

*PacifiCare*®



## CALIFORNIA

Small Business Employer Group Application

Effective April 1, 2005

# SMALL BUSINESS GROUP APPLICATION

|             |            |
|-------------|------------|
| Source Code | Tracking # |
|-------------|------------|

**Important: Please Print or Type All Sections in Black Ink**

|  |                     |   |                     |                  |
|--|---------------------|---|---------------------|------------------|
| Legal Name of Group/DBA  |                     | Phone<br>( )                                  | Fax<br>( )          | E-mail Address   |
| Address  |                     | City  | County              | State            |
| <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other: |                     | Start Date of Business                        |                     | Employer Tax ID# |
| Executive/Employer Contact   |                     | Title   | Phone<br>( )        | E-mail Address   |
| Administrative/Service Contact   |                     | Title   | Phone<br>( )        | E-mail Address   |
| Billing Contact  |                     | Title   | Phone<br>( )        | E-mail Address   |
| Billing Address  |                     | City  | State               | ZIP              |
| List Current Medical Carrier(s):   | Years with Carrier: | List Current Dental and/or Vision Carrier(s): | 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 <b>eligible employees</b> waiving medical coverage: _____ | Number of <b>permanent full-time</b> (30+ hours per week) employees: _____ | Number of <b>permanent full-time</b> (30+ hours per week) employees who work or reside <b>outside of CA</b> : _____ |
|---|--|---|

Please complete if offering health care coverage to **permanent part-time** employees (at least 20 but less than 29 hours per week):      Number of **permanent part-time** employees: \_\_\_\_\_      Number of **permanent part-time** employees who work or reside **outside of CA**: \_\_\_\_\_

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

**Eligibility**

NOTE: Independent contractors whose income is reported on IRS Form 1099, part-time, seasonal and leased employees are ineligible. Eligible employees and rehires must be full-time permanent employees who work at least thirty (30) hours per week or permanent part-time 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 health care premiums for employees on leave of absence? (max. 6 months): _____ |
|---|--|--|

**Continuation Coverage**

Do you currently have any Federal COBRA, Cal-COBRA or Extended/Disabled COBRA participants?  Yes  No

If yes, please provide details below:

|      |   |                  |      |
|------|---|------------------|------|
| Name | <input type="checkbox"/> Federal COBRA <input type="checkbox"/> Extended/Disabled COBRA<br><input type="checkbox"/> Cal-COBRA | Qualifying Event | Date |
| Name | <input type="checkbox"/> Federal COBRA <input type="checkbox"/> Extended/Disabled COBRA<br><input type="checkbox"/> Cal-COBRA | Qualifying Event | Date |
| Name | <input type="checkbox"/> Federal COBRA <input type="checkbox"/> Extended/Disabled COBRA<br><input type="checkbox"/> Cal-COBRA | Qualifying Event | Date |
| Name | <input type="checkbox"/> Federal COBRA <input type="checkbox"/> Extended/Disabled COBRA<br><input type="checkbox"/> Cal-COBRA | Qualifying Event | Date |

**CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.**

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**Plan Coverage**

*Note:* PacifiCare SignatureOptions<sup>SM</sup>, PacifiCare SignatureIndependence<sup>SM</sup> and PacifiCare SignatureFreedom<sup>SM</sup> plans are underwritten by PacifiCare Life and Health Insurance Company.

