

Master group application

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

For 2 to 50 eligible employees

Effective January 1, 2012

Get on the fast track

This 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.**

- Master group application (form C15385)
- Verification and Statement of Understanding (C20283)
- Employee enrollment application (form C12914) or Refusal for Coverage (C19927) completed for each eligible employee. Please verify each employee and enrolling dependent has listed their Social Security number.
- Health Statements (form C15825) are required for guaranteed-issue groups of 6 to 14 enrolling employees and all non-guaranteed-issue groups. Groups of less than 6 enrolling employees will automatically be rated at a 1.1 RAF. To apply for a RAF between 1.1 and 1.0, the submission of health statements is required.
- 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.
- Sole Proprietor, Partner, or Corporate Officer Statement (form C15293) for all enrolling owners/officers.
- Wage information for each enrolling employee will be required for eligibility verification as follows:
 - DE-9C for the previous quarter (notate updated employee status, i.e., part-time, full-time, or terminated)
 - All four DE-9C 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-9C filing)
 - Proof of owner/employer's eligibility if the owner/ employer is not listed on the DE-9C (same as noted under "Owner Only Groups" below)
- Refusal of Coverage Forms for all eligible employees and any eligible dependents who refuse coverage. Applications for dental, vision or life insurance coverage only, do not require Refusal of Coverage Forms when two or more employees enroll in any single Specialty benefits plan the group offers.
- A copy of the previous carrier's current billing statement (if applicable)
- Disability form (if applicable)
- 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.
- For groups that choose Blue Shield dental, vision or life insurance coverage 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.
- Owner Only Groups are required to submit documentation verifying that they are active businesses, employing permanent, full-time employees, including but not limited to the following documentation:
 - 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 January 1, 2012

Group billing unit

Do not write in shaded area

Premier PPO/Enhanced PPO*† plans		Base PPO plans*†		Shield Spectrum PPO SM plans*†		Simple Savings plans*†	
Access+ HMO [®] plans		Local Access+ HMO [®] plans		Access Baja [®] HMO plan		Dental PPO plans	
Dental INO plans*†		Dental HMO plans		Group Term Life/Accidental Death & Dismemberment (AD&D) insurance plans*			
Mental Health Parity benefits			Vision plans			Other	

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: _____

Secondary group contact name/title _____ Phone number () _____

Fax number () _____ E-mail address: _____

Online Account Access may be established for either you or your producer to view and/or manage your group account at blueshieldca.com/employer. If you are interested in establishing an online account, please designate and provide the following contact information for your group online administrator (GOA):

Name _____ Phone number () _____ E-mail address _____

Important Note: Even if your broker will be managing the account on your behalf, Blue Shield will first send a registration email with an activation link to the designated online administrator contact within your organization. After registering, you may then choose to delegate access to your broker.

5 Legal entity Corporation Partnership Sole proprietorship Other (specify) _____
 Federal Tax Identification number _____ Do you have multiple tax ID numbers? Yes No
 If Yes, provide the Federal Employer Tax ID number for the plan sponsor: _____

6 Type of business (provide as much detail as possible): _____

List the major industries and products/services of your business

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.

If no subsidiary/affiliated companies apply, check "N/A" N/A

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

† All Premier PPO plans (except the Premier PPO 20), Enhanced PPO, Shield Spectrum PPO, Base PPO, and Simple Savings plans and Smile In-Network Only dental plans are pending regulatory approval.

8 Name of prior group health carrier(s) _____ Do you offer other carriers' health plans to your employees? Yes No If yes, enter dates of open enrollment period
Begin date _____ End date _____ From: _____ To: _____
 No

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: _____

9 The Simple Savings 3400/6800 plan*† (HSA-eligible) is the only Blue Shield plan, 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 any of 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 Simple Savings 3400/6800 plan*† your group contract/policy will be cancelled? Yes No

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

Will the group offer a special exception to waiting period of managerial/executive new hires? Yes No

Please indicate exception waiting period here: _____ months (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 8/1/11, and the group has a 3 month waiting period – employee is eligible for enrollment effective 11/1/11. If hire date is 8/2/11, and the group has a three-month waiting period, employee is eligible for enrollment effective 12/1/11.

