

# master group application

**For 51+ eligible employees**

Effective November 1, 2009

C14939 (6/09)

blue  of california

[blueshieldca.com](http://blueshieldca.com)

# Group submission checklist

The following is a checklist of what we need to install your group in a timely and effective manner. Use this guide to assist in assembling your group and employee documents. Check all the boxes, and it's ready to go!

## Medical and Specialty Benefits combined plan installation

### Step 1. Submit your completed Master Group Application with employer and producer signatures.

#### Upon review of your application:

- If you answered YES to Master Group Application
  - Question No. 12E, distribute and collect a completed Medicare Part D application from each eligible member (form PDP00045).
  - Question No. 16, complete the Disability Addendum (form C11248).
- If you are a new 51 to 299 group, please submit a completed Employer Questionnaire (form A16419).
- Is your group a member-level benefit group? If so, please remember to clearly indicate benefit selections for dependents.
- For section 24: Include a business check in the amount of the first month's dues as a deposit, with a breakdown of how the money should be applied.

### Step 2. Collect and submit your completed Employee's Enrollment Applications (form C15390).

#### Review the applications to verify:

- Verify each employee and covered dependent has listed his or her Social Security number.
- Employees enrolling in HMO or POS medical plans – verify each employee and covered dependent has listed a Personal Physician name, provider number, and IPA number.
- Employees enrolling in a dental HMO – verify each employee and covered dependent has listed a dental provider name and dental provider number.
- Retirees enrolling in Blue Shield 65 Plus plans – please verify each member with Medicare completes their own enrollment application (form MG00001) and has listed their:
  - HICN (Medicare number)
  - Date of birth
  - Gender
  - Permanent physical home address (street, city, state, ZIP code – cannot contain a P.O. box)
  - Part A and Part B effective dates
  - Answers to questions related to ESRD and other prescription drug coverage
  - Personal Physician name, Medicare provider number
- If applicable, gather and submit any Declaration of Disability for Over-Age Dependent Child forms (form C3674).
- If applicable, submit completed COBRA applications including primary care provider name, IPA number, the qualifying event for the employee, and the date effective (form C11825-RIM).
- Collect and keep on file all Refusal of Coverage Forms for all eligible employees and eligible dependents who refuse coverage.**

**Blue Shield of California and  
Blue Shield of California Life & Health Insurance Company**

**Group billing unit**

**Do not write in shaded area**

Access+ HMO <sup>®</sup> plans	Shield Spectrum PPO <sup>SM</sup> plans	Added Advantage POS <sup>SM</sup> plans	Shield Spectrum PPO Savings Plus plans	Active Choice <sup>SM</sup> plans*	Foundation group? <input type="checkbox"/> Yes <input type="checkbox"/> No (local Foundation for Medical Care in Kern, Mendocino/Lake, and Tulare/Kings counties)
Access Baja <sup>®</sup> HMO plans	Access+ HMO SaveNet <sup>SM</sup> plans	Core Flex <sup>SM</sup> plans	Vision plans	Group term life/accidental death and dismemberment (AD&D) insurance	
Out of Area (OOA) 100/50 PPO (Plan A or B – for 300+ employees only)	Blue Shield 65 Plus plans	Dental HMO plans	Dental PPO plans		

**Please type or print clearly. Use black ink.**

**1** Check all boxes that apply:  Medical (with or without dental coverage, life insurance, or vision coverage)  
Options:  Dental PPO plans  Dental HMO plans  Group term life and AD&D insurance  Vision plans

**2** Full legal business name \_\_\_\_\_ Effective date (month/day/year) \_\_\_\_\_

**3** Billing address (if P.O. box, complete No. 4 below)

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**4** Physical address of business (if different from above) \_\_\_\_\_ County \_\_\_\_\_

**5** Group contact name \_\_\_\_\_ Title \_\_\_\_\_ Employer tax ID number \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-mail address \_\_\_\_\_ How do you prefer to be contacted? \_\_\_\_\_

**6** Legal entity:  Corporation  Partnership  Sole proprietorship  Other (specify) \_\_\_\_\_

**7** Type of business (provide as much detail as possible):  
Major industries and products/services of your business \_\_\_\_\_  
Standard industry classification code(s) (SIC code) in which the business is classified \_\_\_\_\_

