blue of california

# Master group application

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

For 2 to 50 eligible employees

**Effective January 1, 2011**

## Get on the fast track

**This handy checklist will make it easier for you to assemble all the information and forms we need to process your application package. Check all the boxes, and it's ready to go!**

**Please see important endnotes on page 8.**

- ☐ Master group application (form C15385)
- ☐ Verification and Statement of Understanding (C20283)
- ☐ Employee enrollment application (form C12914) or Refusal for Coverage (C19927) completed for each eligible employee. Please verify each employee and enrolling dependent has listed their Social Security number.
- ☐ Health Statements (form C15825) are required for guaranteed-issue groups of 6 to 14 enrolling employees and all non-guaranteed-issue groups. Groups of less than 6 enrolling employees will automatically be rated at a 1.1 RAF. To apply for a RAF between 1.1 and 1.0, the submission of health statements is required.
- ☐ Employer Questionnaires (form C15146) are required for guaranteed-issue groups of 15 or more enrolling employees. These must be dated within 45 days of the requested effective date.
- ☐ Sole Proprietor, Partner, or Corporate Officer Statement (form C15293) for all enrolling owners/officers.
- ☐ Wage information for each enrolling employee will be required for eligibility verification as follows:
  - DE-6 for the previous quarter (notate updated employee status, i.e., part-time, full-time, or terminated)
  - All four DE-6s from the previous year if group eligibility is based on, or includes, part-time employees
  - Payroll records (for out of state employees and employees hired after the DE-6 filing)
  - Proof of owner/employer's eligibility if the owner/employer is not listed on the DE-6 (same as noted under "Owner Only Groups" below)
- ☐ Refusal of Coverage Forms for all eligible employees and any eligible dependents who refuse coverage. Applications for dental, vision or life insurance only do not require Refusal of Coverage Forms.
- ☐ A copy of the previous carrier's current billing statement (if applicable)
- ☐ Disability form (if applicable)
- ☐ A **business check** in the amount of the first month's dues as a deposit. 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.
- ☐ For groups that choose Blue Shield dental HMO or dental PPO coverage, vision coverage, or life insurance with health coverage, only one binder check is required. Simply note the portion of each product's dues on the check, payable to Blue Shield.
- ☐ Owner Only Groups will be required to submit documentation verifying that they are active businesses, employing permanent, full-time employees, including but not limited to the following documentation:
  - Sole Proprietorship: 1040 Schedule C for the preceding calendar year
  - Partnership: K-1 for the preceding year for each partner
  - Corporation: Articles of Incorporation (state seal affixed) including officers; K-1 or signed refusal for each officer eligible for coverage

An Independent Member of the Blue Shield Association C15385-PR (10/10)

# Master Group Application (for 2 to 50 eligible employees)

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

**Effective January 1, 2011**

**Group billing unit** | **Do not write in shaded area**

| Access+ HMO® plans | Shield Spectrum PPO℠ plans | Added Advantage POS℠ plan | Shield Savings℠ plans |
|---|---|---|---|
| Active Choice℠ plans* | Access Baja® HMO plans | Dental HMO plans | Dental PPO plans |
| Local Access+ HMO® plans | Vision plans | Group Term Life/Accidental Death & Dismemberment (AD&D) insurance plans* | |
| Mental Health Parity benefits | | | Other |

**Please type or print clearly. Use black ink.** **Please see important endnotes on page 8.**

**1** Full legal business name | Effective date

**2** Billing address: number, street, city, state, ZIP (if P.O. Box, complete No. 3 below)

**3** Physical address of business (if different from above) | County

**4** Group contact name/title

Phone number ( ) | Fax number ( )

E-mail address:

**5** Legal entity ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other (specify)

Federal Tax Identification number ________________________ Do you have multiple tax ID numbers? ☐ Yes ☐ No

If Yes, provide the Federal Employer Tax ID number for the plan sponsor. ________________________

**6** Type of business (provide as much detail as possible):

List the major industries and products/services of your business

Standard industry classification code(s) (SIC Code) in which the business is classified:

**7** List subsidiary or affiliated companies. Give name(s) and address(es). Identify which subsidiaries should be included in the coverage.

