Small Business
Employer Group Application

Effective August 1, 2003



PacifiCare®

PacifiCare®

Source Code	Tracking #

P.O. Box 6006
M/S CY24-515
Cypress, CA 90630

Small Business Group Application

Important: Please Print or Type All Sections in Black Ink

Legal Name of Group/DBA	Phone	Fax	E-mail Address
	( )	( )	

Address	City	County	State	ZIP

☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other: Employer Tax ID#

Executive/Employer Contact	Title	Phone	E-mail Address
		( )	

Administrative/Service Contact	Title	Phone	E-mail Address
		( )	

Billing Contact	Title	Phone	E-mail Address
		( )	

Billing Address	City	State	ZIP

List Current Medical Carrier(s) if any: List Current Dental and/or Vision Carrier(s) if any: Years with Carrier

Are you subject to a local living wage law? ☐ Yes ☐ No

Did you have health care coverage for the employees under the local living wage law prior to January 1, 2003? ☐ Yes ☐ No

Are you subject to ERISA regulations? ☐ Yes ☐ No

Do you currently have a Workers' Compensation policy in force? ☐ Yes ☐ No

Type of Business SIC Code

List current Workers' Compensation Carrier:

Are all employees covered under Workers' Compensation? ☐ Yes ☐ No If no, please state reason:

Please list the name and job title of all individuals to be included for medical coverage not eligible for Workers' Compensation:

Name	Title	E-mail Address
Name	Title	E-mail Address

Total number of **eligible employees enrolling** in PacifiCare: Medical: Dental: Vision: Life:

Number of **eligible employees** waiving medical coverage:

Number of **permanent full-time** (30+ hours per week) employees:

Number of **permanent part-time** (at least 20 but less than 29 hours per week) employees:

Number of **permanent full-time** (30+ hours per week) employees who work or reside **outside of CA**:

Number of **permanent part-time** (at least 20 but less than 29 hours per week) employees who work or reside **outside of CA**:

Contribution

Medical (Employer: 50% min.)	Dental (Employer: 50% min.)	Vision (Employer: 50% min.)	Life
Employee _____% Dependents _____%	Employee _____% Dependents _____%	Employee _____%	Employee _____%

Eligibility

NOTE: Independent contractors whose income is reported on IRS Form 1099, part-time, seasonal and lease employees are ineligible. Eligible employees and rehires must be full-time permanent employees who work at least thirty (30) hours per week or permanent employees who work at least twenty (20) hours per week but not more than twenty-nine (29) hours per week, and the employer offers employees health coverage under a health benefit plan to all similarly situated individuals. In addition, eligible employees must complete the employer's required waiting period of: _____ (max. 6 months).

Rehire Eligibility: 1st of month following _____ months	Total employees in waiting period:	How long do you continue paying healthcare premiums for employees on leave of absence? (max. 6 months)

Continuation Coverage

Have you contacted your current carrier(s) for the name(s) and address(es) of current COBRA participants? ☐ Yes ☐ No (please attach)

Is employer required to offer:

(a) **Federal COBRA** ☐ Yes ☐ No (b) **Cal-COBRA** ☐ Yes ☐ No (c) **Extended/Disabled COBRA** ☐ Yes ☐ No

Name	Federal COBRA Qualifying Event	Date
Name	Federal COBRA Qualifying Event	Date
Name	Cal-COBRA Qualifying Event	Date
Name	Cal-COBRA Qualifying Event	Date

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Plan Coverage

Note: SignatureOptions, SignatureIndependence and SignatureFreedom plans are underwritten by PacifiCare Life and Health Insurance Company.

Requested effective date:
(coverage must begin 1st of the month)

Medical Plans

PacifiCare SignatureValue (HMO)	PacifiCare SignatureOptions (PPO)	PacifiCare SignatureIndependence[3] (Out-of-State Indemnity)	
☐ 10–30/100 ☐ 15–30/250a ☐ 20–40/500d[1] ☐ 30–40/70[1]	☐ 20/80–60/250 ☐ 30/70–50/250 ☐ 35/80–60/500 ☐ 35/70–50/1000 ☐ 70–50/2000	☐ 80/250 **PacifiCare SignaturePOS (POS)** ☐ 10/80–70 **PacifiCare SignatureFreedom (SDHP)** ☐ 70–50/2000	**Stand Alone –** Select any plan, except SignatureIndependence **Dual Option –** Select 1 SignatureValue and 1 SignatureOptions plan, except SignatureOptions 70–50/2000 **Choice Series[2] –** Select up to 4 SignatureValue and/or SignatureOptions plans, except SignatureOptions 70–50/2000

