

Small Group Master Application  
for Ancillary Products

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

Group Billing Unit			Do not write in shaded area
Dental PPO plans	Dental HMO plans	Vision plans	Group Life and Accidental Death & Dismemberment (AD&D) insurance

**Please type or print clearly using ink**

**1** Check all boxes that apply:  Dental PPO (2-50)  Dental HMO (2-50)  
 Vision (2-50)  Group Life/AD&D Insurance (10-50)

**2** Full Legal Business Name \_\_\_\_\_ Effective Date \_\_\_\_\_

**3** Billing Address (Number, Street, City, State, ZIP) If P.O. Box, complete No. 4 below \_\_\_\_\_

**4** Physical Address of Business (if different from above) \_\_\_\_\_ County \_\_\_\_\_

**5** Group Contact Name \_\_\_\_\_ Title \_\_\_\_\_ Employer Tax ID No. \_\_\_\_\_

Phone Number ( ) ( )	Fax Number ( ) ( )	E-mail Address	How do you prefer to be contacted?
Does group have a current medical plan with Blue Shield: <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, what is the group number?	

**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 \_\_\_\_\_ Years in business \_\_\_\_\_

**8** Subsidiaries, Branches and/or Associated Companies to be insured:  No  Yes, Full Legal Name and Address:  
1. \_\_\_\_\_ 2. \_\_\_\_\_

**9** Prior carrier(s)  Yes  No Coverage type: \_\_\_\_\_ Termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mo / day / year

All or part of this Life/AD&D and/or Vision insurance will replace similar coverage:  Yes  No  
If yes, please submit copies of policy(ies) and/or certificate(s)

**10** Domestic Partner Coverage – Domestic partners in options 1 and 2 must also meet Blue Shield’s dependent eligibility requirements as contractually defined (check one).  
 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 or opposite sex partners are 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)

**11** Dental Eligibility

**a.**

1. Future employee waiting period: \_\_\_\_\_ Months (minimum 0, maximum 6 months).
2. Does this waiting period apply to current employees?  Yes  No
3. Unless otherwise noted, employees hired on the 1<sup>st</sup> of the month will be effective on the 1<sup>st</sup> of the month following the completion of the waiting period. Employees effective date is the first bill date following the waiting period.
4. Total No. of all employees: \_\_\_\_\_  
Total No. of eligible employees: \_\_\_\_\_  
Total No. of all active enrolling employees: \_\_\_\_\_

**11 Vision Eligibility**

- b.** Being a full-time employee is a requirement for coverage.
1. Eligible employees are: full-time employees who work a minimum of \_\_\_\_\_ hours per week (standard (30)).
  2. Waiting period (in days):  NONE  30  60  90  OTHER: \_\_\_\_\_
  3. Waiting period will be waived for: full-time employees.  Yes  No
  4. Waiting period will be waived for: part-time employees upon attaining full-time status.  Yes  No
  5. Waiting period will be waived for: employees rehired within  6 months  \_\_\_\_\_ of their termination date.  Yes  No
  6. Coverage becomes effective on:  1<sup>st</sup> day of the month following completion of waiting period.  
 the day following completion of the waiting period.  date of hire (if no waiting period).
  7. Number of eligible employees \_\_\_\_\_ Number of employees enrolled \_\_\_\_\_  
(100% participation required for non-contributory plan, minimum 75% participation for contributory plan)

**11 Life/AD&D Eligibility**

- c.** Being actively at work is a requirement for coverage.
1. Eligible employees are: all active, full-time employees who work a minimum of \_\_\_\_\_ hours per week (standard (30)).
  2. Waiting period (in days):  NONE  30  60  90  OTHER: \_\_\_\_\_
  3. Waiting period will be waived for: actively at work employees.  Yes  No
  4. Waiting period will be waived for: part-time employees upon attaining full-time status.  Yes  No
  5. Waiting period will be waived for: employees rehired within  6 months  \_\_\_\_\_ of their termination date.  Yes  No
  6. Coverage becomes effective on:  1<sup>st</sup> day of the month following completion of waiting period.  
 the day following completion of the waiting period.  date of hire (if no waiting period).
  7. Number of eligible employees \_\_\_\_\_ Number of employees enrolled \_\_\_\_\_  
(100% participation required for non-contributory plan, minimum 75% participation for contributory plan)

**12 Employer Contribution, enter percent of dues paid by employer for EEs (employees) and DEPs (dependents). If 100%, all are eligible.**