**8** 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."  N/A

**9** Prior group health carrier(s) (If prior carrier was Blue Shield, please note) \_\_\_\_\_ Do you offer other carriers' health plans to your employees?  Yes  No  
If Yes, list carrier name(s): \_\_\_\_\_ Employees to be effective on (month/day/year): \_\_\_\_\_  
Prior dental carrier(s)  Yes  No If Yes, list carrier name(s): \_\_\_\_\_

**10** New employee waiting period (minimum 0, maximum 6 months):  
 Date of hire (example: employee hired 11/15/09 is effective 11/15/09)  
 First of the month following date of hire (example: employee hired 11/15/09 is effective 12/1/09)  
 First of the month following 30 days (example: employee hired 11/15/09 is effective 1/1/10)  
 First of the month following \_\_\_ months (example: if waiting period is 1 month, employee hired 11/1/09 is effective 12/1/09)  
 Other: \_\_\_\_\_  
If the group has a special exception to waiting period of managerial or executive new hires, please indicate here: (minimum 0, maximum 6 months): \_\_\_\_\_  
Will the waiting period be waived:  
For current, actively at-work employees  Yes  No  
For part-time employees upon attaining full-time status  Yes  No  
For employees rehired within  6 months  \_\_\_\_\_ of their termination date  Yes  No

An Independent Member of the Blue Shield Association

<b>11</b> Total number of employees _____ Total number of eligible employees _____ 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	Number of full-time employees in waiting period: _____ Number of employees who are declining coverage: _____	<b>Employer is responsible for collecting and retaining Refusal of Coverage Forms. For dental, life insurance, and vision-only products, where no medical plan is also being offered, Refusal of Coverage Forms are not required.</b>
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**12** A. Are all full-time eligible employees being offered health coverage?  Yes  No If No, please explain: \_\_\_\_\_

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B. Are all of the full-time eligible employees to whom you will be offering health coverage actively working at least 30 hours per week?  
 Yes  No If No, please explain: \_\_\_\_\_

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C. Are you offering coverage to employees working at least 20 hours per week but fewer than 30 hours per week?  
 Yes  No

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D. Are retirees eligible for benefits?  Yes  No  
 If Yes, please check any that apply:  Early retirees under age 65  Retirees 65 years and over (attach a copy of both Medicare Part A and B cards for installation. For paper applications only.)

Will you contribute to retiree coverage?  Yes  No

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E. Will you offer Medicare Part D options?  Yes  No If Yes, please check any that apply:  
 Retirees only  Actives and retirees  Enhanced PDP  Retiree drug subsidy  Blue Shield 65 Plus

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F. Definition of dependent children: To be considered eligible, dependent children 19 through 24 years of age must be enrolled full-time in college (minimum of 12 units), trade school, or on an approved medical leave of absence from a college or trade school. Dependent coverage over age 18 for full-time students is not available to dependents of legal guardians. Dependents with a physical or mental disabling injury or illness are not subject to any age restrictions and will continue to be covered.  
 Age 19 through 24 if full-time student  
 Other If "Other," please specify: \_\_\_\_\_

**13** Domestic partner coverage (check one) – Domestic partners in options 1 and 2 must also meet Blue Shield’s dependent eligibility requirements as contractually defined.

1. Narrow coverage: California state registered (both partners have filed a Declaration of Domestic Partnership with the state of California. Both partners must be the same sex. Opposite-sex partners allowed if one partner is at least 62 and eligible for Social Security).

2. Broad coverage: California state registration not required (both partners may be the same or opposite sex).

**14** A. For employer contribution – Enter percentage of dues paid by employer for employees and dependents. If 100%, all eligible employees must enroll.

