Blue Shield of California

An Independent Member of the Blue Shield Association

Master Group Application For 2–50 Employees

C-15385-REV (7/04)

Get on the fast track

This handy 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!

- ☐ Master group application
- ☐ Employees' enrollment applications
- ☐ Health Statements are required for guaranteed issue groups of 2 – 14 eligible enrolling employees.
- ☐ Employer Questionnaires are required for guaranteed issue groups of 15 or more eligible enrolling employees These must be dated within 45 days of the requested effective date.
- ☐ "Sole Proprietor, Partner, or Corporate Officer Statement" (form C-15293) for all enrolling owners/officers.
- ☐ Wage information for each enrolling employee will be required for eligibility verification as follows:
  - DE-6 for the previous quarter (notate updated employee status, i.e., part-time, full-time or terminated.
  - All four DE-6s from the previous year if group eligibility is based on, or includes, part-time employees.
  - Payroll records (for employees hired after the DE-6 filing)
  - Proof of owner/employer's eligibility if the owner/employer is not listed on the DE-6 (same as noted under "Owner Only Groups" below)
- ☐ Refusal of Coverage Forms for all eligible employees and any eligible dependents who refuse coverage.
- ☐ 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 HMO or Dental PPO only, enclose a separate business check for the deposit for the dental portion of the dues, payable to Blue Shield.
- ☐ Owner Only Groups will be required to submit documentation stating 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

checklist

Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

Blue Shield of California
An Independent Member of the Blue Shield Association

MASTER GROUP APPLICATION
(for 2-50 employees)

GROUP BILLING UNIT

DO NOT WRITE IN SHADED AREA

ACCESS+ HMO	Shield Spectrum PPO*	Added Advantage POS	Shield Spectrum PPO Savings Plan	ACTIVE CHOICE PLAN*	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

3 Physical Address Of Business (If Different From Above) | County

4 Group Ceo Name | Group Contact Person Name/title | Phone Number ( ) | Fax Number ( )

5 Legal Entity
☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ 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" ☐ N/A

8 Prior group health carrier(s) | Do you offer other carrier's health plans to your employees? ☐ Yes ☐ 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:

Are you planning on offering any type of self-funded wrap-around plan, in addition to your Blue Shield/Blue Shield Life group plan? ☐ Yes ☐ No | Prior dental carrier(s) | Do you offer other carrier's dental plans to your employees? ☐ Yes ☐ 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? ☐ Yes ☐ No
Employees who are hired on the 1st of the month will be effective on the 1st of the month following the completion of the waiting period. Employees effective date is first bill date following waiting period.

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Total # of all Employees	Total # of Elegible Employess	Total # of **Enrolled** Employees	ACCESS+ HMO	Shield Spectrum PPO	Shield Spectrum PPO Plan 3000*	Added Advantage POS	Shield Spectrum PPO Savings Plan	Active Choice*	Access Baja HMO	Dental HMO	Dental PPO	Vision

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? ☐ Yes ☐ No **If yes, please provide a copy of qualifying medicare card(s).**

Are there any out-of-state employees? ☐ Yes ☐ No How many out-of-state employees do you have? _____
Do you wish to offer coverage to your out-of-state employees? ☐ Yes ☐ No

11 **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

12 Do you wish to offer coverage for domestic partners? ☐ Yes ☐ No

*Shield Spectrum PPO Plan 3000 and Active Choice Plans are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

OPTIONAL BENEFITS (CANNOT BE PURCHASED WITHOUT A MEDICAL PLAN)

18 **For Dual Choice and Planselect℠ Packages, the same optional benefits must be purchased for all the plans selected**

☐ Inpatient substance abuse treatment ☐ Infertility Rider ☐ Flexible Spending Account: Flex 1-2-3

☐ Vision Basic $0/$100 ☐ Vision Basic $10/$75 ☐ Premium Only Plan (POP)

☐ Access+ HMO and/or POS Chiropractic Rider ☐ Access+ HMO and/or POS Chiro/Acupuncture Rider

DENTAL BENEFITS

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☐ DENTAL PPO PLAN - SMILE℠ BASIC	☐ DENTAL PPO PLAN - SMILE℠ DELUXE	☐ DENTAL HMO BASIC	☐ DENTAL HMO DELUXE
☐ DENTAL PPO PLAN - SMILE℠	☐ DENTAL PPO PLAN - SMILE℠ DELUXE GOLD	☐ DENTAL HMO VOLUNTARY	
☐ DENTAL PPO PLAN - SMILE℠ PLUS	☐ DENTAL PPO PLAN - SMILE℠ BASIC VOLUNTARY	☐ DENTAL HMO PLUS	

GROUP TERM LIFE AND AD&D

20 **EMPLOYEE LIFE:** (MINIMUM BENEFIT $15,000. IF CHOOSING GRADED, INCLUDE CLASS DESCRIPTION.)