<b>Dental PPO Plans</b> For EEs ____% For DEPs ____%	<b>Dental HMO Plans</b> For EEs ____% For DEPs ____%	<b>Vision Plans</b> For EEs ____% For DEPs ____% (For vision plans, minimum employer contribution of 25% toward employee's coverage for all plans except voluntary plans.)	<b>Life/AD&amp;D</b> <input type="checkbox"/> 100% employer paid For EEs ____% (minimum of 25%) For DEPs ____% Retirees ____% (if applicable)	<b>Supplemental Life Insurance</b> (if applicable) For EEs ____% For DEPs ____%
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**Dental Benefits (for groups with 2-50)**

- 13**
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Dental PPO Plan – Smile Basic Voluntary | <input type="checkbox"/> Dental PPO Plan – Smile Plus Gold        | <input type="checkbox"/> Dental HMO Basic     |
| <input type="checkbox"/> Dental PPO Plan – Smile Basic           | <input type="checkbox"/> Dental PPO Plan – Smile Deluxe 2000      | <input type="checkbox"/> Dental HMO Voluntary |
| <input type="checkbox"/> Dental PPO Plan – Smile Value           | <input type="checkbox"/> Dental PPO Plan – Smile Deluxe           | <input type="checkbox"/> Dental HMO Plus      |
| <input type="checkbox"/> Dental PPO Plan – Smile                 | <input type="checkbox"/> Dental PPO Plan – Smile Deluxe Plus 2000 | <input type="checkbox"/> Dental HMO Deluxe    |
| <input type="checkbox"/> Dental PPO Plan – Smile Plus            | <input type="checkbox"/> Dental PPO Plan – Smile Deluxe Gold      | <input type="checkbox"/> Other _____          |

**Vision Benefits (for groups with 2-50)**

- 14** **Blue Shield Life Vision Standard (annual deductible/frame allowance)**  
Exam every 12 months, lenses or contacts every 24 months, frames every 24 months  
 0/130       10/130       0/100       0/75       10/75       25/75
- Blue Shield Life Vision Plus (annual deductible/frame allowance)**  
Exam every 12 months, lenses or contacts every 12 months, frames every 24 months  
 0/130       10/130       0/100       10/100       0/75       10/75
- Blue Shield Life Vision Deluxe (annual deductible/frame allowance)**  
Exam every 12 months, lenses or contacts every 12 months, frames every 12 months  
 0/130       10/130       0/100       10/100  
 Other \_\_\_\_\_

Rates: Employee only \$ \_\_\_\_\_ Employee/spouse/domestic partner \$ \_\_\_\_\_

Employee/child(ren) \$ \_\_\_\_\_ Family \$ \_\_\_\_\_

**Life and AD&D Insurance Benefits (for groups with 10-50)**

**15** Check all boxes that apply:  Life  AD&D  Dependent Life  Supplemental Life  
 Supplemental AD&D  Dependent Supplemental Life

Eligibility description:	No. in Class:	Life and AD&D benefit: (AD&D benefit must equal life benefit)
Class 1. <input type="checkbox"/> All Eligible Full-Time Employees <input type="checkbox"/> Other: _____		<input type="checkbox"/> Flat \$ _____ <input type="checkbox"/> _____ x basic annual earnings to a maximum of \$ _____
Class 2.		<input type="checkbox"/> Flat \$ _____ <input type="checkbox"/> _____ x basic annual earnings to a maximum of \$ _____
Class 3.		<input type="checkbox"/> Flat \$ _____ <input type="checkbox"/> _____ x basic annual earnings to a maximum of \$ _____

Separate certificates are to be issued for each class:  Yes  No  
 Salaried benefits are rounded to the  nearest  next highest \$1,000. Please indicate minimum if applicable \$ \_\_\_\_\_  
**Age reduction:**  Standard – Benefits reduce by 35% at age 65, by 50% of the original amount at 70, and terminate at retirement.  
 Other: \_\_\_\_\_

**Basic Dependent Life Insurance\***  Yes  No  
 If yes, Blue Shield Life includes coverage for state registered domestic partners only. Do you wish to select coverage to include additional domestic partners who are registered with municipalities, counties, or who submit a statement?  Yes  No

