CaliforniaChoice®
Your Health. Your Choice.®

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Orange, CA 92868
www.calchoice.com

# Employer Application

Please complete using black ink or typewriter. Return signed and completed application — and those of employees — to your broker.

Group # ☐☐☐☐☐ (for CaliforniaChoice® use only)

## A. Employer Information

| | | |
|---|---|---|
| **1.** Legal Company Name: | **2.** Date Business Started: / / | **3.** CA Federal Tax ID # (9 digits)—NOT Social Security # ☐☐—☐☐☐☐☐☐☐ |
| **4.** DBA Name (Doing Business As): | **5.** Exact Nature of Business: | **6.** Owner/President Name: |
| **7.** Company Structure: ❑ Corporation ❑ Sole Proprietorship ❑ LLC ❑ S Corporation ❑ Partnership ❑ Other ________________ | | **8.** Contact Name: |

| | | | |
|---|---|---|---|
| **9.** Contact Job Title: | **10.** Contact Phone: ( ) | **11.** Contact Fax: ( ) | **12.** Contact E-mail: |

| | | | | | |
|---|---|---|---|---|---|
| **13.** Billing Address Street: | Suite/Unit #: | City: | State: | Zip: | Check if Residence ❑ |
| **14.** Street Address (if different) (no P.O. Box) Street: | Suite/Unit #: | City: | State: CA | Zip: | Check if Residence ❑ |

| | | |
|---|---|---|
| **15.** Workers' Comp Carrier Name: (not broker or agency name) | **16.** Policy #: | **17.** Future Renewal Date: (mo/day/year) / / |

**Note: Workers' Compensation Coverage must be effective on or prior to the effective date requested with California*Choice***

**18.** ❑ **We are not covered by Workers' Compensation coverage due to legal exemption under the following checked condition:**

❑ Corporation: 100% owners/shareholders (Corporation must be closed and officers must be owners and own all stock)

❑ LLC/Partnership: 100% owners/partners (General partnership must be set up as a Corporation with all partners as owners)

❑ 100% family-related running business out of home (does not include domestic partners; family members must reside at the same residence)

## B. Enrollment & Eligibility Information

**1. Requested effective date:** (mo/day/year) / /

**2.** Have you employed 20 or more employees during at least 50% of the preceding calendar year? (COBRA) ❑ Yes ❑ No — Total # of COBRA enrollees:

**3.** If you answered YES to question #2, do you want your COBRA participants on your bill? ❑ Yes ❑ No
(If yes, you must complete the "Group COBRA Direct Billing" contract)

**4.** Have you employed 20 or more employees for 20 or more weeks during the current or preceding year? (TEFRA) ❑ Yes ❑ No

**5.** Does your group currently have group medical coverage? ❑ Yes ❑ No — Carrier Name: — Policy #: — Termination Date: / /

**6.** Eligible employees must work the following number of hours to qualify: ❑ 20+ hours a week ❑ 30+ hours a week

**7.** All new employees and their dependents will be eligible for coverage the first of the month following a waiting period of:
❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days ❑ 365 days *(Other options are not available, please do not write in)*

**8.** Waiting period applies to: ❑ Future employees (hired after the effective date)
❑ Current and future employees (Current=hired on or prior to effective date) — # in Waiting Period

**9.** Total number of employees on payroll regardless of hours worked: ______________ (including owners, seasonal, etc.)
Total number of active eligible employees on payroll: ______________ (including owners and partners)
Total number of eligible employees applying for medical: ______________ (including owners and partners)

**10.** Number of employees waiving due to: A) Other Group Coverage ______________ B) Other Individual Coverage ______________

**11.** Total number of ineligible employees in each of the following categories: (write "0" if none)
A) Union: ________ B) Part-time: ________ C) Seasonal: ________ D) Temporary: ________ E) Terminated: ________

**12.** How many of the employees (including owners) enrolling are related by blood or marriage? ________

## C. Premium Contribution Method

**NOTE:** Employer must pay for at least 50% of each employee's lowest cost premium.
Dependent contributions are optional for employer.
Employer contribution cannot be applied toward the Salud HMO y mas or Salud Mexico plan.

**CHOOSE ONLY ONE OPTION BELOW:**

❑ **OPTION 1** **PERCENTAGE OF COST**

**STEP 1: Enter the percentage amount you will contribute toward:**

Employee Premium: ___________ % (50% minimum) Dependent Premium: __________ % (write 0 if none)

**STEP 2: Apply contribution toward one HMO, PPO or ANY Plan Option (A, B, or C)**

**A. ❑ HMO:**

- ❑ Lowest cost plan in HMO benefit level:
- ❑ Highest cost plan in HMO benefit level:
- ❑ All plans in HMO benefit level:

→ ❑ 15 ❑ 25 ❑ 30 ❑ 40 ❑ 25 Value ❑ 30 Value ❑ 40 Value

- ❑ Specific Health Plan (select one from list): →

| Carrier | HMO 15 | HMO 25 | HMO 25 Value | Elect Open Access | HMO 30 | HMO 30 Value | HMO 40 | HMO 40 Value |
|---|---|---|---|---|---|---|---|---|
| Blue Shield | ❑ | ❑ | ❑ | | ❑ | | ❑ | ❑ |
| Health Net | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Kaiser Permanente | ❑ | ❑ | | | ❑ | | ❑ | |
| Sharp | ❑ | ❑ | | | ❑ | | ❑ | |
| Western Health Advantage | ❑ | ❑ | | | ❑ | | ❑ | ❑ |

**B. ❑ PPO:** ❑ 750 ❑ 1000 ❑ 2400 ❑ HSA 1500* ❑ HSA 2400* ❑ Active Choice℠ 500

*PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE*

**HSA-Qualified High Deductible Health Plan*

**C. ❑** Any HMO or PPO plan selected by employee

❑ **OPTION 2** **EMPLOYER FIXED DOLLAR AMOUNT**

**Enter the dollar amount you will contribute which will be applied to any plan selected by employee:**

$ ________for Employee
$ ________for Dependents

**OR** $ ________Combined amount for Employee and Dependents

Please be advised that Employee Enrollment Application forms are available in the following languages: Spanish, Vietnamese and Chinese - please contact your broker or California*Choice*®. Some translations in these languages are also available to your employees on an on-going basis as well as interpretation services in 150 different languages. California*Choice* would be glad to give you copies of the Employee Enrollment Application Form in the "threshold languages" of the Plan(s) your employees select. Please contact us or your broker to receive these.

| **To be completed by BROKER:** | | **General Agent/PPGA Name: (if applicable)** | |
|---|---|---|---|
| Broker Name (please print) **Must be broker name—not agency** | | Co-broker name (please print) | |
| Phone: ( ) | Fax: ( ) | Phone: ( ) | Fax: ( ) |
| Commissions payable to: | % Commission if split: | Commissions payable to: | % Commission if split: |
| ***I certify that the employer applying for coverage through the CaliforniaChoice Program has met the 70% participation requirement*** | | | |
| Broker signature: | | Co-broker signature: | |

## D. Statement of Compliance

**I hereby certify that all the information contained in the employer and employee applications are true and correct to the best of my knowledge. I have read and understand the following statements and confirm that my group complies with all the rules and regulations of the California*Choice*® Program. I understand that no coverage will become effective until notified by the California*Choice* Underwriting Department.**

- Our Home Office is located in California.
- A majority (51+%) of our eligible employees reside in California.
- I will maintain 70% participation including all eligible employees. (those working either 20+ or 30+ hours per week as checked in Section B).
- California*Choice* coverage will be offered to all eligible employees on a uniform basis for those working either 20+ or 30+ hours per week as checked in Section B.
- All employees enrolling are currently working the minimum number of hours per week to be considered eligible (either 20+ or 30+ hours per week as checked in Section B) to enroll for California*Choice* coverage.

**I understand** that once California*Choice* coverage is approved, group policy changes cannot be implemented until the next Open Enrollment period. These changes shall include, but are not limited to COBRA provisions, new hire waiting period, minimum hours worked per week, and premium contribution amounts.

**I understand** that once membership information is transmitted to the elected health plans, our group coverage effective date cannot be changed nor can our coverage be terminated until after the first month of coverage.

**I understand** that no alterations can be made to this section and that it must be signed exactly as stated.

**I understand** that the above statements are subject to audit at any time.

**I understand** that the above qualifications must be maintained in order for my group to continue coverage through California*Choice*.

**I agree** to provide California*Choice* Benefit Administrators with any and all information necessary to prove the above statements.

**I understand** that if I am unable to provide the requested information, all California*Choice* benefits will terminate 15 days following notice of termination, and employees will be held responsible for all services and charges incurred through California*Choice* program providers.

**I understand** that any persons, business, or health plan that suffers a loss because of false declarations contained in this employer Application may have cause to bring civil action against our company to recover their losses.

**I understand** that premium payments are to be received by California*Choice* by the statement due date and if payment is not received by the due date, my group will be subject to a 10% late fee.

**I DECLARE UNDER THE PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT.**

Owner/Partner Signature ______________________ Witness Signature of Broker of Record ______________________

Print Name ______________ Date ________ Print Name ______________ Date ________

Company Name ______________________

## E. Medical Questionnaire *(15 or more medically enrolling employees*)*

**The employer must answer the following questions to the best of his/her knowledge for all eligible employees, proprietors, partners, corporate officers, COBRA participants and all eligible dependents, including spouses & domestic partners to be enrolled.**

1. Is any employee to be covered not actively at work performing his or her full-time duties or missed five or more days in the last two months due to injury or illness? ❑ YES ❑ NO

   Provide name(s) of employee(s) not actively at work: ______________ ______________

   *(write "NA" if none)* ______________ ______________

2. Has anyone been treated for a serious illness, been hospitalized, had surgery or incurred medical expenses in excess of $5000 during the past 5 years? ❑ YES ❑ NO

