MASTER APPLICATION (Small Group)

COMPANY INFORMATION

Exact Legal Name of Company:	"Doing Business As" (DBA):
Street Address / City / State / Zip Code	
Billing Address *(If different from above):*	Requested Effective Date:

Key Contacts:

Routine:	Phone: ( )	Fax: ( )	E-mail address:
Billing:	Phone: ( )	Fax: ( )	E-mail address:
Executive:	Phone: ( )	Fax : ( )	E-mail address:

Tax ID:	SIC Code:	Type of Business:	Years in Business:

Is your group subject to the Employee Retirement Income Security Act (ERISA)? ☐ Yes ☐ No* *If No, reason for exemption:	Does your group qualify as a Public Agency under CA Government Code § 6500? ☐ Yes ☐ No
Name of Current Workers' Comp Carrier:	Those <u>not</u> covered by Workers' Comp *(List names and why)*:
Prior Health Insurance Carrier:	Other Health Insurance Plans Offered:

PLAN SPECIFICATIONS

Class carve-out? ☐ Yes ☐ No

If Yes, please provide details on carve-out: _____

If offering benefits on a class basis or as part of a multi-choice offering, please indicate class/plan description below:

NETWORK AND MEDICAL PLAN CHOICES:

☐ **Blue** ☐ **Gold**	☐ **10/ 10/ 100/ 3-day max**	(10 PCP & Spec Copay / 100 Hosp; 3 day max / Rx34 10/20/40)
☐ **Blue** ☐ **Gold**	☐ **15/ 15/ 250/ 3-day max**	(15 PCP & Spec Copay / 250 Hosp; 3 day max / Rx46 15/35/50)
☐ **Blue** ☐ **Gold**	☐ **20/ 30/ 500/ 3-day max**	(20 PCP / 30 Spec Copay / 500 Hosp; 3 day max / Rx39 20/35/70)
☐ **Blue** ☐ **Gold**	☐ **20/ 40/ 1000**	(20 PCP/ 40 Spec Copay / 1000 Hosp / Rx46 15/35/50)
☐ **Blue** ☐ **Gold**	☐ **30/ 40/ 1000**	(30 PCP / 40 Spec Copay / 1000 Hosp / Rx39 20/35/70)
☐ **Blue** ☐ **Gold**	☐ **30/ 40/ 750/ day**	(30 PCP / 40 Spec Copay / 750 Hosp, day / Rx39 20/35/70)
☐ **Blue** ☐ **Gold**	☐ **40/ 40/ 750/ day**	(40 PCP & Spec Copay / 750 Hosp, day / Rx49 20/35/70 w/150 ded)
☐ **Blue** ☐ **Gold**	☐ **$1000 ded/ 30/ 40/ 30%**	($30 PCP / $40 Spec Copay / $1000 ded / Rx49 $20/$35/$70 w/$150 ded)
☐ **Blue** ☐ **Gold**	☐ **$1500 ded/ 40/ 40/ 40%**	($40 PCP / $40 Spec Copay / $1500 ded / Rx49 $20/$35/$70 w/$150 ded)

ASSISTED REPRODUCTIVE TECH. (ART) (Supplemental – Available to groups with 20+ eligible employees only)	**CHEMICAL DEP.** (Supplemental)	**CHIROPRACTIC** (Supplemental)	**VISION** (Supplemental)
☐ ART C ☐ ***No ART***	☐ CD1a ($150/$20) ☐ ***No Chemical Dep***	☐ B ($10/30v) ☐ D ($10/20v) ☐ ***No Chiropractic***	☐ A0 ($0) ☐ A2 ($20/$20) ☐ A8 ($30) ☐ ***No Vision***

OWNER/ CORPORATE OFFICER INFORMATION (Please list all)

Is Company a: ☐ Sole Proprietor ☐ Partnership or L.L.C. ☐ Corporation

1. _____ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No
2. _____ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No
3. _____ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No
4. _____ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No

ELIGIBILITY

Total # of Employees:	Total # of Benefit Eligible Employees:	Total # Enrolling in Sharp Health Plan:	Total # Enrolling in other Employer Sponsored Plans:	Total # Declining Coverage:

Are all eligible employees subject to withholding as on a W-2 Form? ☐ Yes ☐ No

If no, please explain: _____

Is your group currently subject to **Cal-COBRA**? ☐ Yes ☐ No *(Employed 2-19 employees during 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)* Is your group currently subject to **Federal COBRA**? ☐ Yes ☐ No *(Employed 20 or more total employees during at least 50% of the working days in the previous calendar year)* Number of existing COBRA or Cal-COBRA participants: _____	Premium Billing Reference: ☐ Bill one location ☐ Bill multiple locations *(with fee)* COBRA Billing Reference *(if applicable):* ☐ Bill employer ☐ Bill COBRA enrollee directly *(with fee)*
Number of hours required per week to be eligible for benefits: Full time EE's ☐ 30 hours ☐ 40 hours ☐ Other _____ Do you want to cover part time employees that work 20-29 hours? ☐ Yes ☐ No ☐ Other _____	Dependent Coverage: Sharp Health Plan will default coverage to include spouse, domestic partner, and children to age 26. If you wish to exclude coverage, please check below. Please note: Offering dependent coverage does not require employer contribution. ☐ No dependent coverage Employer Contribution Levels: Employee _____% Dependent _____%

Waiting Period for **New Hires and Rehires**:

1st of the month following _____days (for **new hires**)

1st of the month following _____days (for **rehires**)

Domestic Partner Coverage (please check one) – Domestic Partner in option A and B must also meet Sharp Health Plan's dependent eligibility requirements as contractually defined:

☐ A. State 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 partners is at least 62 years of age and eligible for Social Security)

☐ B. Expanded Coverage: California State Registration not required (both partners may be the same or opposite sex)

Leave of Absence:

Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence.

(Maximum 3 months) ☐ None ☐ 1 month ☐ 2 months ☐ 3 months

Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence

(Maximum 6 months) ☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Has the group been covered by Sharp Health Plan in the last 12 months? ☐ Yes ☐ No

(If Yes, group is non-guaranteed issue and is subject to Sharp Health Plan's review and approval for eligibility.)

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 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 based upon the contributions established herein for all 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.

_____ _____ _____

X Signature of Company Officer/Owner Print Name/Title Date

BROKER / GENERAL AGENCY INFORMATION	
Broker Name / Agency Name: General Agency Name *(if applicable):*	Tax ID: License: Exp.
Address: City/State/Zip:	Phone: Fax: E-mail:

_____ _____ _____

X Broker/Agent Signature Broker/Agent Name (Print) Date