



MASTER APPLICATION (Small Group)

COMPANY INFORMATION				
Exact Legal Name of Company:		"Doing Business As" (DBA):		
Street Address	City	State	Zip Code	
Billing Address <i>(If different from above):</i>		Requested Effective Date:		
Key Contacts:				
Routine:	Phone: ()	Fax: ()	E-mail address:	
Billing:	Phone: ()	Fax: ()	E-mail address:	
Executive:	Phone: ()	Fax : ()	E-mail address:	
Tax ID:	SIC Code:	Type of Business:	Years in Business:	
Is your group subject to the Employee Retirement Income Security Act (ERISA)? <input type="checkbox"/> Yes <input type="checkbox"/> No*		Does your group qualify as a Public Agency under CA Government Code § 6500? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*If No, reason for exemption:				
Name of Current Workers' Comp Carrier:		Those <u>not</u> covered by Workers' Comp <i>(List names and why):</i>		
Prior Health Insurance Carrier:		Other Health Insurance Plans Offered:		
PLAN SPECIFICATIONS				
Class carve-out? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please provide details on carve-out: _____				
If offering benefits on a class basis or as part of a multi-choice offering, please indicate class/plan description below:				
NETWORK AND MEDICAL PLAN CHOICES:				
<input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> 10/10/100/3-day max (10 PCP & Spec Copay / 100 Hosp; 3 day max / Rx34 10/20/40) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> 15/15/250/3-day max (15 PCP & Spec Copay / 250 Hosp; 3 day max / Rx46 15/35/50) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> 20/30/500/3-day max (20 PCP / 30 Spec Copay / 500 Hosp; 3 day max / Rx39 20/35/70) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> 20/40/1000 (20 PCP/ 40 Spec Copay / 1000 Hosp / Rx46 15/35/50) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> 30/40/1000 (30 PCP / 40 Spec Copay / 1000 Hosp / Rx39 20/35/70) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> 30/40/750/day (30 PCP / 40 Spec Copay / 750 Hosp, day / Rx39 20/35/70) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> 40/40/750/day (40 PCP & Spec Copay / 750 Hosp, day / Rx49 20/35/70 w/150 ded) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> \$1000 ded/30/40/30% (\$30 PCP / \$40 Spec Copay / \$1000 ded / Rx49 \$20/\$35/\$70 w/\$150 ded) <input type="checkbox"/> Blue Choice <input type="checkbox"/> Gold Value <input type="checkbox"/> \$1500 ded/40/40/40% (\$40 PCP / \$40 Spec Copay / \$1500 ded / Rx49 \$20/\$35/\$70 w/\$150 ded)				
ASSISTED REPRODUCTIVE TECH. (ART) (Supplemental – Available to groups with 20+ eligible employees only) <input type="checkbox"/> ART C <input type="checkbox"/> No ART	CHEMICAL DEP. (Supplemental) <input type="checkbox"/> CD1a (\$150/\$20) <input type="checkbox"/> No Chemical Dep	CHIROPRACTIC (Supplemental) <input type="checkbox"/> B (\$10/30v) <input type="checkbox"/> D (\$10/20v) <input type="checkbox"/> No Chiropractic	VISION (Supplemental) <input type="checkbox"/> A0 (\$0) <input type="checkbox"/> A2 (\$20/\$20) <input type="checkbox"/> A8 (\$30) <input type="checkbox"/> No Vision	
OWNER/CORPORATE OFFICER INFORMATION (Please list all)				
Is Company a: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership or L.L.C. <input type="checkbox"/> Corporation				
1. _____	Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. _____	Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. _____	Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. _____	Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
ELIGIBILITY				
Total # of Employees:	Total # of Benefit Eligible Employees:	Total # Enrolling in Sharp Health Plan:	Total # Enrolling in other Employer Sponsored Plans:	Total # Declining Coverage:

