



BeneFits from Blue Cross

Small business solutions.
A package that fits.

Employer Application

BeneFits is a package of plans designed to help small businesses offer coverage for a range of unique needs. Included are health plans from Blue Cross of California (BCC) and BC Life & Health Insurance Company (BCL&H), plus the options to add dental coverage from BCC or BCL&H, and life coverage from BCL&H.

- From BCL&H:**
- Hospital BeneFits* Hospitalization only benefits
 - Hospital BeneFits Plus* Hospitalization plus limited doctor visit benefits
 - Hospital BeneFits Preferred* Hospitalization and limited doctor visit, dental & vision benefits
 - PPO \$35 Copay GenRx* Comprehensive PPO coverage with generic-only drug benefits
- From BCC:** *Power Select HMO* Comprehensive HMO coverage in selected areas

Please complete using black ink/type and return to your Blue Cross agent.

1. Please tell us about your company...

Company Name		Group No. (For existing groups)	
Street Address	City	State	ZIP Code
Billing Address	City	State	ZIP Code
Employer is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Other (Explain):	SIC Code	Type of Business (Be specific)	
Date Business Established (Mo/Yr)	Company Contact Person	Phone No. ()	Fax No. ()
Has company been insured by Blue Cross in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior Blue Cross coverage terminated:		E-mail Address	

2. How much will you contribute to employee/dependent monthly premiums?

Employee contribution – please fill in one option or the other, not both:

\$ _____ (\$50 or more, in \$5 increments) **OR** _____ % (25% or more, in 5% increments)

Employees' dependent's contribution (optional) – please fill in one option or the other, or leave blank if not applicable:

\$ _____ (\$50 or more, in \$5 increments) **OR** _____ % (25% or more, in 5% increments)

3. Would you like to offer Dental coverage?

Please check one or two choices below if you would like to add dental coverage (note: the Hospital BeneFits Preferred plan includes dental coverage). <input type="checkbox"/> Dental BeneFits from BCL&H <input type="checkbox"/> Dental Net from BCC	If you are adding dental coverage, please specify percentage of employer contribution to monthly premiums: Employee Dental: _____ % (50% or more in 5% increments) Dependent Dental: _____ % (no minimum requirement)
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4. Do you want to offer Life coverage?

Yes No (By selecting \$25,000 or more of Life coverage, your group may qualify for 1% savings on medical premiums)

If Yes:
 Please specify the amount, from \$15,000 to \$50,000 in \$5,000 increments: \$ _____
 Please specify employer contribution (25% or more, in 5% increments): Employee Life: _____ %

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.



5. Do you want to enroll in P.O.P.?

Yes No

The first year is FREE if your group has 5+ enrolling members; otherwise the cost per year is \$125. Please read the P.O.P. brochure for complete details. If you choose to enroll please complete the enrollment form, provide a separate check (if applicable), and submit along with this application.

6. What is your requested effective date?

____ / ____ / ____ Actual effective date will be assigned if application is accepted.

7. Please tell us about your group's eligibility ...

A. Total number of employees (including owners/officers): _____

B. Number of eligible full-time employees (minimum 30 hours per week): _____

C. Are part-time employees to be covered? Yes No

If yes, check one option:

- 20-29 hours weekly
 15-29 hours weekly

D. Are all eligible employees subject to withholding as on a W-2 form? Yes No

If no, please explain:

E. Number of eligible ENROLLING employees: _____

F. Number of eligible employees DECLINING coverage: _____

G. Number of INELIGIBLE employees: _____

Reason for ineligibility:

H. If this group is a class carve-out, please identify the class of employees to be covered: _____

I. Probationary period/waiting period for new employees: 1st of month after hire date
 1 month 4 months
 2 months 5 months
 3 months 6 months

J. Under TEFRA/DEFRA:

Medicare is primary coverage for groups with <20 employees; Blue Cross is primary coverage for groups with 20+ employees (based on total number of employees during 50% of the working days in previous calendar year).

Which one applies for your group? Medicare is primary (<20)
 Blue Cross is primary (20+)

K. Is your group currently subject to Cal-COBRA? Yes No

(Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year employed 2-19 eligible employees on at least 50% of its working days during the previous calendar quarter; and not subject to COBRA)

L. Is your group currently subject to COBRA? Yes No

(Employed 20 or more total employees on at least 50% of the working days in the previous calendar year; and not subject to Cal-COBRA)

M. Is your group subject to the Family Medical Leave Act of 1993? Yes No
(50 or more total employees)

If yes to questions K, L or M, please complete the Cal-COBRA/ COBRA/FMLA questionnaire on page 6.