If no subsidiary/affiliated companies apply, check "N/A" ☐ N/A

**8** Name of prior group health carrier(s)

Begin date | End date

Do you offer other carriers' health plans to your employees? ☐ Yes ☐ No

If yes, enter dates of open enrollment period From: __________ To: ___________

If other health carrier is offered (in addition to Blue Shield), list carrier name and number of employees covered by this carrier

Name: | No. of employees:

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

**9** The Shield Savings℠ 2250/4500, Shield Savings℠ 1800/3600 (both HSA-eligible), and the Shield Spectrum PPO Plan 3000 are the only Blue Shield plans, offered by either Blue Shield of California or Blue Shield of California Life & Health Insurance Company, that may be used with any form of an employer-sponsored wrap plan. Underwriting criteria prohibits pairing its other health plans with a wrap plan at any time, with the exception of a Health Savings Account (HSA) or employee-funded general purpose Flexible Spending Account (FSA).

If you have any questions about this policy, please contact Blue Shield prior to completing this section.

A. Do you offer, or are you planning to offer, any employer-sponsored wrap plan? ☐ Yes ☐ No

If yes, describe the type of wrap plan: ________________________________________

B. If "no" to (A) above, do you understand and acknowledge that, with the exception of an HSA or employee-funded general purpose FSA, if you pair an employer-sponsored wrap plan with any Blue Shield health plan other than the Shield Savings℠ 2250/4500, Shield Savings℠ 1800/3600, or Shield Spectrum PPO Plan 3000, your group contract/policy will be cancelled? ☐ Yes ☐ No

**10** **New employee waiting period:** _____ months (minimum 0, maximum 6 months).

Will the group offer a special exception to waiting period of managerial/executive new hires? ☐ Yes ☐ No
Please indicate exception waiting period here: _____ months (minimum 0, maximum of 6 months).

New employees are eligible for enrollment the first billing date following completion of the group's waiting period.

**Example:** Employee hire date is 8/1/10, and the group has a three-month waiting period – employee is eligible for enrollment effective 11/1/10. If hire date is 8/2/10, and the group has a three-month waiting period, employee is eligible for enrollment effective 12/1/10.

Will the waiting period be waived for current, actively at work employees? ☐ Yes ☐ No

**11** **Total No. of employees** ________ Total No. of **eligible** employees ________

Total No. of **enrolled** employees: **Medical enrollment** ________ **Dental enrollment** ________ **Vision enrollment** ________ **Life enrollment** ________

**Are you required to comply with the Federal Mental Health Parity and Addiction Equity Act of 2008 (HR1424)?** ☐ Yes ☐ No
If yes, please provide at least two quarters DE6 from the prior calendar quarter showing more than 50 total employees. Blue Shield will modify the plan's mental health and/or substance abuse coverage to be at parity with medical coverage once the requirement to comply is verified. If you have any questions regarding this requirement, please contact your Producer for more information.

For 2 to 50 enrolling employees, please have them complete the Employee Application (C12914). If you have 6 to 14 enrolling employees, they must also fill out the Health Statement (C15825). Groups of less than 6 enrolling employees will automatically be rated at a 1.1 RAF, to apply for a RAF between 1.1 and 1.0, health statements are required.

Number of full-time employees in waiting period:_______________ Number of employees who are declining coverage:_______________

**Employer is responsible for collecting refusal of coverage forms.**

**For employers of fewer than 20 employees:**

Do you currently have an employee who is enrolled in Medicare? ☐ Yes ☐ No

If yes, please provide a copy of qualifying Medicare card(s) and copies of two quarters DE-6.

Are there any out-of-state employees? ☐ Yes ☐ No How many out-of-state employees do you have? __________

**12** **Are all full-time eligible employees being offered health coverage?** ☐ Yes ☐ No If no, please explain:

**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:

Do you wish to offer coverage for your permanent employees who work fewer than 30 but not fewer than 20 hours per week? ☐ Yes ☐ No
**Employees working fewer than 30 hours must have been employed for at least 50% of the previous calendar quarter before they are eligible to enroll.**

**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** Are all employees covered by workers' compensation to the extent required by law?

☐ Yes Carrier name:________________________________________

☐ No If no, please explain:

**15** Are any COBRA participants enrolling in a Blue Shield/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 No. C11248.

