MASTER APPLICATION (Small Group)

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:	Years in Business:

Name of Current Workers' Comp Carrier:	Those not covered by Workers' Comp *(List names and why)*:

Prior Health Insurance Carrier:	Other Health Insurance Plans Offered:	Rate Structure: ☐ Age banded

Premium Billing Reference: ☐ Bill one location ☐ Bill multiple locations *(with fee)*	COBRA Billing Reference *(if applicable):* ☐ Bill employer ☐ Bill COBRA enrollee directly *(with fee)*

PLAN SPECIFICATIONS

MEDICAL PLAN CHOICES: (Includes Mental Health benefits)

____
____
____
____
____

☐ **CHEMICAL DEPENDENCY** *(Supplemental)*
☐ CD-1 ($150/$20)
☐ ***No Chemical Dependency***

ASSISTED REPRODUCTIVE TECH. (ART)
(Supplemental – Available to groups with 20+ eligible employees only)
☐ Plan C
☐ ***No ART***

CHIROPRACTIC
(Supplemental)
☐ B ($10/30v)
☐ D ($10/20v)
☐ ***No Chiropractic***

VISION
(Supplemental)
☐ A0 ($0)
☐ A2 ($20/$20)
☐ Other ________
☐ ***No Vision***

PLAN NETWORK (Please select one): **San Diego County**: ☐ Sharp Gold OR ☐ Sharp Blue ☐ **Riverside County** (Sharp Gold and Sharp Blue)

OWNER/CORPORATE OFFICER INFORMATION (Please list all)

1. ____________________ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No
2. ____________________ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No
3. ____________________ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No
4. ____________________ Actively engaged in business & Eligible for benefits? ☐ Yes ☐ No

ELIGIBILITY

Total # of Employees:	Total # of Benefit Eligible Employees:	Total # Enrolling in Sharp Health Plan:	Total # Enrolling in other Employer Sponsored Plans:	Total # Declining Coverage:

Are all eligible employees subject to withholding as on a W-2 Form? ☐ Yes ☐ No
If no, please explain: ____________________

Is your group currently subject to **Cal-COBRA**? ☐ Yes ☐ No
(Employed 2-19 employees during 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)

Is your group currently subject to **Federal COBRA**? ☐ Yes ☐ No
(Employed 20 or more total employees during at least 50% of the working days in the previous calendar year)

Number of hours required per week to be eligible for benefits:
Full time EE's ☐ 30 hours ☐ 40 hours ☐ Other ____________

Do you want to cover part time employees that work 20-29 hours?
☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No	**Waiting Period** for **New Hires and Rehires**: 1st of the month following ________days (for new hires) 1st of the month following ________days (for rehires)

Domestic Partner Coverage (please check one) – Domestic Partner in option A and B must also meet Sharp Health Plan's dependent eligibility requirements as contractually defined:

☐ 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 partners is at least 62 years of age and eligible for Social Security)

☐ 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 **personal** leave of absence.

(Maximum 3 months) ☐ None ☐ 1 month ☐ 2 months ☐ 3 months

Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence

(Maximum 6 months) ☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Has the group been covered by Sharp Health Plan in the last 12 months? ☐ Yes ☐ 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)

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? ☐ Yes ☐ 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? ☐ Yes ☐ No
3) Are there any employees, dependents of employees, or person(s) to be covered under this plan who are currently pregnant? ☐ Yes ☐ No
4) Are there any dependent children incapable of self support because of a physical or mental disability? ☐ Yes ☐ No
5) Are there any employees, dependents of an employee, or person(s) 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? ☐ Yes ☐ No

FOR EACH QUESTION ANSWERED "YES", PLEASE EXPLAIN TO THE BEST OF YOUR ABILITY:

QUESTION # ____

QUESTION # ____

QUESTION # ____

QUESTION # ____

NOTE – The final RAF is based upon Sharp Health Plan and Allied National review of the information submitted. A review of SHP 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 their waiting period.

X Signature of Company Officer/Owner ________ Print Name & Title ________ Date ________

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

X Broker/Agent Signature ________ Broker/Agent Name (Print) ________ Date ________