

MASTER APPLICATION

COMPANY INFORMATION				
Exact Legal Name of Company:		"Doing Business As" (DBA):		
Street Address		City	State	Zip Code
Billing Address <i>(If different from above):</i>			Requested Start Date:	
Key Contacts: Routine:		Phone: ()		
		Fax: ()		
Type of Business <i>(please provide as much detail as possible):</i>				Yrs. In Business:
Name of Current Workers' Comp Carrier:		Those <u>not</u> covered by Workers' Comp <i>(List names and why):</i>		
Was the group in a trust plan? If so, which one and with what carrier?				
Prior Health Insurance Carrier:	Other Health Insurance Plans Offered:		Group Tax ID Number:	
ELIGIBILITY				
Total # of Employees:	Total # of Benefits Eligible Employees:	Total # Enrolled in PacifiCare Health Plan:	Total # Enrolled in other Employer Sponsored Plans:	Total # Declining Coverage:
Is your group currently subject to <u>Cal-COBRA</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <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>			Billing Options: <input type="checkbox"/> HOURLY (eligibility hours _____) <input type="checkbox"/> MONTHLY	
Is your group currently subject to <u>Federal COBRA</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Employed 20 or more total employees during at least 50% of the working days in the previous calendar year)</i>				
Number of existing COBRA or Cal-COBRA participants: _____		Employer Contributions Levels: Employee _____% Dependents _____%		
MEDICAL PLAN <i>(Includes Mental / Nervous benefits)</i>				
HMO Plans		UHC Choice Plus – PPO		Health Savings Account
<input type="checkbox"/> Standard 20-40/500d		<input type="checkbox"/> Choice+ 25/2000/80%		<input type="checkbox"/> Choice+ H.S.A 2500/80%
<input type="checkbox"/> Standard 25/70%		<input type="checkbox"/> Choice 30/2500/100%		
<input type="checkbox"/> Standard 20-40/50%				
BROKER / GENERAL AGENCY INFORMATION				
Broker Name: Agency Name:		Tax ID: (commission will be reported under this number)		
Address:		Phone:	Fax:	

Application is hereby made for a PacifiCare 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 PacifiCare 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