**16 If existing Cal-COBRA/COBRA enrollees or those in the Cal-COBRA/COBRA election period are not disclosed at the time of the group's initial enrollment, the group may be re-rated.**

A. Is your group subject to federal COBRA? ☐ Yes ☐ No

**B. How many existing Cal-COBRA or COBRA participants do you have? ________________**

**C. Existing Cal-COBRA or COBRA participants: Please complete for each employee or family member currently on Cal-COBRA or COBRA.**

Name __________________________________ Date of birth ______________ Social Security number ______________________

Qualifying event description __________________________________________ Date _______________

Name __________________________________ Date of birth ______________ Social Security number ______________________

Qualifying event description __________________________________________ Date _______________

Name __________________________________ Date of birth ______________ Social Security number ______________________

Qualifying event description __________________________________________ Date _______________

Name __________________________________ Date of birth ______________ Social Security number ______________________

Qualifying event description __________________________________________ Date _______________

**D. How many employees and/or family members are in a Cal-COBRA/COBRA eligibility/election period? ___________**

**Please complete the following for each employee or family member that is currently in the eligibility/election period.**

Name _________________________________ Date of birth ________________ Social Security number ______________________

Qualifying event description __________________________________________ Date _______________

Please list any health conditions you are aware of for the employee and/or family member(s) _________________________________

________________________________________________________________________________________________________

Name _________________________________ Date of birth ________________ Social Security number ______________________

Qualifying event description __________________________________________ Date _______________

Please list any health conditions you are aware of for the employee and/or family member(s) _________________________________

________________________________________________________________________________________________________

Name _________________________________ Date of birth ________________ Social Security number ______________________

Qualifying event description __________________________________________ Date _______________

Please list any health conditions you are aware of for the employee and/or family member(s) _________________________________

________________________________________________________________________________________________________

## Medical benefits plan

**17** **Stand-Alone Plan** ☐ Check this box to offer a single plan option

**Dual Choice** ☐ Check this box for Dual Choice (2+ eligible employees). Choose one Access+ HMO plan, Local Access+ HMO[5] or POS plan AND one other non-HMO plan.

**Suite Deal Package**[1] ☐ Check this box to offer all of the specified plans listed below (2+ enrolling employees).
Employers can offer Access Baja® HMO in addition to the Suite Deal Package.

| Shield Spectrum PPO | Shield Savings[SM3] | Access+ HMO |
|---|---|---|
| Shield Spectrum PPO Plan 500 Standard* | Shield Savings[SM] 2000/4000*,† | Access+ HMO Plan 20 Value |
| Shield Spectrum PPO Plan 500 Value* | Shield Savings[SM] 3000/6000* | Access+ HMO Plan 30 |
| Shield Spectrum PPO Plan 1000 Value*,† | Shield Savings[SM] QS 2000/4000 | OR |
| Shield Spectrum PPO Plan 1500 Value*,† | Shield Savings[SM] QS 3000/6000 | Local Access+ HMO Plan 20 Value |
| Shield Spectrum PPO Plan 2000 Value*,4,† | | Local Access+ HMO Plan 30 |

**Employers in certain counties and cities:** If you are an employer whose eligible employees live and/or work in the Local Access+ HMO service area[5] you have the option of choosing the Suite Deal medical plan package with either the Access+ HMO plans or the Local Access+ HMO plans but not both. The Local Access+ HMO plans have the same benefits as our Access+ HMO plans, at a reduced rate.

**One HMO plan option must be selected; both options are not available to combine.**
☐ Access+ HMO Plan 20 Value and Access+ HMO Plan 30 **OR** ☐ Local Access+ HMO Plan 20 Value and Local Access+ HMO Plan 30

**PlanSelect[SM] Packages**[2] Groups with 2 to 50 enrolled employees, select between 2 and up to 35 plans from the list below, not including Access Baja plans. Employers can offer Access Baja in addition to PlanSelect.

**Employers in certain counties and cities:** If you are an employer whose eligible employees live and/or work in the Local Access+ HMO service area[5] you have the option of selecting a PlanSelect package with either Access+ HMO plans or Local Access+ HMO plans. Local Access+ HMO products are available as part of the PlanSelect Package provided they are the exclusive HMO plan option. Local Access+ HMO plan options may not be combined with or offered alongside any other full network HMO or POS product except Access Baja HMO. The Local Access+ plans have the same benefits as our Access+ HMO plans, at a reduced rate. The Local Access+ HMO network is an exclusive network of providers and not as broad as the Access+ HMO network. Please review the Benefit Summary Guide (form A16609) for detailed information regarding the Local Access+ HMO provider network and service area.

