



MASTER GROUP APPLICATION

COMPANY INFORMATION				
Exact Legal Name of Company:			"Doing Business As" (DBA):	
Street Address		City	State	Zip Code
Billing Address (If different from above):			Requested Start Date:	
			Requested Renewal Date:	
Key Contacts:		Routine:	Phone # ()	Fax # ()
		Billing:	Phone # ()	Fax # ()
		Executive:	Phone # ()	Fax # ()
Type of Business (please provide as much detail as possible):				Yrs. In Business:
Current Workers' Comp Carrier:		Prior Health Insurance Carrier:		Other Health Insurance Plans Offered:
Premium Billing Preference:			COBRA Billing Preference (if applicable):	
Bill to one location		Bill to multiple locations (with Fee)	Bill to Employer	
			Bill to Employee (with Fee)	
PLAN SPECIFICATIONS				
MEDICAL PLAN <i>(Includes Mental / Nervous benefits)</i>		PHARMACY <i>(Optional)</i>	CHEMICAL DEPENDENCY <i>(Optional)</i>	CHIROPRACTIC <i>(Optional)</i>
Small Group Large Group			CD-1 (\$150/\$20)	B (\$10/30v)
AS A (\$5 office copay/100% hosp.)		\$5/\$10	No Chemical Dep.	D (\$10/20v)
ABS AB (\$10 office copay/100% hosp.)		\$5/\$15		Other _____
CS C (\$15 office copay/\$250 hosp.)		\$5/\$20	VISION	No Chiro
ADS AD (\$15 office copay/\$500 hosp.)		\$10/\$15	<i>(Optional)</i>	MIND/BODY
AES AE (\$20 office copay/\$750 hosp.)		\$10/\$20	A0 (\$0)	<i>(Optional)</i>
		\$10/\$25	A2 (\$20/\$20)	A (\$5)
ASSISTED REPRODUCTIVE TECH. ("ART")		No Pharmacy	Other _____	B (\$10)
<i>(Optional) (Available to groups with 20+ employees only)</i>			No Vision	No Mind/Body
Plan A Plan B No ART				
ELIGIBILITY				
Total # of Employees:	Total # of Benefits Eligible Employees:	Total # Enrolled in Sharp Health Plan:	Total # Enrolled in other Employer Sponsored Plans:	Total # Declining Coverage:
Is your group currently subject to <u>Cal-COBRA</u> ? Yes No			Full-time employee (eligible for benefits) works how many hours per week?	
<i>(Employed 2-19 employees on at least 50% of the working days in the previous calendar year or previous quarter if not in business in the previous calendar year, and are not subject to Federal COBRA)</i>				
Is your group currently subject to <u>Federal COBRA</u> ? Yes No				
<i>(Employed 20 or more total employees during at least 50% of the working days in the previous calendar year)</i>			20 hrs 30 hrs 40 hrs	
How many existing COBRA or Cal-COBRA participants do you have? _____			Other _____	
Coverage for Full-time college students?	Coverage for Domestic Partners?	Waiting Period for New Hires :		Employer Contributions:
Yes → to 23 to 25	Yes	1st of the month following _____		Employee _____ %
No	No	Waiting Period for Re-Hires :		Dependents _____ %
		1st of the month following _____		
BROKER / GENERAL AGENCY INFORMATION				
Broker Name / Agency Name:			Tax ID #:	
General Agency Name (if applicable):			License #:	Exp.
Address:			Phone #:	
City/State/Zip:			Fax #:	

Application is hereby made for a Sharp Health Plan HMO Contract. This is an application only. Issuance of a Group Agreement is subject to receipt of first month's premium and to review and approval by Sharp Health Plan. All eligible employees and dependents will be offered this benefit package. If accepted, the employer agrees to make required payroll deductions for employees who enroll in this plan. The applicant also agrees to notify all eligible employees of their ability to enroll in the plan after their waiting period.

Date _____

Authorized Signature / Title _____