Access+ HMO plans	Active Choice plans	Out of area 100/50 PPO A or B Active Choice plans	Added Advantage POS plans
For employees _____%	For employees _____%	For employees _____%	For employees _____%
For dependents _____%	For dependents _____%	For dependents _____%	For dependents _____%
For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%
For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%

  

Blue Shield 65 Plus plans	Shield Spectrum PPO plans	Shield Spectrum PPO Savings Plus plans	Core Flex Basic
For employees _____%	For employees _____%	For employees _____%	For employees _____ 100 _____%
For dependents _____%	For dependents _____%	For dependents _____%	For dependents _____%
For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%
For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%

  

Core Flex 70/50	Core Flex 80/60	Core Flex 90/70	Core Flex 90/70 Premier
For employees _____%	For employees _____%	For employees _____%	For employees _____%
For dependents _____%	For dependents _____%	For dependents _____%	For dependents _____%
For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%
For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%

  

Core Flex Basic HMO 45	Core Flex HMO 40	Core Flex HMO 30	Core Flex HMO 20
For employees _____ 100 _____%	For employees _____%	For employees _____%	For employees _____%
For dependents _____%	For dependents _____%	For dependents _____%	For dependents _____%
For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%	For retirees (if applicable) _____%
For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%	For retirees’ dependents (if applicable) _____%

<b>14 Dental plans including Core Flex</b> <b>Dental PPO</b> For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____% <b>Dental HMO PPO</b> For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____% (For dental plans, minimum employer contribution of 50% toward employee's coverage is required. 75% of all eligible employees must enroll.)	<b>Vision plans including Core Flex</b> For employees _____% For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____% (For vision plans, minimum employer contribution of 25% toward employee's coverage for all plans except voluntary plans is required. For voluntary plans, employer contribution must be less than 25%.)	<b>Group term life and AD&amp;D insurance</b> <input type="checkbox"/> 100% employer paid For employees _____% (minimum of 25%) For dependents _____% For retirees (if applicable) _____% For retirees' dependents (if applicable) _____%
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B. Tax savings options: Please indicate if you plan on offering any of the following options (check all that apply) and the administrator of each program. Also indicate any amount to be funded by employer contribution.

Program	Name of Administrator	Employer Contribution Amount Individual Coverage	Employer Contribution Amount Family Coverage
<input type="checkbox"/> Health Savings Account (HSA)			
<input type="checkbox"/> Health Reimbursement Arrangement (HRA)			
<input type="checkbox"/> Employer-funded or partially funded wraparound plan*			
<input type="checkbox"/> Flexible Spending Account (FSA)			
<input type="checkbox"/> Premium Only Plan (POP)			

Note: Blue Shield does not offer tax advice, nor do we offer HSAs, HRAs, or FSAs.

\*A "wraparound plan" includes any employer-sponsored plan, that is:

- (1) paid for or funded in whole or in part by the employer and/or the employee;
- (2) (a) provides reimbursement for health plan deductibles, copayments, coinsurance, or medical expenses, or (b) provides for the payment of set amounts in the event of hospitalization.

Examples include: an employer-funded flexible spending account (FSA), a health reimbursement account (HRA), self-funding of the deductible, an IRS Section 105 plan, a medical expense reimbursement plan (MERP).

**15** Are all employees covered by workers' compensation to the extent required by law?  
 Yes Carrier name: \_\_\_\_\_  No If No, please explain:

**16** Are any COBRA participants enrolling in a Blue Shield of California/Blue Shield of California Life & Health Insurance Company (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 C11248).  
 Name of COBRA Administrator: \_\_\_\_\_

**17** 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.  
 Note: The employer is solely responsible for all aspects of the administration of Title X. of the Consolidated Omnibus Budget Reconciliation Act (COBRA).  
 How many existing COBRA or Cal-COBRA participants do you have? \_\_\_\_\_ How many in eligibility period? \_\_\_\_\_

## Medical plan benefits

### 18 Access+ HMO plans

- HMO 5-0 Inpatient
- HMO 10-0 Inpatient
- HMO 10-100/Day Inpatient
- HMO 10-200/Day Inpatient
- HMO 10-250/Admit Inpatient
- HMO 10-20%/Zero Facility Deductible
- HMO 15-500/Admit Inpatient
- HMO 15-500/Day Inpatient
- HMO 15-20%/Zero Facility Deductible
- HMO 15-10%/1500 Facility Deductible
- HMO 20-250/Admit Inpatient
- HMO 20-500/Admit Inpatient
- HMO 20-25%/Zero Facility Deductible
- HMO 25-500/Admit Inpatient
- HMO 25-750/Day Inpatient
- HMO 30-20%/Zero Facility Deductible
- HMO 30-10%/1500 Facility Deductible
- HMO 40-1000/Day Inpatient
- HMO 40-40%/Zero Facility Deductible
- HMO 45-50%/Zero Facility Deductible
- Custom plan (attach custom menu)**