☐ **All plans w/Access+ HMO/POS plan options**
☐ **All plans w/Access+ HMO/POS plan options (except SS1800/SS2250/PPO3000)**
☐ **All plans w/Local Access+ HMO plan options (excludes Access+ HMO and POS plans)**
☐ **All plans w/Local Access+ HMO plan options (except SS1800/SS2250/PPO3000, Access+ HMO and POS plans)**
☐ **Selected plans (choose at least two plans from below when not offering all plans)**

**Access+ HMO**

| | | | |
|---|---|---|---|
| ☐ Access+ HMO Plan 5 | ☐ Access+ HMO Plan 10 | ☐ Access+ HMO Plan 15 | ☐ Access+ HMO Plan 20 |
| ☐ Access+ HMO Plan 20 Value | ☐ Access+ HMO Plan 30 | ☐ Access+ HMO Plan 25 | ☐ Access+ HMO Plan 40 |

**Local Access+ HMO**[5]

| | | | |
|---|---|---|---|
| ☐ Local Access+ HMO Plan 5 | ☐ Local Access+ HMO Plan 10 | ☐ Local Access+ HMO Plan 15 | ☐ Local Access+ HMO Plan 20 |
| ☐ Local Access+ HMO Plan 20 Value | ☐ Local Access+ HMO Plan 30 | ☐ Local Access+ HMO Plan 25 | ☐ Local Access+ HMO Plan 40 |

**Shield Spectrum PPO**

| | | |
|---|---|---|
| ☐ Shield Spectrum PPO Plan, Zero Deductible | ☐ Shield Spectrum PPO Plan 250 Premier | ☐ Shield Spectrum PPO Plan 250 Standard |
| ☐ Shield Spectrum PPO Plan 500 Premier | ☐ Shield Spectrum PPO Plan 500 Standard* | ☐ Shield Spectrum PPO Plan 1000 |
| ☐ Shield Spectrum PPO Plan 500 Value* | ☐ Shield Spectrum PPO Plan 750 Value*,† | ☐ Shield Spectrum PPO Plan 3000* |
| ☐ Shield Spectrum PPO Plan 1000 Value*,† | ☐ Shield Spectrum PPO Plan 1500 Value*,† | ☐ Shield Spectrum PPO Plan 2000 Value*,4,† |

**Shield Savings[SM3]**

| | | |
|---|---|---|
| ☐ Shield Savings[SM] 1800/3600*,† | ☐ Shield Savings[SM] 2000/4000*,† | ☐ Shield Savings[SM] 2250/4500 |
| ☐ Shield Savings[SM] QS 2000/4000 | ☐ Shield Savings[SM] 3000/6000* | ☐ Shield Savings[SM] 2500* |
| ☐ Shield Savings[SM] 4800* | ☐ Shield Savings[SM] QS 3000/6000 | ☐ Shield Savings[SM] QS 4800* |

**Base PPO*,†**

| | | |
|---|---|---|
| ☐ Base PPO 30 | ☐ Base PPO 40 | ☐ Base PPO 50 |

| Added Advantage POS | Active Choice Plan* | Access Baja HMO |
|---|---|---|
| ☐ Added Advantage POS Plan | ☐ Active Choice Plan 750 SG | ☐ Access Baja HMO Plan 5 |
| | ☐ Active Choice Plan 500 SG | ☐ Access Baja HMO Plan 10 |

☐ **Other** ______________________________

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

† Shield Spectrum PPO Plan 750 Value, Shield Spectrum PPO Plan 1000 Value, Shield Spectrum PPO Plan 1500 Value, Shield Spectrum PPO Plan 2000 Value, Base PPO 30, Base PPO 40, Base PPO 50, Shield Savings[SM] 1800/3600, and Shield Savings[SM] 2000/4000 are pending regulatory approval.

