes  No

2. Name	Beginning Date of Leave	Social Security No.
---------	-------------------------	---------------------

To the best of your knowledge, will this employee return to work?.....  Yes  No  
If no, is this employee presently disabled? .....  Yes  No  
If yes, disabling condition: \_\_\_\_\_

To the best of your knowledge, will this employee/dependent(s) exercise their COBRA option? .....  Yes  No

## SIGNATURE

Signature of Company Official	Title	Company	Date
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If additional space is needed to include all applicable employees, you may list the information on a photocopy of this page and submit it with your completed application.





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