

(for HSA California use only)

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

Group #

## A. Employer Information

<b>1. Legal Company Name:</b>		<b>2. Date Business Started:</b> / /		<b>3. CA Federal Tax ID # (9 digits)—NOT Social Security #</b> - / / / / / / /		
<b>4. DBA Name (Doing Business As):</b>		<b>5. Exact Nature of Business:</b>		<b>6. Owner/President Name:</b>		
<b>7. Company Structure:</b> <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____		<b>8. Contact Name:</b>		<b>9. Contact Job Title:</b>		
<b>10. Contact Phone:</b> ( ) ( )		<b>11. Contact Fax:</b> ( ) ( )		<b>12. Contact E-mail:</b>		
<b>13. Billing Address:</b> Street: Suite/Unit #: City: State: Zip: Check if Residence <input type="checkbox"/>		<b>14. Street Address (if different) (no P.O. Box):</b> Street: Suite/Unit #: City: State: Zip: <b>CA</b> Check if Residence <input type="checkbox"/>		<b>15. Workers' Comp Carrier Name: (not broker or agency name)</b>		
<b>16. Policy #</b>		<b>17. Future Renewal Date: (mo/day/year)</b> / /				
<b>Note: Workers' Compensation Coverage must be effective on or prior to the effective date requested with HSA California</b>						
<b>18. <input type="checkbox"/> We are not covered by Workers' Compensation coverage due to legal exemption under the following checked condition:</b> <input type="checkbox"/> Corporation: 100% owners/shareholders (Corporation must be closed and officers must be owners and own all stock) <input type="checkbox"/> LLC/Partnership: 100% owners/partners (General partnership must be set up as a Corporation with all partners as owners) <input type="checkbox"/> 100% family-related running business out of home (does not include domestic partners; family members must reside at the same residence)						

## B. Health Savings Account (HSA) Options

*HSA California has partnered with Bancorp to provide you with a quick and convenient way to setup HSA Funding. Please indicate your preferences:*

**1. Do you wish to fund a portion of your employees' Health Savings Account through Bancorp?**  Yes  No  
IF YES:  

- Select your contribution method(s): **a)** \$ \_\_\_\_\_ flat amount per employee; **b)** \$ \_\_\_\_\_ monthly amount per employee (If you would like to contribute both a flat and a monthly amount, complete **both** (a) and (b).)
- Bancorp will contact you to complete your funding setup. You may also go online to complete funding setup at: <http://www.bancorphsa-hsacalifornia.com>
- A Health Savings Account will be automatically created for each enrolled employee, unless they choose to opt out on their enrollment application.

**NOTE: All qualified employees must receive the same employer Health Savings Account contribution, which is not to exceed IRS limits. Employees that are not enrolled in an HSA-qualified plan may not open or have funds contributed to a Health Savings Account.**

**2. Although you are not funding, would you like HSA California to arrange for Health Savings Accounts to be opened with Bancorp for your enrolled employees at no charge? (Each employee will be given the option to opt out.)**  Yes  No

**3. If you have chosen not to fund your employees' HSA at this time, would you still like to receive information for funding at a later date?**  Yes  No

## C. Enrollment & Eligibility Information

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

<b>2. Have you employed 20 or more employees during at least 50% of the preceding calendar year? (COBRA)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Total # of COBRA enrollees: _____	
<b>3. If you answered YES to question #2, do you want your COBRA participants on your bill?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, you must complete the "Group COBRA Direct Billing" contract)			
<b>4. Have you employed 20 or more employees for 20 or more weeks during the current or preceding year? (TEFRA)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>5. Does your group currently have group medical coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Carrier Name: _____	Policy #: _____	Termination Date: / /
<b>6. Eligible employees must work the following number of hours to qualify:</b> <input type="checkbox"/> 20+ hours a week <input type="checkbox"/> 30+ hours a week			
<b>7. All new employees and their dependents will be eligible for coverage the first of the month following a waiting period of:</b> <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days (Other options are not available, please do not write in)			
<b>8. Waiting period applies to:</b> <input type="checkbox"/> Future employees (hired after the effective date) <input type="checkbox"/> Current and future employees (Current=hired on or prior to effective date)			# in Waiting Period _____
<b>9. Total number of employees on payroll regardless of hours worked:</b> _____ (including owners, seasonal, etc.) Total number of <u>active eligible</u> employees on payroll: _____ (including owners and partners) Total number of eligible employees <u>applying</u> for medical: _____ (including owners and partners)			
<b>10. Number of employees waiving due to:</b> A) Other Group Coverage _____ B) Other Individual Coverage _____			
<b>11. Total number of <u>ineligible</u> employees in each of the following categories: (write "0" if none)</b> Union _____ Part-time _____ Seasonal _____ Temporary _____ Terminated _____			
<b>12. How many of the employees (including owners) enrolling are related by blood or marriage?</b> _____			

## D. Premium Contribution Method

**NOTE:** Employer must pay for at least 50% of each employee's lowest cost premium.  
Dependent contributions are optional for employer.

### 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:**     1800     2200     2600     2800B

**B.  PPO:**     2500     3500     4500

**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

**OR**

\$ \_\_\_\_\_ Combined amount for Employee and Dependents

\$ \_\_\_\_\_ for Dependents

Please be advised that Employee Enrollment Application forms are available in the following languages: Spanish, Vietnamese and Chinese - please contact your broker or HSA California. 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. HSA California 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**

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Commissions payable to: \_\_\_\_\_ % if commission split: \_\_\_\_\_

Co-broker name (please print)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Commissions payable to: \_\_\_\_\_ % if commission split: \_\_\_\_\_

**I certify that the employer applying for coverage through the HSA California Program has met the 70% participation requirement**

Broker signature: \_\_\_\_\_ Co-broker signature: \_\_\_\_\_

## E. 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 HSA California Program. I understand that no coverage will become effective until notified by the HSA California 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).
- HSA California 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 C.
- 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 C) to enroll for HSA California coverage.

**I understand** that once HSA California coverage is approved, group policy changes cannot be implemented until the next Renewal 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 HSA California.

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Company Name

## F. 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: \_\_\_\_\_

## G. Dental Insurance

## SmileSaver<sup>SM</sup> (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

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

### Step 2: Complete numbers 1-6 below for buy up dental plans only:

*(Do not complete for Voluntary 3000)*

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: \_\_\_\_\_

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

## H. Voluntary Vision

## Combined Insurance Company of America

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

## I. Life Insurance

## Assurity Life Insurance Company

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

### OPTION 1: Flat Amount

Select a Flat amount for all employees:

Amount \$:

### ← CHOOSE ONE OPTION ONLY →

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

\*Employees must fall under classification to qualify for specified amount →

# of eligible employees:

### OPTION 2: Scheduled Amount

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

*(Amounts must be in increments of \$5000)*

Life Amount	Employee Classification* <i>(i.e. management, executives, etc.)</i>
\$ _____	_____
\$ _____	_____
\$ _____	_____
\$ _____	_____

## 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 HSA California Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Employer Signature: \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_