**Supplemental Life Insurance\***  Yes  No  
 Employee Only  Employee and spouse/domestic partner only  Employee, spouse/domestic partner and child(ren)  
**Employee:**  
 Select from \$ \_\_\_\_\_ to \$ \_\_\_\_\_, in increments of \$ \_\_\_\_\_  
 \_\_\_\_\_ x Basic annual earnings rounded to the  next  nearest \$ \_\_\_\_\_, to a maximum of \$ \_\_\_\_\_  
 Supplemental AD&D benefit equal to Supplemental Life benefit. Available for employees only.  
**Spouse/domestic partner:**  Select from \$ \_\_\_\_\_ to \$ \_\_\_\_\_, in increments of \$ \_\_\_\_\_  
**Child(ren):**  Select from \$5,000 or \$10,000 per child  
 \*Please note: Spouse/domestic partner benefit may not be more than 50% of the employee's benefit. Benefits for children aged 14 days to 6 months are 10% of child benefits. No coverage for infants from birth to 14 days. AD&D coverage is not available to dependents.

**Rates**  
**Basic Term Life Insurance**  
 Age banded premium rate as quoted by Blue Shield Life  
 Composite rate schedule: \$ \_\_\_\_\_ per thousand – Basic Life \$ \_\_\_\_\_ per thousand – Basic AD&D

**Basic Dependent Life Insurance:**  Not applicable  
 Rate per family unit: \$ \_\_\_\_\_

**Supplemental Term Life Insurance:**  Not applicable  
 Employee/spouse/domestic partner (rate for both employee and spouse/domestic partner are based on the attained age of the employee):  
 Age banded premium rate as quoted by Blue Shield Life  
 Composite rate schedule (only available on takeover plans):  
 \$ \_\_\_\_\_ per thousand – Supplemental Life \$ \_\_\_\_\_ per thousand – supplemental employee AD&D  
 Children (rate includes one or more children per family):  
 \$ \_\_\_\_\_/\$5,000 \$ \_\_\_\_\_/\$10,000

**Payment**

**16** The group has enclosed the first month's dues/premium in the amount of \$ \_\_\_\_\_ along with its completed application. If the application for coverage is approved, the group promises to pay Blue Shield Life any balance necessary to constitute full payment for the first month of coverage prior to coverage becoming effective. It is understood that the total amount due will be determined based upon the group's initial enrollment data. It is also understood that coverage will not become effective unless and until the application has been approved, full payment is received, and the conditions of coverage as set forth in the Health Service Agreement/Group Policy are accepted by the group.

Accounting of first month's dues/premium check:  
 \$ \_\_\_\_\_ applied to dental PPO  
 \$ \_\_\_\_\_ applied to dental HMO  
 \$ \_\_\_\_\_ applied to stand-alone Vision  
 \$ \_\_\_\_\_ applied to stand-alone Life/AD&D  
 \$ \_\_\_\_\_ other, please indicate:

## Agreement

- 17** 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 Life receives and approves the application at its home office in San Francisco, California; and
    - b. The group meets Blue Shield Life's underwriting requirements, including minimum participation and contribution requirements.
  2. The group agrees to pay the required monthly dues/premium to Blue Shield Life in a timely manner.
  3. The group agrees to:
    - a. Enroll all employees as they become eligible, if the Health Service Agreement/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 Life.
  5. **For Life/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.

## Acknowledgement

Signature required below. Blue Shield of California/Blue Shield of California Life & Health Insurance Company requires receipt of the completed application with original signature.

- 18** This is an application for coverage. The group acknowledges that no contract for coverage will exist unless and until Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield Life) accepts the application and communicates an effective date of coverage to the group or the group's producer.
- The group certifies to the best of its knowledge and belief, that all of the information provided in this application is true, correct and complete. The group understands that if it has misrepresented or omitted any material fact, any coverage approved by Blue Shield of California/Blue Shield Life may be cancelled, the Health Service Agreement/Group Policy may be rescinded, or monthly dues/premiums may be adjusted.

\_\_\_\_\_  
Authorized Group Representative's Signature

\_\_\_\_\_  
Name and Title (please print)

\_\_\_\_\_  
Date

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

<b>19</b> Producer Name	Phone Number (   )	Fax Number (   )	
E-mail Address			
Company Name	Tax ID No.		
Producer Street Address	Blue Shield Producer No.		
City	State	ZIP	
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.			
General Agent (if applicable)	Telephone	Fax	Blue Shield G.A. No.
Blue Shield Sales Representative	Telephone	Fax	Sales Office
Blue Shield Account Manager	Telephone	Fax	Sales Office
MESVision Sales Representative	Telephone	Fax	Office