Dental and Vision Plans

PacifiCare SignatureValue	PacifiCare SignatureOptions			PacifiCare SignatureIndependence
Contributory	**Contributory[4]**	**Voluntary[5]**	**Contributory**	**Contributory**
☐ Dental 140 ☐ Dental 141 ☐ Dental 142	☐ Dental 400 ☐ Dental 410 ☐ Dental 420 Please choose: Calendar Year Max ☐ $1,000 ☐ $1,500 Cost Management ☐ Yes ☐ No Deductible[6] ☐ $50 In / $50 Out ☐ $50 In / $100 Out	☐ Dental 310 ☐ Dental 312 Please choose: 6 Mo. wait for Basic Services ☐ Yes ☐ No Deductible[6] ☐ $50 In / $50 Out ☐ $50 In / $100 Out	☐ Vision 480 ☐ Vision 490 ☐ Dual Option (Vision 480 and 490)	☐ Dental 800 ☐ Dental 810 ☐ Dental 820 ☐ Dental 830
Voluntary[5]	☐ Dental 460	☐ Dental 460		**Voluntary[5]**
☐ Dental 140 ☐ Dental 141 ☐ Dental 142				☐ Dental 844 ☐ Dental 844-Hi

Other Coverage

☐ **Group Life:** Benefit:_____	☐ **Long Term Disability** (Must be sold with Group Life)	☐ **Domestic Partners Coverage**	☐ **Chiropractic/Acupuncture** Supplemental Chiropractic/ Acupuncture through an arrangement with American Specialty Health Plans (for SignatureValue and SignaturePOS only)

[1] By electing this plan, the Group has chosen not to offer Infertility Services to its employees. The Group understands that PacifiCare covers Infertility Services in other Small Business plans.
[2] Group must have at least 10 eligible employees enrolling with PacifiCare to purchase this option.
[3] Must purchase at least one SignatureValue, SignaturePOS, SignatureOptions or SignatureFreedom plan with this plan.
[4] Groups with 2–9 eligible employees may only select Dental 400, $1,000 CYM, $50 In / $100 Out Deductible.
[5] Groups without any current dental coverage may only select Voluntary Dental plans.
[6] Groups with 2–9 eligible employees may only select $50 In / $100 Out Deductible.

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I hereby certify that all statements on this document are complete and true to the best of my knowledge and belief, and I understand that PacifiCare will rely on these statements and this information as the basis for approving this Application. I have read and understand the information herein. Further, the authorized person agrees to PacifiCare's payment terms and conditions. Undersigned represents that he/she is an authorized person of the small employer group applying for the coverage indicated above and is authorized to enter into a PacifiCare Health Plan Medical and Hospital Group Subscriber Agreement and/or PacifiCare Life and Health Insurance Co. Group Policy on the small employer group's behalf. It is understood for the purposes of compliance with ERISA, the undersigned employer is to be named fiduciary of the employee benefit plan covered under this policy.

EMPLOYER AGREES AND UNDERSTANDS THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, INC., OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Authorized Signature	Date
Print Name	Title

☐ Check here if you do not have a broker of record. If you do, please complete the information below:

Broker Information

(Signature above acknowledges broker assignment) If a split commission, please attach payee information including percentages for each payee.

Agent Name	Firm Name		Phone	E-mail Address
			( )	
Address	City	State	Zip	Fax
				( )
Payee: ☐ Agent		or ☐ Firm		
Payee's SS# or Tax ID #:	Payee's California License #:			Expiration Date
Broker Signature				

FOR INTERNAL USE ONLY:

G.A. #	A.P. #	MKTG. #	G.C. #

Groups with 10–50 enrolling employees must fill out Medical Questionnaire on next page.

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Small Business Medical Questionnaire

(SMALL EMPLOYER GROUPS WITH 10–50 ENROLLING EMPLOYEES ONLY)

Small Business Employers must answer the questions below to the best of their knowledge. PacifiCare reserves the right to use the entire New Group Submission materials, including, but not limited to, Employer Group Application, Employer Medical Questionnaire, DE6, Enrollment/Declination Forms and any other requested documentation to determine the group's Risk Adjustment Factor and eligibility. Rates and eligibility are based on the actual number of enrolled and on Underwriting approval.