   If "yes" please enter reason: ______________________

3. Is anyone currently being treated or been advised to seek treatment for cancer, chest pain, heart disease, stroke, high blood pressure, kidney disorder, liver disease, birth defects, transplants, brain tumor, nervous system disorders, diabetes, AIDS, AIDS Related Complex, Chronic respiratory disease, alcoholism, chemical dependency, mental disorder, depression or any other serious conditions? If "yes" please circle condition(s) ❑ YES ❑ NO

4. Is anyone currently pregnant? ❑ YES ❑ NO

   If "yes" how many? [ ]

* **IMPORTANT:** Employees must complete an individual Health Questionnaire if less than 15 employees are medically enrolled. (COBRA participants are not counted as employees.)

# Optional Benefits Application GROUP NAME: ____________

## F. Dental Insurance

**SmileSaver[SM] (Prepaid)/Ameritas Group (EPO & PPO)**

When electing dental coverage, the undersigned employer hereby applies for membership in the Bakers Life Nebraska Preferred Trust and agrees to be bound by all the terms and conditions of the Declaration of Trust.

**Step 1: Select one plan offering:**

- ❑ All buy-up dental plans: Prepaid 1000 & 3000, EPO 3500, and PPO 4000 & 5000 WITHOUT Ortho
- ❑ All buy-up dental plans: Prepaid 1000 & 3000, EPO 3500*, and PPO 4000* & 5000* WITH Ortho*
- ❑ Voluntary 3000 and FDH Access 100
- ❑ FDH Access 100 only

**PPO plans with Ortho are only available to groups with 5 or more eligible employees*

Groups electing 3500, 4000 or 5000 with 10 or more employees qualify for takeover benefits by submitting the following: 1) Group's most recent prior dental billing statement; 2) Statement from 12 months prior to effective date; 3) and 24 months prior showing Ortho for Ortho takeover

**Step 2: Complete numbers 1-6 below for buy up dental plans only:**
*(Do not complete for Voluntary 3000 or FDH 100)*

1. Total number of employees applying for dental coverage: ________
2. Total number of COBRA eligibles applying for dental coverage: ________
3. Percentage of employee-only premium paid by Employer: ________ % *(Employer must pay a minimum of 50%)*
4. Percentage of dependent premium paid by Employer: ________ % *(write 0 if none)*
5. Employer contribution is based on plan: ❑ 1000 ❑ 3000 ❑ 3500 ❑ 4000 ❑ 5000 *(Check one box only.)*
6. Does your group currently have dental? ❑ Yes ❑ No If yes, carrier name: ____________________

## G. Voluntary Vision

❑ Check this box if you would like to offer Voluntary Vision at an additional charge to your employees

**Combined Insurance Company of America**

## H. Chiro Plus

**Landmark Healthcare, Inc.**

CHOOSE ONE PLAN ONLY: ❑ Chiropractic Only ❑ Chiropractic & Acupuncture

## I. Life Insurance

CHOOSE ONE OPTION ONLY

**Assurity Life Insurance Company**

❑ **OPTION 1:** Flat Amount

**Select a Flat amount for all employees:**

1. Amount $: ________
2. # of eligible employees: ________

Guaranteed Issue Amounts available for both Options

| Eligible Employees | Minimum | Maximum |
|---|---|---|
| 2-10 | $10,000 | $25,000 |
| 11-25 | $10,000 | $50,000 |
| 26-50 | $10,000 | $75,000 |

**Amounts in between available in increments of $5000**

100% of all eligible employees (whether enrolling or waiving medical) must enroll for life coverage.

***Employees must fall under classification to qualify for specified amount ➔**

❑ **OPTION 2:** Scheduled Amount

**Select up to 4 amounts with the highest being NO MORE THAN 2.5 X the lowest.**

(highest amount ok in increments of $500)

| Life Amount | Employee Classification* (i.e. management, executives, etc.) |
|---|---|
| $ | |
| $ | |
| $ | |
| $ | |

## J. Section 125—Premium Only Plan

**CONEXIS Benefit Administrators**

***A one time $100 Enrollment Fee must be submitted with the premium deposit**

1. Name of Company President, Principal, or Partners: ____________________
2. Name of Corporate Secretary: (if applicable) ____________________
3. Plan Number: ________ (usually 501)
4. State of Incorporation (if applicable): ____________
5. Company Structure:
   ❑ Corporation ❑ S Corporation ❑ Partnership ❑ Sole Proprietorship ❑ LLC ❑ Other ________
6. Premium payments may be elected for: ❑ Medical ❑ Dental ❑ Vision ❑ Other: ________
7. Last day of first Plan year: ____/____/____ Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date.

**Participation Limitations**

P.O.P. rules require that all participants in the plan be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore, are ineligible to participate in the P.O.P.

**IMPORTANT:** Read the information provided in the California*Choice* Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Employer Signature: ____________ Print Name ____________ Date ____________