### Access+ HMO SaveNet<sup>1</sup> plans

- Access+ HMO SaveNet 10-250/Admit Inpatient
- Access+ HMO SaveNet 15-500/Admit Inpatient
- Access+ HMO SaveNet 15-20%/Zero Facility Deductible
- Access+ HMO SaveNet 10-50%/Zero Facility Deductible
- Access+ HMO SaveNet 40-40%/Zero Facility Deductible

### Access Baja HMO plans

- Access Baja HMO Plan 5
- Access Baja HMO Plan 10
- Access Baja dependent only coverage (split contract option – special eligibility requirements apply)

- Check this box for Dual Choice.  
**Choose one Access+ HMO plan and one other non-HMO plan**

### Shield Spectrum PPO plans

Choose deductible and copayment:

- Shield Spectrum PPO 0/500-90/70 Premier
- Shield Spectrum PPO 0/500-90/70 Standard
- Shield Spectrum PPO 0/500-100/50
- Shield Spectrum PPO 250-80/60 Standard
- Shield Spectrum PPO 250-90/70 Premier
- Shield Spectrum PPO 250-90/70 Standard
- Shield Spectrum PPO 250-90/70 Value
- Shield Spectrum PPO 250-80/60
- Shield Spectrum PPO 500-90/70
- Shield Spectrum PPO 500-80/60
- Shield Spectrum PPO 1000-80/50
- Shield Spectrum PPO 1000-80/60 Premier\*
- Shield Spectrum PPO 1000-90/70
- Shield Spectrum PPO 3000-80/60\*
- Custom plan (attach custom menu)**

### PlanSelect<sup>SM</sup> packages

Available with all plans except Access Baja HMO, Access+ HMO SaveNet, Active Choice, Core Flex, and Foundation plans

- Yes  No

### Shield Spectrum PPO Savings Plus (PSP)<sup>2</sup> plans

- Shield Spectrum PPO Savings Plus 1500\*
- Shield Spectrum PPO Savings Plus 1800\*
- Shield Spectrum PPO Savings Plus 2400 Individual/4800 Family\*
- Shield Spectrum PPO Savings Plus 2250
- Shield Spectrum PPO Savings Plus 2600 Individual/5200 Family\*
- Shield Spectrum PPO Savings Plus 3000 Individual/6000 Family

### Added Advantage POS plans

- Added Advantage POS 250-100/80/50
- Added Advantage POS 300-100/90/70 Premier
- Will you contribute to retiree coverage?  
 Yes  No
- Added Advantage POS 300-100/70
- Added Advantage POS 300-100/80/60
- Added Advantage POS 500-100/80/60
- Custom plan (attach custom menu)**

### Active Choice\* plans

- Active Choice Plan 750\*
- Active Choice Plan 500\*
- Custom plan (attach custom menu)**

### Blue Shield 65 Plus plans

- Custom Plan (attach custom menu)

### Core Flex package<sup>3</sup>

- Check this box to offer the Core Flex package listed below
  - Core Flex Basic<sup>2</sup>
  - Core Flex 70/50
  - Core Flex 80/60
  - Core Flex 90/70
  - Core Flex 90/70 Premier

Choose from the Core Flex Specialty Benefits Options Below:

- Core Flex Dental Package
  - Core Flex Basic Dental PPO 75/1000/No Ortho/MAC
  - Core Flex Dental PPO 50/1000/No Ortho/MAC
  - Core Flex Dental PPO 50/1000/Ortho/U90
  - Core Flex Dental PPO Premier Plus 50/1500/Ortho/U90
- Core Flex Vision Package
  - Core Flex Vision Standard 0/25/75
  - Core Flex Vision Plus 0/10/100
  - Core Flex Vision Deluxe 0/0/130

