

## 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, 2011

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 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-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 out of state employees and 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. Applications for dental, vision or life insurance only do not require Refusal of Coverage Forms.
- 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 coverage, vision coverage, or life insurance 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 will be 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, 2011

### Group billing unit

Do not write in shaded area

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

Please type or print clearly. Use black ink. Please see important endnotes on page 8.

**1** Full legal business name \_\_\_\_\_ Effective date \_\_\_\_\_

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**2** Billing address: number, street, city, state, ZIP (if P.O. Box, complete No. 3 below) \_\_\_\_\_

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**3** Physical address of business (if different from above) \_\_\_\_\_ County \_\_\_\_\_

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**4** Group contact name/title \_\_\_\_\_

Phone number (     ) \_\_\_\_\_ Fax number (     ) \_\_\_\_\_

E-mail address: \_\_\_\_\_

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**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. \_\_\_\_\_

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**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: \_\_\_\_\_

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**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

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**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: \_\_\_\_\_

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 Savings<sup>SM</sup> 2250/4500, Shield Savings<sup>SM</sup> 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 Savings<sup>SM</sup> 2250/4500, Shield Savings<sup>SM</sup> 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).

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 8/1/10, and the group has a three-month waiting period – employee is eligible for enrollment effective 11/1/10. If hire date is 8/2/10, and the group has a three-month waiting period, employee is eligible for enrollment effective 12/1/10.

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. 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 Producer 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 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) \_\_\_\_\_

