



# Master Group Application



For 2-50 Employees

## 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 – 14 eligible enrolling employees.
- Employer Questionnaires are required for guaranteed issue groups of 15 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 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 only, enclose a separate business check for the deposit for the dental portion of the dues, payable to Blue Shield.
- 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

# MASTER GROUP APPLICATION

(for 2-50 employees)

GROUP BILLING UNIT

DO NOT WRITE IN SHADED AREA

Access+ HMO® plans	Shield Spectrum™ PPO* plans	Added Advantage POS™ plan	Shield Spectrum™ PPO Savings plans*	Active Choice™ plans*	Access Baja™ HMO plans	Dental PPO plans	Dental HMO plans	Other
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**Please Type or Print Clearly. Use Black Ink.**

<b>1</b>	Full Legal Business Name	Effective date
<b>2</b>	Billing Address (Number, Street, City, State, Zip) If P.O. Box, complete No. 3 below	
<b>3</b>	Physical Address of Business (If different from above)	County
<b>4</b>	Group CEO Name	Group Contact Name/Title
		Phone Number ( )
		Fax Number ( )
<b>5</b>	Legal Entity <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other (specify)	Employer Tax ID Number Employer Tax ID # _____
<b>6</b>	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.	
<b>7</b>	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" <input type="checkbox"/> N/A
<b>8</b>	Prior group health carrier(s)	Do you offer other carrier's health plans to your employees? <input type="checkbox"/> Yes <input type="checkbox"/> 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 group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior dental carrier(s)
		Do you offer other carrier's dental plans to your employees? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
<b>9</b>	Future employee waiting period: _____ months (minimum 0, maximum 6 months). Does this waiting period apply to current employees? <input type="checkbox"/> Yes <input type="checkbox"/> No Employees who are hired on the 1 <sup>st</sup> of the month will be effective on the 1 <sup>st</sup> of the month following the completion of the waiting period. Employees effective date is first bill date following waiting period.	
<b>10</b>	Total # of Employees _____ Total # of Eligible Employees _____ Total # of Enrolled Employees _____	
	For 2-14 enrolling employees, please have your enrolling employees complete Form Number C-12914. If you have 15-50 enrolling employees, please have your enrolling employees complete Form Number C-15389.	
	Number of full time employees in waiting period: _____ Number of employees who are declining coverage _____	
	<b>Employer is responsible for collecting refusal of coverage.</b>	
	<b>For Employers of fewer than 20 employees:</b>	
	Do you currently have an employee who is 65 years or older and is eligible for Medicare Primary Rates? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide a copy of qualifying Medicare card(s).	
	Are there any out-of-state employees? <input type="checkbox"/> Yes <input type="checkbox"/> No How many out-of-state employees do you have? _____	
	Do you wish to offer coverage to your out-of-state employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>11</b>	Are all full time eligible employees being offered health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>12</b>	Blue Shield plans include coverage for state registered domestic partners only. Do you wish to select supplemental coverage to include additional domestic partners who are registered with municipalities, counties or who submit an affidavit? (Check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	

\*Shield Spectrum PPO 3000, Shield Spectrum PPO Plan, Zero Deductible-Value, Active Choice Plans 500 and 750, and PPO Savings Plans 1250 and 2600 are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

- 13** Are all employees, officers and partners covered by workers' compensation, as required by law?  
 Yes Carrier Name: \_\_\_\_\_  If no please explain: \_\_\_\_\_
- 14** 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 Number C-11248
- 15** Your group is subject to federal COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year.  
 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 for 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 Ceridian COBRA Services?  Yes  No If Yes, please attach a copy of the Ceridian COBRA Services Waiver Form.  
 D.) How many existing COBRA or Cal-COBRA participants do you have? \_\_\_\_\_ How many in eligibility period? \_\_\_\_\_

**Medical Benefits**

**16** **PLANSELECT<sup>SM</sup> PACKAGES** Select the appropriate combination of plans except Access Baja plans. Employers can offer Access Baja in addition to PlanSelect. (See Small Group UW Guidelines for requirements)

**(5-9 Subscribers)<sup>1</sup>**

If Access+ HMO Plan 5, Access+ HMO Plan 10, PPO Zero Deductible, PPO 250 Premier or a POS Plan is selected, then Active Choice 500,\* Shield Spectrum PPO 3000\*, Shield Spectrum PPO Plan, Zero Deductible – Value\* cannot be included in PlanSelect package.

