

Master group application

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

For 2 to 50 eligible employees

Effective October 1, 2010

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!

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 2 to 14 enrolling employees and all non-guaranteed-issue groups.
- 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:
 - ² C²²²² . q² f² o² W² @² V² r² 1/2² 1/2² C² W² ~ f² 2² W² 1/2² N² W² employee status, i.e., part-time, full-time, or terminated)
 - ² C²²²² p² u² r² f² 1/2² . q² ~ f² y² 2² o² W² @² V² r² 1/2² A² W² e² r² g² f² 1/2² eligibility is based on, or includes, part-time employees
 - ² C²²²² 2² A² g² u² r² o² W² f² o² r² f² 1/2² f² ~ 2² W² y² ' y² A² W² 2² 2² ~ N² W² y² ' y² A² W² f² o² r² o² W² 2² ~ W² o² W² . q² 2² u² r² g²"
 - ² C²²²² 2² C² f² f² 2² f² A² ~ W² o² W² y² ' y² A² W² e² r² g² u² r² o² W² f² o² r² f² A² ~ W²

Master Group Application (for 2 to 50 eligible employees)

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

Effective October 1, 2010

Group billing unit

Do not write in shaded area

Access+ HMO [®] plans	Shield Spectrum PPO SM plans	Added Advantage POS SM plan	Shield Savings SM plans
Active Choice SM plans*	Access Baja [®] HMO plans	Dental HMO plans	Dental PPO plans
Local Access+ HMO [®] plans	Vision plans	Other	
Group Term Life/Accidental Death & Dismemberment (AD&D) insurance plans*			Parity benefits

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: _____

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): _____

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

8 Prior group health carrier(s) _____

Begin date _____	End date _____	Do you offer other carriers' health plans to your employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, enter dates of open enrollment period From: _____ To: _____
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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: _____

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

9 The Shield SavingsSM 2250/4500, Shield SavingsSM 1800/3600 (both HSA-eligible), and the Shield Spectrum PPO Plan 3000 are the only Blue Shield plans, 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 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 Shield SavingsSM 2250/4500, Shield SavingsSM 1800/3600, or Shield Spectrum PPO Plan 3000, your group contract/policy will be cancelled? Yes No

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

If the group has a special exception to waiting period of managerial/executive new hires, please indicate here (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 8/1/09, and the group has a three-month waiting period – employee is eligible for enrollment effective 11/1/09. If hire date is 8/2/09, and the group has a three-month waiting period, employee is eligible for enrollment effective 12/1/09.

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 DE6 from the prior calendar quarter showing more than 50 total employees

If you have any questions regarding this requirement, please contact your Producer for more information.

For 2 to 50 enrolling employees, please have them complete the Employee Application (C12914). If you have 2 to 14 enrolling employees, they must also fill out the Health Statement (C15825).

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 who is enrolled in Medicare? Yes No

If yes, please provide a copy of qualifying Medicare card(s) and copies of two quarters DE-6.

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:

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 Dual Choice¹** Check this box for Dual Choice (2+ eligible employees). Choose one Access+ HMO plan, Local Access+ HMO⁸, or POS plan AND one other non-HMO plan.

Suite Deal Package^{1,2} Check this box to offer all of the specified plans listed below (2+ enrolling employees). Employers can offer Access Baja[®] HMO in addition to the Suite Deal Package.

Shield Spectrum PPO	Shield Savings ^{SM5}	Access+ HMO
Shield Spectrum PPO Plan 500 Standard*	Shield Savings SM 2000/4000*†	Access+ HMO Plan 20 Value
Shield Spectrum PPO Plan 500 Value*	Shield Savings SM 3000/6000*	Access+ HMO Plan 30
Shield Spectrum PPO Plan 1000 Value*†	Shield Savings SM QS 2000/4000	OR
Shield Spectrum PPO Plan 1500 Value*†	Shield Savings SM QS 3000/6000	Local Access+ HMO Plan 20 Value
Shield Spectrum PPO Plan 2000 Value* ^{6,†}		Local Access+ HMO Plan 30

Employers in certain Southern California counties and cities: If you are a Southern California employer whose eligible employees live and/or work in the Local Access+ HMO service area⁸ you have the option of choosing the Suite Deal medical plan package with either the Access+ HMO plans or the Local Access+ HMO plans but not both. The Local Access+ HMO plans have the same benefits as our Access+ HMO plans, at a reduced rate.

One HMO plan option must be selected; both options are not available to combine.

- Access+ HMO Plan 20 Value and Access+ HMO Plan 30 **OR** Local Access+ HMO Plan 20 Value and Local Access+ HMO Plan 30

PlanSelectSM Packages^{3,4} Groups with 2 to 50 enrolled employees, select between 2 and up to 32 plans from the list below, not including Access Baja plans. Employers can offer Access Baja in addition to PlanSelect.

Employers in certain Southern California counties and cities: If you are a Southern California Employer whose eligible employees live and/or work in the Local Access+ HMO service area⁸ you have the option of selecting a PlanSelect package with either Access+ HMO plans or Local Access+ HMO plans. Local Access+ HMO products are available as part of the PlanSelect Package provided they are the exclusive HMO plan option. Local Access+ HMO plan options may not be combined with or offered alongside any other full network HMO or POS product except Access Baja HMO. The Local Access+ plans have the same benefits as our Access+ HMO plans, at a reduced rate. The Local Access+ HMO network is an exclusive 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.