8. Please tell us about your group's medical coverage history ...

Has this group had group health coverage within 90 days of this application's signature date? Yes No

Will this plan replace any existing group coverage? Yes No

If yes:

Current carrier is: _____ Proposed termination date is: _____

9. What about employee Leave of Absence at your firm?

Personal: number of months employees are eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum 3 months). None 2 Months
 1 Month 3 Months

Medical: number of months employees are eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum 6 months). None 4 Months
 1 Month 5 Months
 2 Months 6 Months
 3 Months

10. To your knowledge, is anyone to be covered unable to work due to injury or illness?

Yes No

If yes:

Name(s) _____ Anticipated return date(s): _____

11. Please tell us about your Workers' Compensation coverage ...

Current carrier: _____ Next renewal date: _____
(mm/dd/yy)

Please list the name and job title for any medically enrolling employee under the Blue Cross coverage who is not an employee for the purpose of Workers' Compensation law or similar legislation (see the definition provided below):

Name:	Job Title:	Exempt per definition below?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Definition: Under California Labor Code Section 3351, partners, corporate officers and members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances. In order for individuals holding the above-mentioned positions to fall outside the Workers' Compensation laws, they must be shareholders of the corporation, and all stock of the corporation must be held by persons who are either officers or members of the board of directors of the corporation.



12. This section is important to protect you as a small group employer ...

Please check the box that applies:

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employment Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employment Retirement Income Security Act), and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Blue Cross/BC Life & Health may rely on this application in deciding whether to provide coverage. If the application is not complete, Blue Cross reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Blue Cross and only if we have paid our first month's contribution and this application is accepted, that we should keep prior coverage in force until notified of acceptance in writing by Blue Cross/BC Life & Health and that no agent or broker has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Blue Cross/BC Life & Health.

Coverage may be rescinded if there are misstatements in this application. We have provided the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, with an explicit written notice specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of twelve (12) months as well as a six-month preexisting condition exclusion, and we have received signed acknowledgment.

For BC Life & Health insurance coverages, we, the employer, apply to become a participating employer in the Small Group Trust to obtain the coverages indicated. We understand that the Small Group Trust and the underwriting companies may rely on the application, deciding whether to allow us to participate in the Small Group Trust. We hereby acknowledge receipt of BC Life & Health's benefit description attached to and made a part hereof. We understand and agree that: 1) no coverage will be effective before the date determined by the Small Group Trust and the underwriting companies and only if: a) we have paid for the first month's contribution; and b) this

application, and any individual applications have been approved by the Small Group Trust and the underwriting companies; 2) this application, if accepted, and any subsequent amendments become our participation agreement with the Small Group Trust, and 3) the trust agreement and contracts under which we elected coverage are incorporated in and are made a part of the participation agreement. The employer agrees to comply with all provisions of the Small Group Trust. I understand and agree to all of the above. I understand that it is required to submit a DECLINATION of coverage any time that an employee and/or dependent is/or becomes eligible for coverage, but does NOT enroll.

ARBITRATION AGREEMENT:

WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND BC LIFE & HEALTH MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BC LIFE & HEALTH AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.

WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND BLUE CROSS OF CALIFORNIA AND ITS AFFILIATES, INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BLUE CROSS AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.

If we are enrolled as an administrator of an Employee Welfare Benefit Plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) we understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, we further understand that any dispute we may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process has been completed.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Name of Company Officer <i>(Please print)</i>	Title of Company Officer
Signature of Company Officer X	Date <i>(Month/Day/Year)</i>



14. Please complete this page if any "Yes" answers to K, L or M in Section 7...

Cal-COBRA: California law SB719 requires employers with 2-19 eligible (AB1672-qualified) employees to extend health coverage programs to former employees.

COBRA: The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with 20 or more total employees to extend health coverage programs to former employees, spouses (widowed/ divorced), and their dependents when a qualifying event occurs.

FMLA: The Family and Medical Leave Act of 1993 requires groups with 50 or more employees to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

A. Cal-COBRA and COBRA:

Complete for each employee or family member currently on Cal-COBRA or COBRA.

Name	Birth Date	Social Security or ID No.	Type	Qualifying Event	
				Description	Date
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		

B. Cal-COBRA: Complete for each employee terminated in the last 60 days who has had a qualifying event.

COBRA: Complete for each employee terminated in the last 90 days who has had a qualifying event.

1. Name _____ Social Security or ID No. _____ Cal-COBRA COBRA If terminated, what date? _____

If qualifying event, please describe: _____

To the best of your knowledge, Will this employee/dependent exercise their Cal-COBRA option? Yes No

Is this employee/dependent presently disabled? Yes No

If yes, disabling condition: _____

2. Name _____ Social Security or ID No. _____ Cal-COBRA COBRA If terminated, what date? _____

If qualifying event, please describe: _____

To the best of your knowledge, Will this employee/dependent exercise their Cal-COBRA option? Yes No

Is this employee/dependent presently disabled? Yes No

If yes, disabling condition: _____

C. FMLA: Complete for each employee on family or medical leave.

1. Name _____ Social Security or ID No. _____ Beginning date of leave _____

To the best of your knowledge, will this employee return to work? Yes No

If no, is this employee presently disabled? Yes No

If yes, disabling condition: _____

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA option? Yes No

2. Name _____ Social Security or ID No. _____ Beginning date of leave _____

To the best of your knowledge, will this employee return to work? Yes No

If no, is this employee presently disabled? Yes No

If yes, disabling condition: _____

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA option? Yes No

Signature of Company Official	Title	Company Name	Date
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If additional space is needed to include all applicable employees, please use a photocopy of this page.

