

MASTER GROUP APPLICATION

(for 2-299 employees)

GROUP BILLING UNIT

DO NOT WRITE IN SHADED AREA

ACCESS+ HMO	PPO	POS	PSP	ACTIVE CHOICE	ACCESS BAJA HMO	DENTAL HMO	DENTAL PPO	OTHER

PLEASE TYPE OR PRINT CLEARLY. USE BLACK INK.

1	FULL LEGAL BUSINESS NAME	EFFECTIVE DATE																																			
2	BILLING ADDRESS (NUMBER, STREET, CITY, STATE, ZIP) IF P.O. BOX, COMPLETE NO. 3 BELOW	COUNTY																																			
3	PHYSICAL ADDRESS OF BUSINESS (IF DIFFERENT FROM ABOVE)																																				
4	GROUP CONTACT PERSON NAME/TITLE	GROUP CEO NAME																																			
5	LEGAL ENTITY <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> OTHER (SPECIFY) _____	EMPLOYER TAX ID NUMBER EMPLOYER TAX ID # _____																																			
6	TYPE OF BUSINESS (PROVIDE AS MUCH DETAIL AS POSSIBLE), LIST THE MAJOR INDUSTRIES AND PRODUCTS/SERVICES OF YOUR BUSINESS. IF KNOWN, LIST THE STANDARD INDUSTRY CLASSIFICATION CODE(S) (SIC CODE) IN WHICH THE BUSINESS IS CLASSIFIED.																																				
7	LIST SUBSIDIARY, OR AFFILIATED COMPANIES. GIVE NAME(S), ADDRESS(ES). IDENTIFY WHICH SUBSIDIARIES SHOULD BE INCLUDED IN THE COVERAGE.	IF NO SUBSIDIARY/AFFILIATED COMPANIES APPLY, CHECK "N/A" <input type="checkbox"/> N/A																																			
8	PRIOR GROUP HEALTH CARRIER(S)	DO YOU OFFER OTHER CARRIER'S HEALTH PLANS TO YOUR EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO																																			
	IF YES, ENTER DATES OF OPEN ENROLLMENT PERIOD FROM: _____ TO: _____																																				
	EMPLOYEES TO BE EFFECTIVE ON																																				
	IF OTHER HEALTH CARRIER IS OFFERED (IN ADDITION TO BLUE SHIELD) LIST CARRIER NAME AND # OF EMPLOYEES COVERED BY THIS CARRIER NAME: _____ # EMPLOYEES _____																																				
	PRIOR DENTAL CARRIER(S)	DO YOU OFFER OTHER CARRIER'S DENTAL PLANS TO YOUR EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO																																			
	IF YES, ENTER DATES OF OPEN ENROLLMENT PERIOD FROM: _____ TO: _____																																				
	EMPLOYEES TO BE EFFECTIVE ON																																				
	IF OTHER DENTAL CARRIER IS OFFERED (IN ADDITION TO BLUE SHIELD) LIST CARRIER NAME AND # OF EMPLOYEES COVERED BY THIS CARRIER NAME: _____ # EMPLOYEES _____																																				
9	FUTURE EMPLOYEE WAITING PERIOD: _____ MONTHS (MINIMUM 0, MAXIMUM 6 MONTHS). DOES THIS WAITING PERIOD APPLY TO CURRENT EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO UNLESS OTHERWISE NOTED, EMPLOYEES HIRED ON THE 1 ST OF THE MONTH WILL BE EFFECTIVE ON THE 1 ST OF THE MONTH FOLLOWING THE COMPLETION OF THE WAITING PERIOD. EMPLOYEES EFFECTIVE DATE IS THE FIRST BILL DATE FOLLOWING THE WAITING PERIOD.																																				
10	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 10%;">TOTAL # OF ALL EMPLOYEES</th> <th style="width: 10%;">TOTAL # OF ALL FULL TIME EMPLOYEES</th> <th style="width: 10%;">TOTAL # OF ALL ACTIVE ENROLLING EMPLOYEES</th> <th style="width: 10%;">TOTAL # OF ENROLLED EMPLOYEES</th> <th style="width: 5%;">ACCESS+ HMO</th> <th style="width: 5%;">PPO</th> <th style="width: 5%;">POS</th> <th style="width: 5%;">PSP</th> <th style="width: 5%;">ACTIVE CHOICE</th> <th style="width: 5%;">ACCESS BAJA HMO</th> <th style="width: 5%;">DENTAL HMO</th> <th style="width: 5%;">DENTAL PPO</th> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>												TOTAL # OF ALL EMPLOYEES	TOTAL # OF ALL FULL TIME EMPLOYEES	TOTAL # OF ALL ACTIVE ENROLLING EMPLOYEES	TOTAL # OF ENROLLED EMPLOYEES	ACCESS+ HMO	PPO	POS	PSP	ACTIVE CHOICE	ACCESS BAJA HMO	DENTAL HMO	DENTAL PPO													