- All plans w/Access+ HMO/POS plan options
 All plans w/Access+ HMO/POS plan options (except SS1800/SS2250/PP03000)
 All plans w/Local Access+ HMO plan options (excludes Access+ HMO and POS plans)
 All plans w/Local Access+ HMO plan options (except SS1800/SS2250/PP03000, Access+ HMO and POS plans)
 Selected plans (choose at least two plans from below when not offering all plans)

Access+ HMO

- Access+ HMO Plan 5 Access+ HMO Plan 10 Access+ HMO Plan 15 Access+ HMO Plan 20
 Access+ HMO Plan 20 Value Access+ HMO Plan 30 Access+ HMO Plan 25 Access+ HMO Plan 40

Local Access+ HMO⁸

- Local Access+ HMO Plan 20 Value Local Access+ HMO Plan 30

Shield Spectrum PPO

- Shield Spectrum PPO Plan, Zero Deductible Shield Spectrum PPO Plan 250 Premier Shield Spectrum PPO Plan 250 Standard
 Shield Spectrum PPO Plan 500 Premier Shield Spectrum PPO Plan 500 Standard* Shield Spectrum PPO Plan 1000
 Shield Spectrum PPO Plan 500 Value* Shield Spectrum PPO Plan 750 Value*† Shield Spectrum PPO Plan 3000*
 Shield Spectrum PPO Plan 1000 Value*† Shield Spectrum PPO Plan 1500 Value*† Shield Spectrum PPO Plan 2000 Value*^{6,†}

Shield Savings^{SM5}

- Shield SavingsSM 1800/3600*† Shield SavingsSM 2000/4000*† Shield SavingsSM 2250/4500
 Shield SavingsSM QS 2000/4000 Shield SavingsSM 3000/6000* Shield SavingsSM 2500*
 Shield SavingsSM 4800*⁷ Shield SavingsSM QS 3000/6000 Shield SavingsSM QS 4800*

Added Advantage POS

- Added Advantage POS Plan

Active Choice Plan^{*7}

- Active Choice Plan 750 SG
 Active Choice Plan 500 SG

Access Baja HMO

- Access Baja HMO Plan 5
 Access Baja HMO Plan 10

- Other _____

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

† Shield Spectrum PPO Plan 750 Value, Shield Spectrum PPO Plan 1000 Value, Shield Spectrum PPO Plan 1500 Value, Shield Spectrum PPO Plan 2000 Value, Shield SavingsSM 1800/3600, and Shield SavingsSM 2000/4000 are pending regulatory approval.

Optional benefits (cannot be purchased without a medical plan)

18 For Dual Choice, Suite Deal, and PlanSelect packages, each optional benefit must be purchased for all medical plans selected.

<input type="checkbox"/> Inpatient substance abuse treatment ^Δ	<input type="checkbox"/> Flexible Spending Account: Flex 123
<input type="checkbox"/> Infertility rider ^Δ	<input type="checkbox"/> Premium Only Plan (POP)
<input type="checkbox"/> Local Access+ HMO and Access+ HMO and/or POS Chiropractic rider	
<input type="checkbox"/> Local Access+ HMO and Access+ HMO and/or POS Chiropractic/Acupuncture rider	

Dental benefit plans⁹

19 Suite Deal Dental Package¹⁰ Check this box to offer all five of the specified plans listed below (2+ enrolling employees).

Dental PPO – Smile Basic 75/1000/No Ortho/MAC	Dental HMO Basic
Dental PPO – Smile Value 50/1500/No Ortho/MAC	Dental HMO Plus
Dental PPO – Smile Deluxe Plus 2000 50/2000/Ortho/MAC	

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

PPO Smile plans

<input type="checkbox"/> Dental PPO – Smile SM Basic 75/1000/No Ortho/MAC	<input type="checkbox"/> Dental PPO – Smile Deluxe 2000 50/2000/No Ortho/MAC
<input type="checkbox"/> Dental PPO – Smile Basic Voluntary ¹¹	<input type="checkbox"/> Dental PPO – Smile Deluxe 50/1500/Ortho/MAC
<input type="checkbox"/> Dental PPO – Smile Value 50/1500/No Ortho/MAC	<input type="checkbox"/> Dental PPO – Smile Deluxe Plus 2000 50/2000/Ortho/MAC
<input type="checkbox"/> Dental PPO – Smile 50/1500/No Ortho/MAC	<input type="checkbox"/> Dental PPO – Smile Deluxe Gold 50/1500/Ortho/U85
<input type="checkbox"/> Dental PPO – Smile Plus 50/1500/Ortho/MAC	
<input type="checkbox"/> Dental PPO – Smile Plus Gold 50/1500/Ortho/U85	

Dental HMO plans

<input type="checkbox"/> Dental HMO Basic	<input type="checkbox"/> Other dental (specify) _____
<input type="checkbox"/> Dental HMO Plus	_____
<input type="checkbox"/> Dental HMO Deluxe	_____
<input type="checkbox"/> Dental HMO Voluntary ¹¹	_____

Vision coverage* (can be purchased with or without a medical plan)

20 Vision Standard (12/24/24)	Vision Plus (12/12/24)	Vision Deluxe (12/12/12)
<input type="checkbox"/> Vision Standard 0/25/100	<input type="checkbox"/> Vision Plus 0/25/100	<input type="checkbox"/> Vision Deluxe 0/25/100
<input type="checkbox"/> Vision Standard 0/15/120	<input type="checkbox"/> Vision Plus 0/15/120	<input type="checkbox"/> Vision Deluxe 0/15/120
<input type="checkbox"/> Vision Standard 0/25/130	<input type="checkbox"/> Vision Plus 0/25/130	<input type="checkbox"/> Vision Deluxe 0/25/130
<input type="checkbox"/> Vision Standard 0/0/130	<input type="checkbox"/> Vision Plus 0/0/130	<input type="checkbox"/> Vision Deluxe 0/0/130
<input type="checkbox"/> Vision Standard 0/25/120 Voluntary**		

^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).

** A voluntary vision plan requires a minimum of 10 enrolling employees.