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 DE9C from the prior calendar year showing more than 50 total employees. Blue Shield will modify the plan's mental health and/or substance abuse coverage to be at parity with medical coverage once the requirement to comply is verified. If you have any questions regarding this requirement, please contact your broker for more information.

For 2 to 50 enrolling employees, please have them complete the Employee Application (C12914). If you have 6 to 14 enrolling employees, they must also fill out the Health Statement (C15825). Groups of less than 6 enrolling employees will automatically be rated at a 1.1 RAF, to apply for a RAF between 1.1 and 1.0, health statements are required.

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(s) who are enrolled in Medicare? Yes No

If yes, please provide a copy of qualifying Medicare card(s) and copies of two quarters DE9C.

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:

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† The Simple Savings 3400/6800 plan is pending regulatory approval.

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 Single Medical Plan Option^{1,2} Check this box to offer a single plan option. Choose from the plans listed below.

SimpleSelect plan package² Groups with 2 to 50 enrolled employees, may select any number of plans between 2 and up to 28 from the list below, not including the Access Baja plan. Employers can offer Access Baja in addition to SimpleSelect.

- Selected plans (designated below)
 ALL PLANS except Local Access+ HMO plans (includes Access+ HMO plans)
 ALL PLANS except Access+ HMO plans (includes Local Access+ HMO plans)

Premier PPO plan(s)^{*,†} 5 15 25 35 45

Enhanced PPO plan(s)^{*,†} 15 25 35 45

Base PPO plan(s)^{*,†} 30 40 50

Shield Spectrum PPOSM Plan(s)^{*,†} 750 Value 1000 Value
 1500 Value 2500 Value

Simple Savings plan(s)^{*,†,4} 2500/5000 3500/7000 4500/9000 5500/11000

HMO coverage is available with a choice of network. You must select either the Access+ HMO network or the Local Access+ HMO network for all HMO options offered. Options may not be combined.

Employers in certain counties and cities: If you are located and your eligible employees live and/or work in the Local Access+ HMO service area³ you have the option to choose our Local Access+ HMO network. The Local Access+ HMO network is a select network of providers and not as broad as the Access+ HMO network. Please review the Benefit Summary Guide (form A16609) for detailed information regarding the Local Access+ HMO provider network and service area.

Access+ HMO plan(s)

Premier 15 25 35 45

Enhanced 15 25 35 45

Access Baja HMO Plan 10

Local Access+ HMO plan(s)

Premier 15 25 35 45

Enhanced 15 25 35 45

Other

SimpleSync plan package^{5,6} Groups with 5 to 50 enrolled employees, may select any number of 9 plans listed below. SimpleSync plans may not be combined with any other plans not specifically listed below, except Access Baja. The SimpleSync package does not include a Local Access+ HMO plan option. Employers can offer Access Baja in addition to SimpleSync.

- Premier PPO 20 Enhanced PPO 30^{*,†} Enhanced PPO 40^{*,†} Simple Savings 3400/6800^{*,†,4} Shield Spectrum PPO Plan 750 Value^{*,†}
 Shield Spectrum PPO Plan 1000 Value^{*,†} Shield Spectrum PPO Plan 1500 Value^{*,†} Shield Spectrum PPO Plan 2500 Value^{*,†}
 Access+ HMO Enhanced 40

Optional benefits (cannot be purchased without a medical plan)

18 For SimpleSelect and SimpleSync plan packages, each optional benefit must be purchased for all medical plans selected.

- | | |
|---|---|
| <input type="checkbox"/> Inpatient substance abuse treatment ^Δ | <input type="checkbox"/> HMO Chiropractic/Acupuncture rider |
| <input type="checkbox"/> Infertility rider ^Δ | <input type="checkbox"/> Flexible Spending Account: Flex 123 ⁷ |
| <input type="checkbox"/> HMO Chiropractic rider | <input type="checkbox"/> Premium Only Plan (POP) ⁷ |

Dental benefit plans⁸

19 Single Dental Plan Option Check this box to offer a single dental plan option. Choose from the plans below.

Dual option Check this box for Dual Option (2+ enrolling employees). Choose any two dental plans below.