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	NUMBER OF FULL TIME EMPLOYEES IN WAITING PERIOD: _____ NUMBER OF EMPLOYEES WHO ARE DECLINING COVERAGE _____ EMPLOYER IS RESPONSIBLE FOR COLLECTING REFUSAL OF COVERAGE.																																				
	FOR EMPLOYERS OF FEWER THAN 20 EMPLOYEES: DO YOU CURRENTLY HAVE AN EMPLOYEE WHO IS 65 YEARS OR OLDER AND IS ELIGIBLE FOR MEDICARE PRIMARY RATES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE A COPY OF QUALIFYING MEDICARE CARD(S).																																				
	ARE THERE ANY OUT-OF-STATE EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MANY OUT-OF-STATE EMPLOYEES DO YOU HAVE? _____																																				
	DO YOU WISH TO OFFER COVERAGE TO YOUR OUT-OF-STATE EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO																																				
11	ARE ALL FULL TIME ELIGIBLE EMPLOYEES BEING OFFERED HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO																																				
12	DO YOU WISH TO OFFER COVERAGE FOR DOMESTIC PARTNERS? <input type="checkbox"/> YES <input type="checkbox"/> NO FOR GROUPS OF 51+: IF YES, COVERAGE FOR: <input type="checkbox"/> SAME SEX <input type="checkbox"/> SAME SEX AND OPPOSITE SEX																																				
13	FOR EMPLOYER CONTRIBUTION, ENTER PERCENT OF DUES PAID BY EMPLOYER FOR EEs (EMPLOYEES) AND DEPs (DEPENDENTS). IF 100%, ALL ELIGIBLE EMPLOYEES MUST ENROLL.																																				
	ACCESS+ HMO	FOR EEs _____ % FOR DEPs _____ %	POS	FOR EEs _____ % FOR DEPs _____ %	PPO	FOR EEs _____ % FOR DEPs _____ %	PSP	FOR EEs _____ % FOR DEPs _____ %	DENTAL HMO	FOR EEs _____ % FOR DEPs _____ %	DENTAL PPO	FOR EEs _____ % FOR DEPs _____ %																									
14	ARE ALL EMPLOYEES COVERED BY WORKERS' COMPENSATION, AS REQUIRED BY LAW? <input type="checkbox"/> YES CARRIER NAME: _____ <input type="checkbox"/> NO PLEASE EXPLAIN: ARE ALL OFFICERS AND PARTNERS COVERED BY WORKERS' COMPENSATION, AS REQUIRED BY LAW? <input type="checkbox"/> YES CARRIER NAME: _____ <input type="checkbox"/> NO PLEASE EXPLAIN:																																				
15	ARE ANY EMPLOYEES, DEPENDENTS OR COBRA PARTICIPANTS ENROLLING IN THIS BLUE SHIELD PLAN WHO ARE NOT ACTIVELY WORKING, TOTALLY DISABLED OR HOSPITALIZED AS OF THIS DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, COMPLETE DISABILITY ADDENDUM FORM NUMBER C-11248)																																				
16	<p>A) IS YOUR GROUP CURRENTLY SUBJECT TO CAL-COBRA? (EMPLOYED 2-19 EMPLOYEES FOR AT LEAST 50% OF THE WORKING DAYS IN THE PREVIOUS CALENDAR YEAR) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>B) IS YOUR GROUP SUBJECT TO FEDERAL COBRA? (EMPLOYED 20 OR MORE EMPLOYEES DURING AT LEAST 50% OF THE WORKING DAYS IN THE PREVIOUS CALENDAR YEAR) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>C) IF YOUR GROUP IS SUBJECT TO FEDERAL COBRA, DO YOU WISH TO WAIVE COBRASERV? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE ATTACH A COPY OF THE COBRASERV WAIVER FORM.</p> <p>D) HOW MANY EXISTING COBRA OR CAL-COBRA PARTICIPANTS DO YOU HAVE? _____ HOW MANY IN ELIGIBILITY PERIOD? _____</p>																																				