### Core Flex HMO package<sup>3</sup>

- Check this box to offer the Core Flex package listed below
  - Core Flex HMO Basic 45
  - Core Flex HMO 40
  - Core Flex HMO 30
  - Core Flex HMO 20

The Core Flex Specialty Benefits Options<sup>4</sup> include Vision only: Below:

- Core Flex Vision Package
  - Core Flex Vision Standard 0/25/75
  - Core Flex Vision Plus 0/10/100
  - Core Flex Vision Deluxe 0/0/130

### Foundation plans (Available in Kern, Mendocino/Lake, and Tulare/Kings counties)

- Shield Spectrum PPO 0/500 90/70 Standard Foundation\*
- Shield Spectrum PPO 250 80/60 Foundation\*
- Shield Spectrum PPO 250-90/70 Value Foundation\*
- Shield Spectrum PPO 500-90/70 Foundation\*
- Shield Spectrum PPO 500-80/60 Foundation\*
- Active Choice<sup>SM</sup> 750 Foundation\*
- Shield Spectrum PPO Savings Plus 1800\*
- Shield Spectrum PPO Savings Plus 2400 Individual/4800 Family Foundation\*<sup>2</sup>
- Custom Plan (attach custom menu)

**Other**  Specify below: \_\_\_\_\_

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

1 Access+ HMO SaveNet products are only available alongside our Access+ HMO products in designated Southern California counties: Orange and portions of Los Angeles, San Diego, San Bernardino, and Riverside.

2 These high-deductible health plans are HSA-compatible.

3 Core Flex plans can only be sold as a package. Neither Core Flex package can be offered with any competitive plan. For additional competitive option information, please contact your broker or Blue Shield sales representative. Core Flex dental and vision packages are only available when you purchase the Core Flex medical package. You can also purchase alternative dental and/or vision plans with your Core Flex medical package that are not included in the Core Flex dental and/or vision packages; however, they will be subject to our usual dental and/or vision underwriting guidelines. Purchase of the Core Flex dental and/or vision packages are not required to purchase the Core Flex medical package.

4 For groups that offer a Core Flex package, Specialty Benefits options are (1) Core Flex Dental Package, or up to two dental plans shown in section 20 and/or (2) Core Flex Vision Package, or one of the vision plans shown in section 19 or 21. For groups that offer the Core Flex HMO package, Specialty Benefits options are (1) up to two dental plans shown in section 20 and/or (2) Core Flex Vision Package, or one of the vision plans shown in section 19 or 21.

**Optional benefits** (cannot be purchased without a medical plan)

**19 For Dual Choice packages, the same optional benefits must be purchased for all the plans selected**

- Inpatient substance abuse treatment  
Select plan option(s):
  - HMO
  - PPO
  - POS
  - PSP
  - Active Choice
  - Core Flex
  - Foundation
- Infertility rider  
Select plan option(s):
  - HMO
  - PPO
  - POS
  - PSP
  - Active Choice
  - Core Flex
  - Foundation
- Access+ HMO and/or POS chiropractic rider
- Access+ HMO and/or POS chiropractic/acupuncture rider
- Hearing-aid rider  
Select plan option(s):
  - PPO
  - Active Choice
  - Foundation
- Blue Shield Vision Basic 0/25/100
- Blue Shield Vision Basic 0/15/120
- Blue Shield Vision Basic 0/0/130
- Blue Shield Vision Basic Plus 0/15/120
- Blue Shield Life Vision Basic 0/25/100
- Blue Shield Life Vision Basic 0/15/120
- Blue Shield Life Vision Basic 0/0/130
- Blue Shield Life Vision Basic Plus 0/15/120
- Blue Shield Eye Exam Only
- Blue Shield Life Eye Exam Only

