



**MASTER APPLICATION (Small Groups in San Diego County Only)**

COMPANY INFORMATION				
Exact Legal Name of Company:			"Doing Business As" (DBA):	
Street Address		City	State	Zip Code
Billing Address (If different from above):			Requested Start Date:	
Key Contacts: Routine:		Phone: ( )	Fax: ( )	
Billing:		Phone: ( )	Fax: ( )	
Executive:		Phone: ( )	Fax: ( )	
e-mail address:				
Type of Business (please provide as much detail as possible):				
Tax ID:		SIC Code:		Yrs. In Business:
Name of Current Workers' Comp Carrier:			Those <u>not</u> covered by Workers' Comp (List names and why):	
Prior Health Insurance Carrier:		Other Health Insurance Plans Offered:	Rate Structure (Small groups only): <input type="checkbox"/> Age-banded	
Premium Billing Preference: <input type="checkbox"/> Bill one location <input type="checkbox"/> Bill multiple locations (with fee)			COBRA Billing Preference (if applicable): <input type="checkbox"/> Bill employer <input type="checkbox"/> Bill COBRA enrollee directly (with fee)	
PLAN SPECIFICATIONS				
<b>Plan Network (Please select one):</b> <input type="checkbox"/> Sharp Gold <input type="checkbox"/> Sharp Blue				
<b>MEDICAL PLAN(S) Small Group (Includes Mental Health benefits)</b>  <input type="checkbox"/> Sharp 10/10/0 (\$10 PCP Copay/\$10 Specialist Copay/100% Hosp.; RX \$10/\$20/\$40) <input type="checkbox"/> Sharp 15/15/250 (\$15 PCP Copay/\$15 Specialist Copay/\$250 Hosp.; RX \$10/\$20/\$40) <input type="checkbox"/> Sharp 20/30/500 (\$20 PCP Copay/\$30 Specialist Copay/\$500 Hosp.; RX \$15/\$35/\$50) <input type="checkbox"/> Sharp 20/40/1000 (\$20 PCP Copay/\$40 Specialist Copay/\$1000 Hosp.; RX \$15/\$35/\$50) <input type="checkbox"/> Sharp 30/40/1000 (\$30 PCP Copay/\$40 Specialist Copay/\$1000 Hosp.; RX \$20/\$35/\$70) <input type="checkbox"/> Sharp 30/40/750/day (\$30 PCP Copay/\$40 Specialist Copay/\$750 Hosp. per day; RX \$20/\$35/\$70) <input type="checkbox"/> Sharp 40/40/750/day (\$40 PCP Copay/\$40 Specialist Copay/\$750 Hosp. per day; RX \$20/\$35/\$70)			<b>CHEMICAL DEP. (Supplemental)</b> <input type="checkbox"/> CD-1 (\$150/\$20) <input type="checkbox"/> <b>No Chemical Dep.</b>  <b>VISION (Supplemental)</b> <input type="checkbox"/> A0 (\$0) <input type="checkbox"/> A2 (\$20/\$20) <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>No Vision</b>	
<b>ASSISTED REPRODUCTIVE TECH. ("ART")</b> <i>(Supplemental - Available to groups with 20+ eligible employees only)</i> <input type="checkbox"/> Plan C <input type="checkbox"/> <b>No ART</b>			<b>CHIROPRACTIC (Supplemental)</b> <input type="checkbox"/> B (\$10/30v) <input type="checkbox"/> D (\$10/20v) <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>No Chiro</b>	
OWNER/CORPORATE OFFICER INFORMATION (Please List All)				
1. _____ Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name		Title		
2. _____ Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name		Title		
3. _____ Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name		Title		
4. _____ Actively engaged in business & Eligible for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name		Title		
ELIGIBILITY				
Total # of Employees:	Total # of Benefit Eligible Employees:	Total # Enrolled in Sharp Health Plan:	Total # Enrolled in other Employer Sponsored Plans:	Total # Declining Coverage:
Are all eligible employees subject to withholding as on a W-2 Form? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, please explain: _____				
Is your group currently subject to <u>Cal-COBRA</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Employed 2-19 employees on at least 50% of the working days in the previous calendar year or previous quarter if not in business in the previous calendar year, and are not subject to Federal COBRA)</i> Is your group currently subject to <u>Federal COBRA</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Employed 20 or more total employees during at least 50% of the working days in the previous calendar year)</i>			Number of hours required per week to be eligible for benefits: <b>Full time EE's</b> <input type="checkbox"/> 30 hours <input type="checkbox"/> 40 hours <input type="checkbox"/> Other _____ Do you want to cover part time employees that work 20 - 29 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____	