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

**Medical Plans**

|  | PacifiCare SignatureValue <sup>SM</sup><br>(HMO)   | PacifiCare SignatureOptions <sup>SM</sup><br>(PPO)  | PacifiCare SignatureOptions <sup>SM</sup><br>(HSA-Compatible)   |
|--|--|---|---|
| <b>Stand Alone</b> – Select any plan, except PacifiCare SignatureIndependence  | <input type="checkbox"/> 10–30/100<br><input type="checkbox"/> 15–30/250a<br><input type="checkbox"/> 10/500d <sup>3</sup><br><input type="checkbox"/> 20–40/500d <sup>3</sup><br><input type="checkbox"/> 30–40/70 <sup>3</sup> | <input type="checkbox"/> 10/90–70/250<br><input type="checkbox"/> 15/90–50/250<br><input type="checkbox"/> 20/80–60/250<br><input type="checkbox"/> 30/70–50/250<br><input type="checkbox"/> 35/80–60/500<br><input type="checkbox"/> 35/70–50/1000<br><input type="checkbox"/> 35/50–50/1000 | <input type="checkbox"/> 100-50/5000<br><input type="checkbox"/> 80-50/2700<br><input type="checkbox"/> 70-50/3500 (HSA-Compatible)   |
| <b>Dual Option<sup>1</sup></b> – Select 1 PacifiCare SignatureValue and 1 of the following plans: any of the PacifiCare SignatureFreedom <sup>SM</sup> or PacifiCare SignatureOptions <sup>SM</sup> plans (except 70-50/2000 (PPO) and 70-50/3500 (PPO)) |  |   | <b>PacifiCare SignatureIndependence<sup>SM</sup> (Indemnity)</b><br><input type="checkbox"/> 80/1000 <sup>4</sup>   |
| <b>Choice Series<sup>2</sup></b> – Select up to 4 PacifiCare SignatureValue and/or PacifiCare SignatureOptions plans, except 70-50/2000 (PPO), 70-50/3500 (PPO) and all HSA-Compatible plans.  | <b>PacifiCare SignaturePOS<sup>SM</sup> (POS)</b><br><input type="checkbox"/> 15/80–60   | <input type="checkbox"/> 70–50/2000 <sup>5</sup> (PPO)<br><input type="checkbox"/> 70–50/3500 <sup>5</sup> (PPO)  | <b>PacifiCare SignatureFreedom<sup>SM</sup> (SDHP)</b><br><input type="checkbox"/> 80–50/2000<br><input type="checkbox"/> 80–50/2000 with Dental<br><input type="checkbox"/> 70–50/2000 (SDHP)<br><input type="checkbox"/> 70–50/2000 with Dental<br><input type="checkbox"/> 50–50/3000<br><input type="checkbox"/> 50–50/3000 with Dental |

Age Rates    Composite Rates (not available for groups purchasing the Choice Series and for groups with less than 16 enrolled employees)

- 1 Groups must have at least 5 eligible employees enrolling with PacifiCare to purchase this option.
- 2 Groups must have at least 10 eligible employees enrolling with PacifiCare to purchase this option.
- 3 By selecting 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.
- 4 Must purchase at least one PacifiCare SignatureValue, PacifiCare SignaturePOS, PacifiCare SignatureOptions or PacifiCare SignatureFreedom plan with this plan.
- 5 **Please answer the following two questions** if you are purchasing the PacifiCare SignatureOptions (PPO) 70–50/2000 or 70–50/3500 Plan:

|  |  |
|--|--|
| Will you self-fund any portion of your employees' cost-sharing under this PacifiCare Small Group plan?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Will you be purchasing a gap plan in conjunction with this PacifiCare Small Group plan to cover any portion of your employees' cost-sharing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Dental and Vision Plans**

**Dual Choice Dental:** Select 1 PacifiCare SignatureValue and 1 PacifiCare SignatureOptions Dental and/or PacifiCare SignatureIndependence plan

| PacifiCare SignatureValue <sup>SM</sup> (HMO)   | PacifiCare SignatureOptions <sup>SM</sup> (PPO)   |  |  | PacifiCare SignatureIndependence <sup>SM</sup> (Indemnity)  |
|---|---|--|--|---|
| Contributory  | Contributory <sup>6</sup>   | Voluntary <sup>7</sup>   | Contributory   | Contributory  |
| <input type="checkbox"/> Dental 140<br><input type="checkbox"/> Dental 142<br><input type="checkbox"/> Dental 144 | <input type="checkbox"/> Dental 400<br><input type="checkbox"/> Dental 410<br><input type="checkbox"/> Dental 420<br><br>Please choose:<br>Calendar Year Max<br><input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <sup>8</sup><br>Endo, Perio, OS in Major <sup>9</sup><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>Deductible<br><input type="checkbox"/> \$50 In / \$50 Out <sup>10</sup><br><input type="checkbox"/> \$50 In / \$100 Out<br><br><input type="checkbox"/> Dental 460 | <input type="checkbox"/> Dental 310<br><input type="checkbox"/> Dental 312<br><br>Please choose:<br>6 Mo. wait for Basic Services<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Deductible<br><input type="checkbox"/> \$50 In / \$100 Out<br><br><input type="checkbox"/> Dental 460 | <input type="checkbox"/> Vision 480<br><input type="checkbox"/> Vision 490 | <input type="checkbox"/> Dental 800<br><input type="checkbox"/> Dental 810<br><input type="checkbox"/> Dental 820<br><input type="checkbox"/> Dental 830<br><br><b>PacifiCare SignatureSavings<sup>SM11</sup></b><br><input type="checkbox"/> 510 |

**Supplemental Benefits**

**Other Coverage (required)**

|   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> <b>Group Life:</b><br>Benefit: _____ | <input type="checkbox"/> <b>Long Term Disability</b><br>(Must be sold with Group Life) | <input type="checkbox"/> <b>Chiropractic/Acupuncture</b><br>Supplemental Chiropractic/ Acupuncture through an arrangement with American Specialty Health Plans (for PacifiCare SignatureValue and PacifiCare SignaturePOS only) | <b>Domestic Partners Coverage</b><br>All PacifiCare plans include Domestic Partner coverage as required by state law. |
|---|--|---|---|