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

**18** **For Dual Choice, Suite Deal, and PlanSelect packages, each optional benefit must be purchased for all medical plans selected.**

| | |
|---|---|
| ☐ Inpatient substance abuse treatmentΔ | ☐ Flexible Spending Account: Flex 123 |
| ☐ Infertility riderΔ | ☐ Premium Only Plan (POP) |
| ☐ Local Access+ HMO and Access+ HMO and/or POS Chiropractic rider | |
| ☐ Local Access+ HMO and Access+ HMO and/or POS Chiropractic/ Acupuncture rider | |

## Dental benefit plans[6]

**19** **Stand-Alone Dental Plan** ☐ Check this box to offer a single dental plan option.

**Suite Deal Dental Package**[7] ☐ Check this box to offer all five of the specified plans listed below (2+ enrolling employees).

| | |
|---|---|
| Dental PPO – Smile Basic 75/1000/No Ortho/MAC | Dental HMO Basic |
| Dental PPO – Smile Value 50/1500/No Ortho/MAC | Dental HMO Plus |
| Dental PPO – Smile Deluxe Plus 2000 50/2000/Ortho/MAC | |

**Dual option** ☐ Check this box for Dual Option (2+ enrolling employees). Choose any two dental plans below.

**PPO Smile plans**

| | |
|---|---|
| ☐ Dental PPO – Smile℠ Basic 75/1000/No Ortho/MAC | ☐ Dental PPO – Smile Deluxe 2000 50/2000/No Ortho/MAC |
| ☐ Dental PPO – Smile Basic Voluntary 75/1000/ No Ortho/MAC[8] | ☐ Dental PPO – Smile Deluxe 50/1500/Ortho/MAC |
| ☐ Dental PPO – Smile Value 50/1500/No Ortho/MAC | ☐ Dental PPO – Smile Deluxe Plus 2000 50/2000/Ortho/MAC |
| ☐ Dental PPO – Smile 50/1500/No Ortho/MAC | ☐ Dental PPO – Smile Deluxe Gold 50/1500/Ortho/U85 |
| ☐ Dental PPO – Smile Plus 50/1500/Ortho/MAC | |
| ☐ Dental PPO – Smile Plus Gold 50/1500/Ortho/U85 | |

**Dental HMO plans**

| | |
|---|---|
| ☐ Dental HMO Basic | ☐ Other dental (specify) ______________________ |
| ☐ Dental HMO Plus | |
| ☐ Dental HMO Deluxe | ______________________ |
| ☐ Dental HMO Voluntary[8] | ______________________ |

## Vision coverage

**20**

| Vision Basic | Vision Standard* (12/24/24) | Vision Plus* (12/12/24) | Vision Deluxe* (12/12/12) |
|---|---|---|---|
| ☐ Vision Basic 0/25/100 | ☐ Vision Standard 0/25/100 | ☐ Vision Plus 0/25/100 | ☐ Vision Deluxe 0/25/100 |
| ☐ Vision Basic 0/15/120 | ☐ Vision Standard 0/15/120 | ☐ Vision Plus 0/15/120 | ☐ Vision Deluxe 0/15/120 |
| ☐ Vision Basic 0/0/130 | ☐ Vision Standard 0/25/130 | ☐ Vision Plus 0/25/130 | ☐ Vision Deluxe 0/25/130 |
| ☐ Vision Basic Plus 0/15/120 | ☐ Vision Standard 0/0/130 | ☐ Vision Plus 0/0/130 | ☐ Vision Deluxe 0/0/130 |
| | ☐ Vision Standard Voluntary 0/25/120** | | |

Δ Cannot be purchased without a medical plan. Blue Shield of California infertility and substance abuse riders can be sold only with a medical plan underwritten by Blue Shield of California. Blue Shield of California Life & Health Insurance Company infertility and substance abuse riders can be sold only with a medical plan underwritten by Blue Shield of California Life & Health Insurance Company.

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

** A voluntary vision plan requires a minimum of 10 enrolling employees.

## Group Term Life and AD&D Insurance*

**21** **Employee life insurance: (**Minimum benefit $15,000. If choosing graded, include Class description.)

☐ Flat $ ________________ ☐ Multiple of salary ___________ times salary, maximum $ ________________

☐ Graded $ ___________, _______________; $ _____________, _______________;
Class description Class description

$ ___________, _______________; $ _____________, _______________
Class description Class description

**Eligibility**: ☐ All full-time employees ☐ Part-time employees _________ Minimum hours
☐ Only those employees enrolled in the Blue Shield/Blue Shield Life Medical Plan

☐ Dependent life insurance (available only with employee life/AD&D Insurance): $ _____________ spouse/domestic partner/child(ren) (min. $1,000/max. $5,000, in $1,000 increments; spouse/domestic partner benefit must equal child benefit). To be eligible for life insurance coverage, applicants must be actively at work for a minimum of 20 hours per week and cannot be enrolling in the Access Baja plans.

