



# EmployeeElect for 2-50 Member Small Groups

Small Group Health Coverage offered by Blue Cross of California (BCC) and BC Life & Health Insurance Company (BCL&H)  
www.bluecrossca.com

## Employer Application

### 1. Please tell us about your company ...

Company Name		Group No. (For existing groups)	
Street Address	City	State	ZIP Code
Billing Address	City	State	ZIP Code
Employer is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Other (Explain):	SIC Code	Type of Business (Be specific)	
Date Business Established (Mo/Yr)	Company Contact Person	Phone No. ( )	Fax No. ( )
Has the company been insured by Blue Cross in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior Blue Cross coverage terminated: ___ / ___ / ___	E-mail Address	Tax ID No.	

### 2. Medical Coverage Preferences ... what payment options would you like to select?

2a. My Employer Medical Contribution each month will be:

**Traditional Option** I will contribute (50% to 100%): \_\_\_\_\_% per employee \_\_\_\_\_% per dependent

**Fixed Dollar Option** I will contribute (at least \$100 in \$5 increments): \$ \_\_\_\_\_

**Percentage and Plan Option** I will contribute (50-100%) to the following plan (excluding Basic PPO): \_\_\_\_\_  
\_\_\_\_\_ % per employee \_\_\_\_\_ % per dependent

2b. I choose to offer:

**ALL PLANS OR** **DESIGNATED PLANS** (designate Single Plan or Mix 'N Match by checking as many as desired)

**NOTE: Power Select HMO Plan cannot be offered along with any other HMO plan**

<input type="checkbox"/> Basic PPO**	<input type="checkbox"/> Advantage PPO \$25 Copay**	<input type="checkbox"/> PPO 3500 (HSA-Compatible)**	<input type="checkbox"/> Power Select HMO*
<input type="checkbox"/> Saver PPO**	<input type="checkbox"/> Premier PPO \$20 Copay*	<input type="checkbox"/> PPO 2400 (HSA-Compatible)**	<input type="checkbox"/> Saver HMO*
<input type="checkbox"/> PPO \$35 Copay GenRx**	<input type="checkbox"/> Premier PPO \$10 Copay*	<input type="checkbox"/> High Deductible EPO*	<input type="checkbox"/> Classic HMO*
<input type="checkbox"/> PPO \$40 Copay*	<input type="checkbox"/> Power HealthFund 500**	<input type="checkbox"/> Other: _____	<input type="checkbox"/> HMO 100%* <small>* offered by BCC</small>
<input type="checkbox"/> PPO \$30 Copay*	<input type="checkbox"/> Power HealthFund 750**		<small>** offered by BCL&amp;H</small>

### 3. Dental Coverage Preferences ... what payment options and plan choices would you like to select?

3a. My Employer Dental Contribution each month will be:

**Traditional Option** I will contribute (at least 50%): \_\_\_\_\_% per employee \_\_\_\_\_% per dependent

**Fixed Dollar Option** I will contribute (at least \$15 in \$5 increments): \$ \_\_\_\_\_

3b. I choose to offer:

**ALL PLANS OR** **DESIGNATED PLANS** (designate Single Plan or Mix 'N Match by checking as many as desired)

<input type="checkbox"/> Platinum Preferred 2000**	<input type="checkbox"/> High Option PPO**	<input type="checkbox"/> Dental Net*
<input type="checkbox"/> Platinum 2000**	<input type="checkbox"/> Standard Option PPO**	<input type="checkbox"/> Dental SelectHMO*
<input type="checkbox"/> Gold Preferred 1500**	<input type="checkbox"/> Basic Option PPO**	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Gold 1500**		
<input type="checkbox"/> Silver 1000**		

*Fee for service coverage will be substituted if member is outside of PPO service area.*

**Voluntary Dental Coverage**  
Please check below to offer one or both voluntary dental plans. (not available in conjunction with any other dental plans):

Dental Saver SelectHMO\*

PPO Dental Plan\*\*

\* offered by BCC  
\*\* offered by BCL&H

### 4. Vision Coverage Preferences ... what plan choice and payment percentage would you like to select?

4a. I choose to offer:  Blue View AND/OR  Blue View Plus

4b. My employer contribution will be (50-100%): \_\_\_\_\_% per employee \_\_\_\_\_% per dependent

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.



## 5. Life Coverage Selections

Add \$25,000 or more of Life Coverage and your group may qualify for 1% medical premium savings!