- 6 Groups with 2-9 eligible employees may only select Dental 400, \$1,000 Calendar Year Maximum, \$50 In / \$100 Out Deductible.
- 7 Groups without any current dental coverage may only select from the following options: PacifiCare SignatureValue 140 series, PacifiCare SignatureOptions 310, 312, 460 and Vision 480 and 490, and PacifiCare SignatureSavings 510.
- 8 Groups of 10-24 must have a \$1,500 Calendar Year Maximum to purchase \$1,500 Calendar Year Maximum coverage.
- 9 Endo, Perio, OS in Basic is only available to groups 25 or more.
- 10 Groups with 2-24 eligible employees may only select \$50 In / \$100 Out Deductible.
- 11 PacifiCare SignatureSavings is a discount access program; it is not an insurance managed care or vision product.

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**Signature Required for Terms and Conditions and Arbitration Disclosure**

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:

|   |                               |                 |                |
|---|-------------------------------|-----------------|----------------|
| <b>Broker Information</b>   |                               |                 |                |
| (Signature above acknowledges broker assignment) If a split commission, please attach payee information including percentages for each payee. |                               |                 |                |
| Agent Name  | Firm Name                     | Phone<br>( )    | E-mail Address |
| Address   | City                          | State           | ZIP<br>( )     |
| Payee: <input type="checkbox"/> Agent or <input type="checkbox"/> Firm  |                               |                 |                |
| Payee's SS# or Tax ID #:  | Payee's California License #: | Expiration Date |                |
| Broker Signature  |                               |                 |                |

|                               |        |         |        |
|-------------------------------|--------|---------|--------|
| <b>FOR INTERNAL USE ONLY:</b> |        |         |        |
| G.A. #                        | A.P. # | MKTG. # | G.C. # |

**Groups with 10-50 enrolling employees must complete the Medical Questionnaire on the next page.**

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# Small Business Medical Questionnaire

For Small Employer Groups with 10–50 enrolling Employees only

Employer groups with 2-9 enrolling employees must have each employee complete the Small Business Individual Health Statement with the enrollment form.

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 |
|--------------|-------------------------------|

- To the best of your knowledge, are any of your employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) pregnant?  Yes  No If "yes," please list number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- Do you have Federal COBRA participants?  Yes  No Do you have Cal-COBRA participants?  Yes  No If "yes," please list number of Federal COBRA participants \_\_\_\_\_ and/or Cal-COBRA participants \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, 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 number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, 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 number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, have any employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) been advised to have surgery in the past 12 months or anticipate hospitalization for any other reason?  Yes  No If "yes," please list number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, 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 have been hospitalized during the past 24 months?  Yes  No If "yes," please list number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, 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 past 12 months?  Yes  No If "yes," please list number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, are you aware of any employees who are currently being treated for alcoholism or chemical dependency, or have been advised to seek treatment for these conditions?  Yes  No If "yes," please list number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, are you aware of any employees who are currently hospitalized or have been told extensive medical treatment, surgery or hospitalization is required?  Yes  No If "yes," please list number of persons \_\_\_\_\_ and submit a completed Individual Health Statement for each person.

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 continuous coverage.
- For the PacifiCare SignatureIndependence Plan and the PacifiCare SignatureOptions 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 SignatureIndependence or PacifiCare SignatureOptions 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 PacifiCare SignatureIndependence and PacifiCare SignatureOptions dental and vision plans are underwritten by PacifiCare Life and Health Insurance Company.
- The PacifiCare SignatureValue dental plans are offered by PacifiCare Dental.

**For the PacifiCare SignatureIndependence 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 \_\_\_\_\_



**P.O. Box 6006  
M/S CY24-515  
Cypress, CA 90630  
www.pacificare.com**

**Customer Service:**

- PacifiCare SignatureValue<sup>SM</sup> (HMO): . . . . . 1-800-624-8822  
or 1-800-442-8833 (TDHI)
- PacifiCare SignaturePOS<sup>SM</sup> (POS): . . . . . 1-800-913-9133  
or 1-800-442-8833 (TDHI)
- PacifiCare SignatureOptions<sup>SM</sup> (PPO) or  
PacifiCare SignatureIndependence<sup>SM</sup> (Indemnity): . . . . . 1-866-316-9776  
or 1-866-816-2018 (PPO/Indemnity TDHI)
- PacifiCare SignatureFreedom<sup>SM</sup> (SDHP): . . . . . 1-866-867-0700  
or 1-866-867-0701 (TDHI)