Other  
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- Blue Shield Life Rx options**  
 (available for: Active Choice 500 and 750, PPO 1000-80/60 Premier, PPO 3000-80/60, and PPO Foundation plans)
- Choose one calendar-year brand-name deductible option below:
- \$0 per person
  - \$150 per person
  - \$250 per person
  - \$500 per person
- Choose one of the Rx drug plan options below:\*
- \$0 (generic)/\$20 (brand-name formulary)/40 (brand-name non-formulary) Rx drug plan
  - \$3/\$20/\$40 Rx drug plan
  - \$5/\$10/\$25 Rx drug plan
  - \$10/\$15/\$30 Rx drug plan
  - \$10/\$20/\$35 Rx drug plan
  - \$10/\$25/\$40 Rx drug plan
  - \$10/\$30/\$50 Rx drug plan
  - \$15/\$30/\$45 Rx drug plan
  - \$10/\$30/greater of \$45 or 50% Rx drug plan
  - \$15/\$30/ 50% \$45 min \$100 max Rx drug plan
- \* Home self-injectable 30% up to a \$150 maximum

- Blue Shield of California Rx options**  
 (available for PPO plans)
- Choose one calendar-year brand-name deductible option below:
- \$0 per person
  - \$150 per person
  - \$250 per person
- Choose one of the Rx drug plan options below:\*
- PPO \$0 (generic)/\$20 (brand-name formulary)/\$40 (brand-name non-formulary) Rx drug plan
  - PPO \$3/\$20/\$40 Rx drug plan
  - PPO \$5/\$10/\$25 Rx drug plan
  - PPO \$10/\$15/\$30 Rx drug plan
  - PPO \$10/\$20/\$35 Rx drug plan
  - PPO \$10/\$25/\$40 Rx drug plan
  - PPO \$10/\$30/\$50 Rx drug plan
  - PPO \$10/\$30/ 50% \$45 min \$100 max Rx drug plan

- Blue Shield of California Rx options**  
 (available for PPO plans)
- PPO \$15/\$30/\$45 Rx drug plan
  - PPO \$15/\$30/50% \$45 min \$100 max Rx drug plan
- \* Home self-injectable 30% up to a \$150 maximum

- Blue Shield of California Rx options**  
 (available for HMO/POS and Blue Shield 65 Plus plans)
- Choose one calendar-year brand-name deductible option below:
- \$0 per person
  - \$150 per person
  - \$250 per person
- Choose one of the two-tier Rx drug plan options below:†
- HMO/POS \$5 (generic)/\$10 (brand-name formulary) Rx drug plan (closed formulary)
  - HMO/POS \$5/\$15 Rx drug plan
  - HMO/POS \$10/\$15 Rx drug plan
  - HMO/POS \$10/\$20 Rx drug plan
  - HMO/POS \$10/\$25 Rx drug plan
  - HMO/POS \$15/\$25 Rx drug plan
  - HMO/POS \$15/\$30 Rx drug plan
- † Home self-injectable 20% up to a \$100 maximum

- Choose one of the three-tier Rx drug plan options below:†
- HMO/POS \$0 (generic)/\$20 (brand-name formulary)/\$40 (brand-name non-formulary) Rx drug plan
  - HMO/POS \$3/\$20/\$40 Rx drug plan
  - HMO/POS \$5/\$10/\$25 Rx drug plan
  - HMO/POS \$10/\$15/\$30 Rx drug plan
  - HMO/POS \$10/\$20/\$35 Rx drug plan
  - HMO/POS \$10/\$25/\$40 Rx drug plan
  - HMO/POS \$10/\$30/\$50 Rx drug plan
  - HMO/POS \$10/\$30/50% \$45 min \$100 max Rx drug plan
  - HMO/POS \$15/\$30/\$45 Rx drug plan†
  - HMO/POS \$15/\$30/50% \$45 min \$100 max Rx drug plan
- † Home self-injectable 20% up to a \$100 maximum

**Dental benefits (with or without a medical plan)**

**20 Dental PPO plan**

- Dental PPO plan – Smile<sup>SM</sup> Basic
- Dental PPO plan – Smile<sup>SM</sup> Basic Voluntary
- Dental PPO plan – Smile Spectrum<sup>SM</sup>
- Choose calendar-year maximum
- \$1,500
- Orthodontics?  Yes  No
- Choose non-participating provider allowable amount
- MAC  90% UCR
- Custom plan** (Blue Shield to attach RFA. Required for installation.)