Company Name	Number of Enrolling Employees

1. To the best of your knowledge, how many of your employees, dependents or continuation members (COBRA and/or Cal-COBRA) are pregnant? _____ If any, please list due date(s) _____ _____

2. How many current Federal COBRA participants do you have? _____ How many current Cal-COBRA participants do you have? _____

3. Have any employees, dependents or continuation members (COBRA and/or Cal-COBRA) been treated in the last 5 years for cancer, heart disease/condition, stroke, Acquired Immune Deficiency Syndrome (AIDS), ARC, nervous or mental condition, or any other serious or chronic, continuing condition that required hospitalization or medical treatment? ☐ Yes ☐ No
   If "yes," please list person(s), condition(s), medication(s) and date(s) of onset/diagnosis:

4. Have any employees, dependents or continuation members (COBRA and/or Cal-COBRA) been treated in the last 12 months for arthritis, hypertension, diabetes, epilepsy, ulcers, hepatitis or hypo/hyperthyroidism? ☐ Yes ☐ No
   If "yes," please list person(s), condition(s), medication(s) and date(s) of onset/diagnosis:

5. In the last 12 months have any employees, dependents or continuation members (COBRA and/or Cal-COBRA) been advised to have surgery or anticipate hospitalization for any other reason? ☐ Yes ☐ No If "yes," please list:
   Diagnosis: _____ Date(s): _____
   Prognosis: _____ Date(s): _____

6. Are you aware of any employees, dependents or continuation members (COBRA and/or Cal-COBRA) who suffered a condition which resulted in expenses of $5,000 or more, or been hospitalized during the past 24 months? ☐ Yes ☐ No
   If "yes," please list person(s), conditions(s), medication(s) and date(s) of onset/diagnosis:

7. Are you aware of any employees, dependents or continuation members (COBRA and/or Cal-COBRA) to be covered who have been unable to work due to injury or illness within the last 12 months? ☐ Yes ☐ No
   If "yes," please list person(s), conditions(s), medication(s) and date(s) of onset/diagnosis:

8. Are you aware of any employee currently being treated for alcoholism or chemical dependency, or been advised to seek treatment for these conditions? ☐ Yes ☐ No If "yes," please list:
   Diagnosis: _____ Date(s): _____
   Prognosis: _____ Date(s): _____

9. Are you aware of any employee who is currently hospitalized or has been told extensive medical treatment, surgery or hospitalization is required? ☐ Yes ☐ No If "yes," please list:
   Diagnosis: _____ Date(s): _____
   Prognosis: _____ Date(s): _____

I verify, to the best of my knowledge, that the above answers are true and correct.

Small Business Employer's Name: (print) _____

Authorized Representative/Employer's Signature _____ Date _____

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Dental & Vision Administrators Employer Agreement

(SMALL EMPLOYER GROUPS WHO ARE ELECTING DENTAL AND/OR VISION COVERAGE)

- I understand the pre-existing conditions limitations of the insurance plan, and understand that coverage is renewable at the option of the Underwriting Company.
- I understand the underwriting and participation requirements, and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The Open Enrollment period shall be during group's 11th month of annual coverage.
- For the Vanguard Indemnity Plan and the PacifiCare Dental PPO Plan, I understand that there is a one-year waiting period for "Major" dental services. This waiting period will be waived for employees/dependents listed on the prior carrier's billing at the time of transfer to a PacifiCare Indemnity Dental or PPO plan. New hires are subject to a one-year waiting period for all "Major" dental services. "Major" dental services include crowns, dentures and bridges OR crowns, dentures, bridges, oral surgery, periodontics and endodontics.
- The Vanguard Indemnity, PacifiCare Dental PPO Plan and Vision PPO plans are underwritten by PacifiCare Life and Health Insurance Company.
- The Dental HMO Plans are offered by PacifiCare Dental.

For the Vanguard Indemnity plans only, please initial the following statement:

The undersigned employer hereby adopts and enrolls in the group insurance plan of the Vanguard Group Dental Trust and subscribes to the terms of the Trust agreement which established such Trust. It is understood that no coverage is in force until notice of approval has been furnished by the Trust Administrator and premium has been received by the Trust Administrator.

I further acknowledge and agree that no one other than the Trustees or a person designated in writing by the Trustees may accept this application on behalf of the Vanguard Group Dental Plan Trust, and that no agent or broker has the authority to change any provision of the master policy or of the Trust._____ (Initials of authorized person)

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge. I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Signature of authorized person for employer _____ Date signed _____

Broker or General Agent signature _____ Date signed _____

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Managed Care/
SignaturePOS Members:
5701 Katella Ave.
Cypress, CA 90630-5028

SignatureOptions/
SignatureIndependence Enrollees
P.O. Box 6098
Cypress, CA 90630
www.pacificare.com

Customer Service:
800-624-8822 SignatureValue
800-913-9133 SignaturePOS
866-316-9776 SignatureOptions
800-442-8833 (TDHI)

CM-303-42144.30
PC7306-010 Rev. 3/03

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