☐ Flat $ _____ ☐ _____ Times salary, maximum $ _____

☐ Graded $ _____ , _____ ; $ _____ , _____ , $ _____ , _____ ,
Class Description Class Description Class Description

☐ 100% Employer Paid ☐ Contributory: Employer pays _____ % for employees (minimum 25%, _____ % for dependents

Eligibility: ☐ all full time employees ☐ only those employees enrolled in the Blue Shield/Blue Shield Life medical plan.

Dependent life: $ _____ Spouse/child(ren) (min. $1,000/max. $5,000, in $1,000 increments; spouse benefit must equal child benefit)

PAYMENT (DEPOSIT CHECK AMOUNT - THIS AMOUNT WILL BE APPLIED TO THE FIRST MONTH'S PREMIUM)

21 THE GROUP HEREWITH TENDERS THE AMOUNT OF $ _____ AND, IN CONSIDERATION OF APPROVAL OF THE APPLICATION IT WILL MAKE AND IN EVENT OF SUCH APPROVAL, PROMISES TO PAY THIS COMPANY AS APPROPRIATE ANY BALANCE NECESSARY TO CONSTITUTE THE FULL INITIAL PAYMENT FOR THE GROUP BENEFITS HEREIN IDENTIFIED ON THE CHECKLIST. IT IS UNDERSTOOD THAT THE RATES WILL BE DETERMINED FROM INITIAL ENROLLMENT DATA. IT IS UNDERSTOOD THAT COVERAGE WILL NOT COMMENCE UNTIL THE APPLICATION HAS BEEN APPROVED AND THE CONDITIONS OF COVERAGE ARE ACCEPTED BY THE EMPLOYER.

AUTHORIZATION THE FOLLOWING AUTHORIZATION SECTION MUST BE SIGNED

(BLUE SHIELD/BLUE SHIELD LIFE REQUIRES AN ORIGINAL COPY OF THIS LEGAL DOCUMENT WITH ORIGINAL SIGNATURE)

22 **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 ABOVE ARE TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT IF I HAVE MISREPRESENTED OR OMITTED ANY MATERIAL FACT, ANY COVERAGE APPROVED BY BLUE SHIELD/BLUE SHIELD LIFE MAY BE CANCELLED, THE HEALTH SERVICE CONTRACT/ INSURANCE POLICY RESCINDED OR THE APPLICABLE DUES/RATES ADJUSTED.**

AUTHORIZED SIGNATURE **NAME AND TITLE (PLEASE PRINT)** **DATE**

NOTE: Blue Shield Life does not offer life insurance coverage to employers of under ten employees due to state law. 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, deciding 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) Employer has paid for the first month's premium. Employer understands and agrees that 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.

PRODUCER INFORMATION (TO BE COMPLETED BY PRODUCER OR GENERAL AGENT)

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Producer name	Producer e-mail	Phone number ( )	Fax number ( )
Producer street address (P.O. Box not acceptable)		General Agent Tax Id#	Producer Tax ID# (Commissions will be reported under this number)
City	State	Zip	Dept. of Insurance License Number
General Agent Name	General Agent e-mail	Would you prefer to be contacted by fax or e-mail?	region / code #
Today's date (required) _____ / _____ / _____	Producer 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
Sales Rep# And Region	Account Manager/service Rep. (If Applicable)		

13 For employer contribution, enter percent of dues paid by employer for ees (employees) and deps (dependents). **If 100%, all eligible employees must enroll. (Does not apply to planselect packages. See below for planselect packages requirements.)**

ACCESS+ HMO	FOR EEs____ % FOR DEPs____%	**ACTIVE CHOICE***	FOR EEs____ % FOR DEPs____%	**SHIELD SPECTRUM PPO SAVINGS PLAN**	FOR EEs____ % FOR DEPs____%	**DENTAL PPO**	FOR EEs____ % FOR DEPs____%
ADDED ADVANTAGE POS	FOR EEs____ % FOR DEPs____%	**SHIELD SPECTRUM PPO**	FOR EEs____ % FOR DEPs____%	**SHIELD SPECTRUM PPO PLAN 3000***	FOR EEs____ % FOR DEPs____%	**DENTAL HMO**	FOR EEs____ % FOR DEPs____%