**Dental PPO plan**

**Smile Spectrum Premier**

- Choose deductible:
- \$50 per person/\$150 per family
- Choose calendar-year maximum
- \$1,500
- \$2,000
- Orthodontics?  Yes  No
- Choose non-participating provider allowable amount
- MAC  90% UCR

**Dental HMO plan**

- Dental HMO Basic
- Dental HMO Voluntary
- Dental HMO Plus
- Dental HMO Deluxe
- Other:

**Vision benefits (with or without a medical plan)**

**21 A. Frequency: 12-24-24**

- Blue Shield Life Vision Standard 0/25/100
- Blue Shield Life Vision Standard 0/0/100
- Blue Shield Life Vision Standard 0/25/120
- Blue Shield Life Vision Standard 0/15/120
- Blue Shield Life Vision Standard 0/25/130
- Blue Shield Life Vision Standard 0/15/130
- Blue Shield Life Vision Standard 0/0/130
- Blue Shield Life Vision Standard Voluntary 0/25/120
- Blue Shield Life Custom Vision plan (proposal required for installation of vision only plans)**

**B. Frequency: 12-12-24**

- Blue Shield Life Vision Plus 0/25/100
- Blue Shield Life Vision Plus 0/0/100
- Blue Shield Life Vision Plus 0/25/120
- Blue Shield Life Vision Plus 0/15/120
- Blue Shield Life Vision Plus 0/25/130
- Blue Shield Life Vision Plus 0/15/130
- Blue Shield Life Vision Plus 0/0/130

**C. Frequency: 12-12-12**

- Blue Shield Life Vision Deluxe 0/25/100
- Blue Shield Life Vision Deluxe 0/0/100
- Blue Shield Life Vision Deluxe 0/25/120
- Blue Shield Life Vision Deluxe 0/15/120
- Blue Shield Life Vision Deluxe 0/25/130
- Blue Shield Life Vision Deluxe 0/15/130
- Blue Shield Life Vision Deluxe 0/0/130
- Other

**D. Rates**

This section is required and must be submitted for complete installation.

Structure and rates, other than published, are available only if quoted.

- Three-tier structure

Employee only:

\$ \_\_\_\_\_

Employee plus one dependent:

\$ \_\_\_\_\_

Family:

\$ \_\_\_\_\_

- Four-tier structure

Employee only:

\$ \_\_\_\_\_

Employee/spouse/domestic partner:

\$ \_\_\_\_\_

Employee/child(ren):

\$ \_\_\_\_\_

Family:

\$ \_\_\_\_\_

**Group term life and AD&D Insurance** (with or without a medical plan)

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**22 Benefit schedule**

Group term life and accidental death and dismemberment (AD&D) insurance:  Life/AD&D  Dependent life insurance only (available only with employee life/AD&D insurance) to be eligible for life coverage, applicants must be actively at work for a minimum of 20 hours per week and cannot be enrolled in the Access Baja plans.

**Eligibility** (check one):  All full-time employees  Only those employees enrolled in the Blue Shield/Blue Shield Life medical plan

**Employee Life Insurance** (check one): (minimum benefit \$15,000. If choosing graded schedule, include benefit amounts and class description.)

Flat \$ \_\_\_\_\_  Multiple of salary \_\_\_\_\_ times salary, maximum \$ \_\_\_\_\_  
 Graded \$ \_\_\_\_\_, \_\_\_\_\_; \$ \_\_\_\_\_, \_\_\_\_\_; \$ \_\_\_\_\_, \_\_\_\_\_  
Class description \_\_\_\_\_ Class description \_\_\_\_\_ Class description \_\_\_\_\_

**Dependent Life Insurance (only available with employee life/AD&D insurance):**

Dependent Life Insurance Benefit: \$ \_\_\_\_\_ Spouse/domestic partner/child(ren) benefit (min. \$ 1,000/max. \$5,000, in \$1,000 increments)  
Note: Spouse/domestic partner benefit must equal child(ren) benefit.