PPO SmileSM dental plans

Smile Deluxe Gold 50/1500/Ortho/U85

Smile Deluxe Plus 2000 50/2000/Ortho/MAC

Smile Deluxe 2000 50/2000/No Ortho/MAC

Smile Deluxe 50/1500/Ortho/MAC

Smile Plus Gold 50/1500/Ortho/U85

Smile Plus 50/1500/Ortho/MAC

Smile 50/1500/No Ortho/MAC

Smile Value 50/1500/No Ortho/MAC

Smile Basic 75/1000/No Ortho/MAC

Smile Basic Voluntary 75/1000/No Ortho/MAC⁹

Smile In-Network Only dental plans^{*,†}

50/2500/Endo-Perio Plus/Ortho

50/2500/Endo-Perio Plus/No Ortho

50/2500/Endo-Perio Basic/Ortho

50/2500/Endo-Perio Basic/No Ortho

Smile In-Network Only Voluntary dental plans^{*,†,9}

50/2500/Endo-Perio Plus/Ortho

50/2500/Endo-Perio Plus/No Ortho

50/2500/Endo-Perio Basic/Ortho

50/2500/Endo-Perio Basic/No Ortho

^Δ Cannot be purchased without a medical plan. Blue Shield of California 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 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).

[†] All Premier PPO plans (except the Premier PPO 20), Enhanced PPO, Shield Spectrum PPO, Base PPO, and Simple Savings plans and Smile In-Network Only dental plans are pending regulatory approval.

Form of Member Evidence of Coverage/Certificate of Insurance Booklets

23 You are responsible for the distribution of the *Evidence of Coverage/Certificate of Insurance* booklets to your covered employees. Electronic versions will be distributed via CD. Employer is responsible for distributing the documents using one of the following methods; 1) posting on the employer's intranet for employee access or, 2) emailing these documents directly to their employees. Printed versions will only be mailed to the employer directly upon request.

Please note: Electronic distribution will not apply to life insurance certificates. Printed versions of life insurance certificates will be mailed directly to employees.

I elect to receive printed, not electronic, EOC/COI booklets. I understand that I am responsible for distributing the documents to my covered employees.

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)

24 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 committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application, any coverage approved by Blue Shield/Blue Shield Life may, at the sole discretion of Blue Shield/Blue Shield Life, be cancelled, or following notice, the Health Service Contract/Insurance policy may be rescinded, or the applicable dues/rates may be 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, to decide 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

Broker information (to be completed by broker or general agent)

25 Broker name		Broker e-mail	
Broker contact name/e-mail address	Phone number ()	Fax number ()	
Broker street address (P.O. box not acceptable)			
City		State	ZIP
General agent tax ID number	Broker 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) ____ / ____ / ____	Broker 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 Groups with less than two enrolling employees are limited to a single plan selection.
- 2 75% participation required.
- 3 Local Access+ HMO products are only available in designated counties; portions of Orange, Contra Costa, Los Angeles, San Diego, San Bernardino, Riverside, Kern, Sacramento, San Mateo and Ventura, as well as San Luis Obispo, Santa Clara, Santa Cruz, San Francisco, and Yolo counties. Please review the Benefit Summary Guide (form A16609) for detailed information regarding the Local Access+ HMO provider network and service area.
- 4 HSA-eligible high-deductible health plan.
- 5 65% participation in SimpleSync required with a minimum of five enrolling employees.
- 6 If offered alongside another carrier's benefit plan, 65% of the total number of eligible employees must enroll AND a minimum participation in the combined SimpleSync plans must be equal to the greater of five enrolled employees or 50% of the total number of enrolled employees.
- 7 Offered by Ceridian Benefits Services.
- 8 75% participation required for all dental plans, except voluntary plans.
- 9 When a non-voluntary plan is combined with a voluntary plan, 75% participation of eligible employees is required.
- 10 Vision Basic plans must be purchased alongside a medical plan and enrollment in the Vision Basic plans must match that of the medical plan enrollment.