Number of existing COBRA or Cal-COBRA participants: _____	Employer Contributions Levels: Employee _____% Domestic Partner _____% Dependent _____% Spousal Surcharge _____%
Coverage for Full-time college students to age 25? <input type="checkbox"/> Yes <input type="checkbox"/> No	Waiting Period for <b>New Hires and Rehires</b> : 1st of the month following _____ days (for new hires) 1st of the month following _____ days (for rehires)
Domestic Partner Coverage (please check one) – Domestic Partners in option A and B must also meet Sharp Health Plan's dependent eligibility requirements as contractually defined: <input type="checkbox"/> A. State 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 years of age and eligible for Social Security) <input type="checkbox"/> B. Expanded Coverage: California State Registration not required (both partners may be the same or opposite sex)	
Leave of Absence: Number of months employees are eligible to continue group coverage while on an employer-approved temporary <b>personal</b> leave of absence. (Maximum 3 months) <input type="checkbox"/> None <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months Number of months employees are eligible to continue group coverage while on an employer-approved temporary <b>medical</b> leave of absence. (Maximum 6 months) <input type="checkbox"/> None <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 6 months	
Has the group been covered by Sharp Health Plan in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, group is non-guaranteed issue and is subject to Sharp Health Plan's review and approval for eligibility.)	

### EMPLOYER HEALTH QUESTIONNAIRE (FOR 25+ ENROLLING EMPLOYEES)

*Groups with 2-24 enrolling employees must have each employee complete the individual health questionnaire.*

Please answer the following questions to the best of your knowledge for your employees and/or dependents, including any COBRA participants.

1) Is there any employee, dependent of an employee, or person who will be covered under this plan who has received in excess of \$5,000 in medical care expenses in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Is there any employee, dependent of an employee, or person to be covered under this plan who is unable to work or attend school due to an injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Are there any employees, dependents of employees, or person(s) to be covered under this plan who are currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Are there any dependent children incapable of self support because of a physical or mental disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Are there any employees, dependents of an employee, or person to be covered under this plan being treated or been hospitalized for any of the following: heart disease, kidney disorder, stroke, cancer, AIDS, AIDS Related Complex (ARC), diabetes, respiratory diseases, or any mental or nervous conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
FOR EACH QUESTION ANSWERED "YES", PLEASE EXPLAIN TO THE BEST OF YOUR ABILITY:  QUESTION# _____ QUESTION# _____ QUESTION# _____	
NOTE – The final RAF is based upon Sharp Health Plan's review of the information submitted. A review of prior claims history will be performed for any member who had prior Sharp Health Plan coverage. This review may impact the final RAF applied.	

Application is hereby made for a Sharp Health Plan HMO Contract. This is an application only. Issuance of a Group Agreement is subject to receipt of first month's premium and review and approval by Sharp Health Plan. All eligible employees and dependents will be offered this benefit package. If accepted, the employer agrees to make required payroll deductions based upon the contributions established herein for all employees who enroll in this plan. The applicant also agrees to notify all eligible employees of their ability to enroll in the plan after satisfaction of the applicable waiting period.

\_\_\_\_\_  
X Signature of Company Officer/Owner

\_\_\_\_\_  
Print Name & Title

\_\_\_\_\_  
Date

BROKER / GENERAL AGENCY INFORMATION	
Broker Name / Agency Name:	Tax ID:
General Agency Name (if applicable):	License: Exp.
Address: City/State/Zip:	Phone: Fax: E-mail:

\_\_\_\_\_  
X Broker/Agent Signature

\_\_\_\_\_  
Broker/Agent Name

\_\_\_\_\_  
Date