- I choose to offer Life coverage, and my Employer Life Contributions will be (25-100%):  
\_\_\_\_\_ % per employee \_\_\_\_\_ % per dependent

Please check only one schedule and specify amount of Life coverage  
(from \$15,000 to \$250,000 in \$1,000 increments):

- Schedule A** Coverage is the same for all job titles \$ \_\_\_\_\_
- Schedule B** Coverage differs by job title:  
**Class I**, officers, managers, supervisors \$ \_\_\_\_\_  
**Class II**, all other group members \$ \_\_\_\_\_  
(Coverage amount for Class I cannot exceed 2.5 times coverage amount for Class II)
- Schedule C** Coverage is a percentage of salary (maximum coverage \$250,000);  
check one of the following for **all** employees:  
EITHER  1 times annual salary, maximum Life coverage \$ \_\_\_\_\_  
OR  2 times annual salary, maximum Life coverage \$ \_\_\_\_\_

For Schedule C, please provide list of employees & annual base salaries

- I choose to offer Dependent Life coverage:  
EITHER  \$10,000 spouse, \$10,000 children 6 months  
to 19 years (age 24 if full-time student),  
\$1,000 children under 6 months  
**(only available if employee Life benefit  
is \$20,000 or more)**  
OR  \$5,000 spouse, \$5,000 children 6 months  
to 19 years (age 24 if full-time student),  
\$500 children under 6 months

- I choose to make Supplemental Life coverage available;  
Supplemental Life is 100% employee paid **(only available  
if other Life options are also selected)**

## 6. Do you want to enroll in P.O.P.?

- Yes  No Premium Only Plan (P.O.P.) is a payroll administration service offered by Ceridian Benefit Services, Inc. (an independent company not affiliated with Blue Cross) that helps companies receive IRS Section 125 tax advantages.

The first year may be FREE if your group has 10+ members enrolling in both Medical and Life. Please read the P.O.P. brochure for complete details.  
If you choose to enroll please complete the enrollment form, provide a separate check (if applicable), and submit along with this application.

## 7. Please tell us about your group's eligibility ...

- A. Total number of employees (including owners/officers): \_\_\_\_\_
- B. Number of eligible full-time employees  
(working a minimum of 30 hours per week): \_\_\_\_\_
- C. Are part-time employees to be covered?  Yes  No  
If yes, check one option:  
 20-29 hours weekly  15-29 hours weekly
- D. Number of eligible part-time employees: \_\_\_\_\_
- E. Is this group a class carve-out?  Yes  No  
If yes, state class of employees to be covered: \_\_\_\_\_
- F. Probationary period/waiting period for new employees:  
 1<sup>st</sup> of month after hire date  3 months  5 months  
 1 month  4 months  6 months  
 2 months
- G. Do you wish to offer coverage for opposite sex  
domestic partners\* under the age of 62 years?  Yes  No
- H. Is your group currently subject to Cal-COBRA?  Yes  No  
(Employed 2-19 eligible employees on at least 50% of its working days in the  
previous calendar year; or if not in business during any part of the previous  
calendar year, employed 2-19 eligible employees on at least 50% of its working  
days during the previous calendar quarter; and not subject to COBRA)
- I. Is your group currently subject to COBRA?  Yes  No  
(Employed 20 or more total employees on at least 50% of the working  
days in the previous calendar year; and not subject to Cal-COBRA)
- J. Is your group subject to the Family Medical Leave Act  
of 1993? (50 or more total employees)  Yes  No
- K. Under TEFRA/DEFRA; which one applies for your group?  
 Medicare is primary (less than 20)  Blue Cross is primary (20+)  
Medicare is primary coverage for groups with less than 20 employees;  
Blue Cross is primary coverage for groups with 20+ employees (based on  
total number of employees during 50% of the working days in previous  
calendar year).

\* Blue Cross complies with State law requiring it to cover spouses and qualified registered domestic partners including dependents to the same extent and subject to the same terms and conditions as a spouse. To be an eligible domestic partner one must be a domestic partner registered under a valid Declaration of Domestic Partnership filed with the California Secretary of State, or an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnership.

If yes to questions H, I or J, please complete the Cal-COBRA/COBRA/FMLA questionnaire on page 6.





**13. This section is important to protect you as a small group employer ...**

**Please check the box that applies:**

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employment Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employment Retirement Income Security Act) and therefore not subject to ERISA, apply to obtain the coverage indicated.

**Rescission**

We have provided a complete history of material information that is considered in the acceptance or denial of the enrollment application. Following approval of coverage, if Blue Cross discovers that we intentionally provided incomplete or false material information or withheld material information from Blue Cross prior to the Effective Date of the Agreement, Blue Cross may revoke coverage. This means Blue Cross may cancel coverage as if it never existed.