FOR PLANSELECT PACKAGES ONLY: INDICATE AMOUNT OF DEFINED CONTRIBUTION HERE: $ _____

Employer contribution must be at least $80 per employee (or the cost of the employee premium, whichever is less). If Access+ HMO Plan 5, Access+ HMO Plan 10 Premier SG, Shield Spectrum PPO Plan Zero Deductible, Shield Spectrum PPO Plan 250 Premier or a POS Plan is selected, then Active Choice Plan 500 or Shield Spectrum PPO Plan 3000 cannot be included and the employer must contribute at least $100 per employee (or the cost of the employee premium, whichever is less).

14 Are all employees, officers and partners covered by workers' compensation, as required by law?
☐ YES Carrier name: _____ ☐ NO Please explain:

15 ☐ 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 number C-11248)

16 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) ☐ YES ☐ NO
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) ☐ YES ☐ NO
C) If your group is subject to federal COBRA, do you wish to waive COBRASERV? ☐ YES ☐ NO If yes, please attach a copy of the COBRASERV waiver form.
D) How many existing COBRA or CAL-COBRA participants do you have? _____ How many in eligibility period? _____

MEDICAL BENEFITS

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ACCESS+ HMO

- ☐ ACCESS+ HMO PLAN 5
- ☐ ACCESS+ HMO PLAN 10 PREMIER SG
- ☐ ACCESS+ HMO PLAN 10 STANDARD
- ☐ ACCESS+ HMO PLAN 15
- ☐ Access+ HMO PLAN 25

.....

- ☐ CHECK THIS BOX FOR DUAL CHOICE (2+ EMPLOYEES). CHOOSE ONE HMO PLAN FROM ABOVE AND ONE OF THE FOLLOWING PLANS LISTED BELOW:
- ☐ ADDED ADVANTAGE POS
- ☐ SHIELD SPECTRUM PPO
- ☐ SHIELD SPECTRUM PPO SAVINGS PLAN
- ☐ ACTIVE CHOICE*

SHIELD SPECTRUM PPO

Choose deductible and copay:

- ☐ SHIELD SPECTRUM PPO PLAN, ZERO DEDUCTIBLE
- ☐ SHIELD SPECTRUM PPO PLAN 250 PREMIER
- ☐ SHIELD SPECTRUM PPO PLAN 250 STANDARD
- ☐ SHIELD SPECTRUM PPO PLAN 500
- ☐ SHIELD SPECTRUM PPO PLAN 1000
- ☐ SHIELD SPECTRUM PPO PLAN 3000*

SHIELD SPECTRUM PPO SAVINGS PLAN

- ☐ $2250 INDIVIDUAL DEDUCTIBLE PLAN OR $4500 FAMILY DEDUCTIBLE PLAN

ADDED ADVANTAGE POS

Choose plan:

- ☐ ADDED ADVANTAGE POS PLAN

ACTIVE CHOICE PLAN*

(Only available for employees residing in California)

- ☐ ACTIVE CHOICE PLAN 500
- ☐ ACTIVE CHOICE PLAN 750

ACCESS BAJA HMO

- ☐ ACCESS BAJA HMO PLAN 5
- ☐ ACCESS BAJA HMO PLAN 10

PLANSELECT℠ PACKAGES

Select any combination of 3 plans except Access Baja plans

(5+ EMPLOYEES)

Access Baja is not included in a PlanSelect Package. However, employers can offer it in addition to PlanSelect.

*Note: If Access+ HMO Plan 5, Access+ HMO Plan 10 Premier SG, PPO Zero Deductible, PPO 250 Premier or a POS plan is selected, then Active Choice 500 or Shield Spectrum PPO 3000 cannot be included in a PlanSelect Package.

Depending on the combination of plans selected, the employer must contribute at least $80 or $100 per employee. If employer chooses a combination with HMO 5, HMO 10 Premier SG, PPO Zero Deductible, PPO 250 Premier, or POS, the employer must contribute at least $100 per employee. The employer must contribute at least the minimum defined amount or the cost of the employee premium, whichever is less.

OTHER

_____

_____

_____

_____

FOUNDATION GROUP? ❑ YES ❑ NO

(Local Foundation for Medical Care in Kern County, Mendocino/Lake Counties, and Tulare/Kings Counties)

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