



**Ceridian Application for Services for
Blue Cross of California Small Group Clients**



Company Information

Company Name				EIN / Tax ID#	
Street Address		City	County	State	Zip
Mailing Address (If different)		City	County	State	Zip
Administrative Contact	Title	Telephone	Fax	email address	
Executive Contact	Title	Telephone	Fax	email address	
Number of Locations/States	Total # of Employees		SIC Code		
Blue Cross Group Number (required): Blue Cross Effective Date or Rate Increase Date:	Agent Name: Agent Telephone:		Agent Address, City, State, Zip:		

- | | |
|---|--|
| <input type="checkbox"/> CobraServ - Desired Effective Date: _____
Please complete separate Rate and Plan Sheet
Covered Employees: _____ # COBRA Participants: _____
Plans Subject to COBRA: _____
Coverages available: <input type="checkbox"/> Stand-alone <input type="checkbox"/> Bundled
COBRA Participants: _____
Check Pricing That Applies:
<input type="checkbox"/> Within 30 days of Blue Cross effective date or rate increase date: <u>\$200.00 set up fee, \$24.00 per COBRA participant transferred and \$24.00 per qualifying event, \$30.00 minimum monthly administrative fee paid by the employer. In addition, Ceridian retains the 2% administrative fee paid by COBRA participants.</u>
<input type="checkbox"/> NOT Within 30 days of Blue Cross effective date or rate increase date: <u>\$350.00 set up fee, \$24.00 per COBRA participant transferred and \$24.00 per qualifying event, \$30.00 minimum monthly administrative fee paid by the employer. In addition, Ceridian retains the 2% administrative fee paid by COBRA participants.</u> | <input type="checkbox"/> Flex 1-2-3 – Self Administered FSA -Desired Effective Date: _____
<u>First year \$750.00. Renewal fee \$350.00 per year.</u>

<input type="checkbox"/> FlexServ - Flexible Spending Account Administration
Pre-tax Health Care and Dependent Care Reimbursement
Annual Set-up \$ <u>400.00 first year / \$400.00 renewal</u>
Per Participant Per Month \$ <u>4.85</u>
Minimum Administrative Fee Per Month: <u>\$125.00</u>
Desired Effective Date: _____
New <input type="checkbox"/> or Mid-Year Takeover <input type="checkbox"/> \$ <u>6.00 per participant for mid-year takeover</u>
Start Date: _____ End Date: _____ |
|---|--|

▽ **CobraServ, Flex 1-2-3 and FlexServ applications must be received 30 days prior to the effective date for services. Submission Instructions: Fax completed application to 1-800-272-9654. For questions about Ceridian's CobraServ and FSA services, please call 1-877-548-2794.**

Authorization

This is to acknowledge that our organization has reviewed and understands the information and pricing as outlined in the proposal provided by Ceridian Benefits Services, Inc. All pricing and additional charges are reflected in the proposal provided. We further acknowledge responsibility to pay all fee(s) for service(s) performed in the event full implementation does not occur.

Authorized Employer Representative (Signature)	Date
Print Name	Title
Ceridian Benefits Services Representative	Date