If Blue Cross revokes our Group coverage under the Combined Evidence of Coverage and Disclosure Form, Blue Cross will send a written notice explaining the basis for the decision and our appeal rights. We have the option to submit a new application in the future to be underwritten and considered for enrollment. We will be required to pay for any services that were covered for an employee, and Blue Cross will refund any amounts paid by our Group except amounts already paid by Blue Cross on behalf of our employees.

We have personally read and attest to the completeness and validity of the information provided on this application for coverage. If we are accepted, this application will become part of the contract between Blue Cross and our Group. We and any enrolled family members agree to abide by the terms of that contract. Initials:

We understand and agree that no coverage will be effective before the date determined by Blue Cross and only if we have paid our first month's contribution and this application is accepted, that we should keep prior coverage in force until notified of acceptance in writing by Blue Cross/BC Life & Health Insurance Company and that no agent or broker has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Blue Cross/BC Life & Health Insurance Company.

For BC Life & Health Insurance Company insurance coverages, we, the employer, apply to become a participating employer in the Small Group Trust to obtain the coverages indicated. We understand that the Small Group Trust and the underwriting companies may rely on the application, deciding whether to allow us to participate in the Small Group Trust. We hereby acknowledge receipt of BC Life & Health Insurance Company's benefit description attached to and made a part hereof. We understand and agree that: 1) no coverage will be effective before the date determined by the Small Group Trust and the underwriting companies and only if: a) we have paid for the first month's contribution; and b) this application, and any individual applications have been approved by the Small Group Trust and the underwriting companies; 2) this application,

if accepted, and any subsequent amendments become our participation agreement with the Small Group Trust, and 3) the trust agreement and contracts under which we elected coverage are incorporated in and are made a part of the participation agreement. The employer agrees to comply with all provisions of the Small Group Trust. I understand and agree to all of the above. I understand that it is required to submit a DECLINATION of coverage any time that an employee and/or dependent is/or becomes eligible for coverage, but does NOT enroll.

**For employers offering a Health Savings Account (HSA) compatible EPO Plan:**

We, the employer, understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. We understand that having this coverage does not establish an HSA.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Blue Cross of California/BC Life & Health Insurance Company high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

**ARBITRATION AGREEMENT:**

**WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND BC LIFE & HEALTH INSURANCE COMPANY MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BC LIFE & HEALTH INSURANCE COMPANY AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.**

**WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND BLUE CROSS OF CALIFORNIA AND ITS AFFILIATES, INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BLUE CROSS AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.**

If we are enrolled as an administrator of an Employee Welfare Benefit Plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) we understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, we further understand that any dispute we may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process has been completed.

**NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.**

Name of Company Officer <i>(Please print)</i>	Title of Company Officer
Signature of Company Officer <b>X</b>	Date <i>(Month/Day/Year)</i>





**15. Cal-COBRA/COBRA/FMLA Questionnaire ... please complete this page if any "Yes" answers to H, I or J in Section 6**

Cal-COBRA: California law requires employers with 2-19 eligible qualified employees to extend health coverage programs to former employees spouses (widowed/divorced), and their dependents when a qualifying event occurs.

COBRA: The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with 20 or more total employees to extend health coverage programs to former employees, spouses (widowed/ divorced), and their dependents when a qualifying event occurs, unless the former employee, spouse or dependent was not eligible for continuation of coverage prior to January 1, 2005.

FMLA: The Family and Medical Leave Act of 1993 requires groups with 50 or more employees to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

**A. Cal-COBRA and COBRA:**

**Complete for each employee or family member currently on Cal-COBRA or COBRA.**

Name	Birthdate	Social Security or ID No.	Type	Qualifying Event	
				Description	Date
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		

**B. Cal-COBRA: Complete for each employee terminated in the last 60 days who has had a qualifying event.**

**COBRA: Complete for each employee terminated in the last 90 days who has had a qualifying event.**

1.	Name	Social Security or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	If terminated, what date?
If qualifying event, please describe:				
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this employee/dependent presently disabled?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition:				
2.	Name	Social Security or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	If terminated, what date?
If qualifying event, please describe:				
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this employee/dependent presently disabled?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition:				

**C. FMLA: Complete for each employee on family or medical leave.**

1.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is this employee presently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is this employee presently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Company Official	Title	Company Name	Date
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If additional space is needed to include all applicable employees, please use a photocopy of this page.

