Blue Shield of California

An Independent Member of the Blue Shield Association

Master Group Application For 2–50 Employees

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®´ Registered mark of CPIC Life Insurance Company

C-15385 (7/03)

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 – 24 eligible enrolling employees.
- ☐ Employer Questionnaires are required for guaranteed issue groups of 25 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 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.
- ☐ For groups that choose the stand-alone CPIC Life insurance products, send a separate business check for the deposit made payable to CPIC Life. Send it directly to CPIC Life with a copy of the CPIC Life Group Master Application New Group and Plan Design Summaries, and employee enrollment forms.
- ☐ 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

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CPIC Life
A Blue Shield of California Subsidiary

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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	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 OF CALIFORNIA 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
UNLESS OTHERWISE NOTED, EMPLOYEES 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 THE FIRST BILL DATE FOLLOWING THE WAITING PERIOD.

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TOTAL # OF ALL EMPLOYEES	TOTAL # OF ELIGIBLE EMPLOYEES	TOTAL # OF **ENROLLED** EMPLOYEES	ACCESS+ HMO	Shield Spectrum PPO	Added Advantage POS	Shield Spectrum PPO Savings Plan	ACTIVE CHOICE	ACCESS BAJA HMO	DENTAL HMO	DENTAL PPO

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 IF YES, COVERAGE FOR: ❑ SAME SEX ❑ SAME SEX AND OPPOSITE SEX

13 FOR EMPLOYER CONTRIBUTION, ENTER PERCENT OF DUES PAID BY EMPLOYER FOR EEs (EMPLOYEES) AND DEPs (DEPENDENTS). **IF 100%, ALL ELIGIBLE EMPLOYEES MUST ENROLL.**

	FOR EEs	FOR DEPs
ACCESS+ HMO	____ %	____ %
ADDED ADVANTAGE POS	____ %	____ %
SHIELD SPECTRUM PPO	____ %	____ %
SHIELD SPECTRUM PPO SAVINGS PLAN	____ %	____ %
DENTAL HMO	____ %	____ %
DENTAL PPO	____ %	____ %

14 ARE ALL EMPLOYEES COVERED BY WORKERS' COMPENSATION, AS REQUIRED BY LAW?
❑ YES CARRIER NAME: ____________________________________ ❑ NO PLEASE EXPLAIN:
ARE ALL OFFICERS AND PARTNERS COVERED BY WORKERS' COMPENSATION, AS REQUIRED BY LAW?
❑ YES CARRIER NAME: ____________________________________ ❑ NO PLEASE EXPLAIN:

15 ARE ANY COBRA PARTICIPANTS ENROLLING IN THE BLUE SHIELD PLAN DISABLED OR HOSPITALIZED, AND 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
- ❑ ACCESS+ HMO PLAN 10 STANDARD
- ❑ ACCESS+ HMO PLAN 15

- ❑ CHECK FOR DUAL CHOICE, THEN CHOOSE BLUE SHIELD Added Advantage POS, Shield Spectrum PPO, Active Choice or Shield Spectrum PPO Savings Plan

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 Savings Plan

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

Added Advantage POS

CHOOSE PLAN:

- ❑ ADDED ADVANTAGE POS PLAN

ACTIVE CHOICE

- ❑ ACTIVE CHOICE 500
- ❑ ACTIVE CHOICE 750

ACCESS BAJA HMO

- ❑ ACCESS BAJA $5 COPAY GOLD
- ❑ ACCESS BAJA $10 COPAY SILVER

MultiPlan Packages

(10+ EMPLOYEES)

- ❑ PLATINUM
- ❑ GOLD
- ❑ SILVER
- ❑ COMBINATION

Other

____

____

Foundation Group? ❑ **YES** ❑ **NO**

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

OPTIONAL BENEFITS (CANNOT BE PURCHASED WITHOUT A MEDICAL PLAN)

18

FOR DUAL CHOICE AND MULTIPLAN 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

❑ COMPREHENSIVE VISION NO COPAY OR ❑ COMPREHENSIVE VISION $10 COPAY ❑ PREMIUM ONLY PLAN (POP)

❑ ACCESS+ HMO and/or POS CHIROPRACTIC RIDER ❑ ACCESS+ HMO and/or POS CHIRO/ACUPUNCTURE RIDER

DENTAL BENEFITS

19

- ❑ DENTAL PPO PLAN - SMILE BASIC
- ❑ DENTAL PPO PLAN - SMILE
- ❑ DENTAL PPO PLAN - SMILE PLUS
- ❑ DENTAL PPO PLAN - SMILE DELUXE
- ❑ DENTAL PPO PLAN - SMILE DELUXE GOLD
- ❑ DENTAL HMO PLAN - 190
- ❑ DENTAL HMO PLAN - 200
- ❑ DENTAL HMO PLAN - 220
- ❑ DENTAL HMO PLAN - 230

CPIC LIFE/AD&D (IF CHOOSING GRADED, INCLUDE CLASS DESCRIPTIONS)

20

EMPLOYEE LIFE: (MINIMUM FLAT $15,000)

❑ 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 MEDICAL PLAN

DEPENDENT LIFE: $ ______ SPOUSE/CHILD(REN) (MIN. $1,000/MAX. $5,000, IN $1,000 INCREMENTS; SPOUSE BENEFIT MUST EQUAL CHILD BENEFIT)

APPLICANTS MUST BE ACTIVELY AT WORK FOR A MINIMUM OF 20 HOURS PER WEEK TO BE ELIGIBLE FOR LIFE COVERAGE

PAYMENT

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. GROUPS WITH 2-9 LIVES WILL PARTICIPATE AND COMPLY WITH THE REQUIREMENTS OF THE CPIC LIFE INSURANCE TRUST, AS ILLUSTRATED UNDER THE EMPLOYER ADOPTION AGREEMENT, FORM NUMBER CPU-1145.

AUTHORIZATION THE FOLLOWING AUTHORIZATION SECTION MUST BE SIGNED (BLUE SHIELD 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 OF CALIFORNIA 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 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/CPIC *LIFE* MAY BE CANCELLED, THE HEALTH SERVICE CONTRACT/INSURANCE POLICY RESCINDED OR THE APPLICABLE DUES RATE ADJUSTED.

____

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

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

23

PRODUCER NAME	PRODUCER E-MAIL	PHONE NUMBER ( )	FAX NUMBER ( )
PRODUCER STREET ADDRESS (P.O. BOX NOT ACCEPTABLE)		IRS REPORTING 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 EMAIL?	REGION / CODE #

BLUE SHIELD ACCOUNT EXECUTIVE	PHONE NUMBER	FAX NUMBER	OFFICE NUMBER
SALES REP # AND REGION	ACCOUNT MANAGER/SERVICE REP. (IF APPLICABLE)		

* Blue Shield of California protects the confidentiality and privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number and Social Security number. We will not disclose this information, except as permitted by law.

** CPIC Life Insurance Company, a wholly owned subsidiary of Blue Shield of California, has filed for a legal name change with the California Department of Insurance and the BlueCross BlueShield Association. Approval is pending until further notice.