**(10+ Subscribers)**

ALL PLANS (Available to groups with 10+ subscribes only)

**ACCESS+ HMO**

- Access+ HMO Plan 5
- Access+ HMO Plan 10
- Access+ HMO Plan 15
- Access+ HMO Plan 20
- Access+ HMO Plan 25

**DUAL CHOICE**

- Check This Box For Dual Choice. (2+ Employees) Choose One HMO Plan Above and one of the following plans listed below:
- Added Advantage POS plan
- Shield Spectrum PPO plan\*
- Shield Spectrum PPO Savings plan
- Active Choice\* plan

**SHIELD SPECTRUM PPO**  
Choose Deductible and Copay:

- Shield Spectrum PPO Plan, Zero Deductible
- Shield Spectrum PPO Plan, Zero Deductible – Value\*
- 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 Plan 3000\*

**SHIELD SPECTRUM PPO SAVINGS PLAN\***

- Shield Spectrum PPO Savings Plan 1250<sup>2\*</sup>
- Shield Spectrum PPO Savings Plan 2250<sup>2</sup>
- Shield Spectrum PPO Savings Plan 2600<sup>2\*</sup>

**ADDED ADVANTAGE POS**  
Choose Plan:

- Added Advantage POS Plan

**ACTIVE CHOICE PLAN\***  
(Only available for employees residing in California)

- Active Choice Plan 500\*
- Active Choice Plan 750\*

**ACCESS BAJA HMO**

- Access Baja HMO Plan 5
- Access Baja HMO Plan 10

**For PlanSelect Packages Only:**

Depending on the combination of plans selected, the employer must contribute at least \$80 or \$100 per employee (of the cost of the total employee premium, whichever is less). If employer chooses a combination with HMO 5, HMO 10, PPO Zero Deductible, PPO 250 Premier, or POS, the employer must contribute at least \$100 per employee. The employer must contribute at least the minimum defined amount or the cost of the employee premium, whichever is less.

**Indicate amount of defined contribution here:** For EEs \_\_\_\_\_% or \$\_\_\_\_\_ For DEPs \_\_\_\_\_% or \$\_\_\_\_\_

**For all other plan offerings:**

For employer contribution, enter percent of dues paid (must be at least 50% of total employee premium) by employer for EEs (employees) and DEPs (dependents). If 100%, all eligible employees must enroll. (Does not apply to PlanSelect Packages. See below for PlanSelect Packages Requirements.)

**ACCESS+ HMO PLANS** [ FOR EEs \_\_\_\_\_ %  
[ FOR DEPs \_\_\_\_\_ %

**ACTIVE CHOICE\* PLANS** [ FOR EEs \_\_\_\_\_ %  
[ FOR DEPs \_\_\_\_\_ %

**DENTAL PPO PLANS** [ FOR EEs \_\_\_\_\_ %  
[ FOR DEPs \_\_\_\_\_ %

**ADDED ADVANTAGE POS PLAN** [ FOR EEs \_\_\_\_\_ %  
[ FOR DEPs \_\_\_\_\_ %

**SHIELD SPECTRUM PPO\* PLANS** [ FOR EEs \_\_\_\_\_ %  
[ FOR DEPs \_\_\_\_\_ %

**DENTAL HMO PLANS** [ FOR EEs \_\_\_\_\_ %  
[ FOR DEPs \_\_\_\_\_ %

**SHIELD SPECTRUM PPO SAVINGS PLANS\*** [ FOR EEs \_\_\_\_\_ %  
[ FOR DEPs \_\_\_\_\_ %

<sup>1</sup>80% participation in Blue Shield PlanSelect plans required with a minimum of 5 or more employees enrolled.

<sup>2</sup>PPO Savings Plans are HSA eligible.

\*Shield Spectrum PPO 3000, Shield Spectrum PPO Plan, Zero Deductible-Value, Active Choice Plans 500 and 750, and PPO Savings Plans 1250 and 2600 are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