**Form of Member Evidence of Coverage/Certificate of Insurance Booklets**

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**23** You are responsible for the distribution of the *Evidence of Coverage/Certificate of Insurance* booklets to your covered employees. In what form would you prefer to receive their plan *Evidence of Coverage* or *Certificate of Insurance*? (check one)

**Please note: available only for custom groups, or groups who enroll in vision benefits, or group term life and AD&D benefits without a medical plan.**

- Electronic format only: Documents will be distributed to the employer via CD-ROM. Employer is responsible for posting these documents on the company intranet for employee access.
- Electronic and printed format: Electronic versions will be distributed via CD-ROM. Employer is responsible for posting these documents on the company intranet for employee access. Printed versions will be mailed to the employer directly. Employers will receive 10% of the total subscriber count to distribute to employees.
- Printed format only: Printed versions will be mailed to the employer directly. Employers will receive the total subscriber count to distribute to employees.

**Payment** (deposit check amount – this amount will be applied to the first month's premium)

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**24** The group herewith tenders the amount of \$ \_\_\_\_\_ and, in consideration of approval of the application it will make and in event of such approval, promises to pay this company as appropriate any balance necessary to constitute the full initial payment for the group benefits herein identified on the checklist. It is understood that the rates will be determined from the initial enrollment data. It is understood that coverage will not commence until the application has been approved and the conditions of coverage are accepted by the employer.

Please note that depositing the group's check does not constitute approval of the group's application. 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.

Detail of how deposit check amount should be applied:

\$ _____ applied to medical	\$ _____ applied to standalone vision
\$ _____ applied to dental PPO	\$ _____ applied to life insurance
\$ _____ applied to dental HMO	\$ _____ other, please indicate:

**Agreement**

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**25** The group hereby applies for the group products selected on this application, as those benefit plans are outlined in the benefit summary(ies), with the understanding and agreement that:

1. Group benefits will not become effective, unless:
  - a. Blue Shield receives and approves the application at its home office in San Francisco, California; and
  - b. The group meets Blue Shield's underwriting requirements, including minimum participation and contribution requirements.
2. The group agrees to pay the required monthly dues/premium to Blue Shield in a timely manner.
3. The group agrees to:
  - a. Enroll all employees as they become eligible, if the Group Policy is issued on a non-contributory basis; or
  - b. Give all eligible employees an opportunity to apply for such group benefits, if the Health Service Agreement/Group Policy is issued on a contributory basis.
4. No waiver or requested change in coverage will become effective unless agreed to and signed by an officer of Blue Shield.
5. For life insurance/AD&D products only: enrolling employees must be actively at work or meet the active employment provisions for coverage before coverage may become effective. Coverage for any person not meeting these provisions on the effective date of the Health Service Agreement/Group Policy, or any increase in coverage for any person not meeting these provisions on the effective date of such increase in coverage, will be deferred until the person returns to work or active employment.

**Authorization** The following authorization section must be signed (Blue Shield of California/Blue Shield Life requires an original copy of this legal document with original signature).

**26 This is an application for coverage only. No contract for coverage will exist until Blue Shield of California/Blue Shield Life has completed its review and communicated to the applicant or the applicant's producer that the application has been accepted and a group health service contract/group policy will be issued. I certify to the best of my knowledge and belief, all of the responses given are true, correct, and complete. I understand that if I have misrepresented or omitted any material fact, any coverage approved by Blue Shield of California/Blue Shield Life may be cancelled, the Health Service Contract/Group Policy rescinded, or the applicable dues/premiums adjusted.**

Authorized signature	Name and title (please print)	Date
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**Producer information** (to be completed by producer or general agent)

<b>27</b> Producer name	Phone number	Fax number
Producer address (P.O. box not acceptable)		
City	State	ZIP
Producer e-mail	Producer tax ID number (commissions will be reported under this number)	
General agent tax ID number	Department of Insurance license number	
General agent name	General agent e-mail	
Would you prefer to be contacted by fax or e-mail? <input type="checkbox"/> Fax <input type="checkbox"/> E-mail	Region	Code number
Today's date (required)	Producer signature (required)	Print name

**I certify to the best of my knowledge and belief that all responses given above are true and correct and complete.**

Blue Shield account executive	Phone number	Fax number	Office number
Sales representative number and region	Account manager/sales analyst (if applicable)		