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

## Employer contribution

**22** **Medical contribution –** The employer must contribute either (1) a defined contribution of a minimum $100 per employee (or the cost of the total employee rates, whichever is less), or (2) a minimum of 50% of the total employee rates.

**Indicate contribution amount here:** For employees _____% or $ ________ For dependents _____% or $________

If the employer contributes 100% of employee rates, all employees eligible for a group health plan must enroll in coverage offered by the group from any carrier or health plan.

**Dental contribution –** For employer contribution, enter percent of dues paid (must be at least 50% of total employee rates except voluntary) by employer for employees and dependents. If 100%, all eligible employees must enroll.

Indicate contribution amount here: For employees _____% For dependents _____%

**Vision contribution –** For employer contribution, enter percent of dues paid (must be at least 25% of total employee rates for all plans except voluntary) by employer for employees and dependents. If 100%, all eligible employees must enroll.

Indicate contribution amount here: For employees _____% For dependents _____%

**Life insurance contribution**

☐ 100% employer paid ☐ Contributory: Employer pays _____% for employees (minimum 25%), _____% for dependents

## 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)

**23** This is an application for coverage only. No contract for coverage will exist until Blue Shield/Blue Shield Life has completed its review and communicated to the applicant or the applicant's broker 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 committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application, any coverage approved by Blue Shield/Blue Shield Life may, at the sole discretion of Blue Shield/Blue Shield Life, be cancelled, or following notice, the Health Service Contract/Insurance policy may be rescinded, or the applicable dues/rates may be adjusted.

NOTE: Blue Shield Life does not offer life insurance coverage to employers of under ten employees. However, by applying to become a participating employer in the Small Employer Group Trust, this coverage may be obtained. Employer understands that the Small Employer Group Trust and its underwriting company may rely on this application and any individual applications, to decide whether to allow Employer to participate in the Small Employer Group Trust. Employer understands and agrees that no coverage shall be effective: 1) before the date determined by the Small Employer Group Trust and its underwriting company; and 2) before Employer has paid for the first month's premium. Employer understands and agrees that the Employer will receive a Small Employer Group Trust Participation Amendment and such Participation Amendment shall be incorporated into and become a part of the Small Employer Group Trust group life insurance policy. Employer understands and agrees that the Small Employer Group Trust shall provide Employer with a copy of such Small Employer Group Trust group life insurance policy, and that all communications regarding such policy shall be addressed to and handled directly by the Small Employer Group Trust and its underwriting company.

_______________________ _______________________ ___________

Authorized signature Name and title (please print) Date

## Producer information (to be completed by producer or general agent)

**24**

| Producer name | | | Producer e-mail | |
|---|---|---|---|---|
| Producer contact name/e-mail address | Phone number ( ) | | Fax number ( ) | |
| Producer street address (P.O. box not acceptable) | | | | |
| City | | State | ZIP | |
| General agent tax ID number | Producer tax ID number (commissions will be reported under this number) | | | |
| Department of Insurance license number | | Region | Code number | |
| Is this a split commission? ☐ Yes ☐ No | If yes, define split _______ % / _______ % | Name of second writing agent | | |
| General agent name | | General agent e-mail | | |
| Would you prefer to be contacted by fax or e-mail? | | | | |

Today's date (required) _______ / ________ / ________

Producer signature (required) X___________________________________

Print name ___________________________________

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

| Blue Shield account executive | Phone number | Fax number | Office number |
|---|---|---|---|
| Account executive and region | | Account manager/service representative (if applicable) | |

## Endnotes:

1 65% participation in Suite Deal Package required.
2 75% participation in Blue Shield PlanSelect plans required.
3 HSA-eligible high-deductible health plan.
4 Prescription drug coverage for this plan only provides coverage for generic drugs and specifically excludes coverage for brand name prescriptions.
5 Local Access+ HMO products are only available in designated counties: portions of Orange, Los Angeles, San Diego, San Bernardino, Riverside, Kern, Sacramento, San Mateo, and Ventura, as well as San Luis Obispo, Santa Clara, Santa Cruz, and Yolo counties. Please review the *Benefit Summary Guide* (form A16609) for detailed information regarding the Local Access+ provider network and service area.
6 75% participation required for all dental plans,except the Suite Deal Dental package and voluntary plans.
7 65% participation in the Suite Deal Dental package is required.
8 When a non-voluntary plan is combined with a voluntary plan, 75% participation of eligible employees is required.