



# Small Business Group Change Request

Effective July 1, 2024

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

**Current Blue Shield Small Business group:** Use this form to change company information, contacts, group elections, or plans. Blue Shield will send you an amended contract, if needed, after processing your requests. It's the group's responsibility to keep its contact information up to date. This form cannot be used to add, remove, or change member information.

Please type or print clearly in black ink. Subsequent billing will reflect requested changes once processed by Blue Shield.

**Instructions:** 1) Complete all of sections 1 and 2. 2) Fill out the remainder of the document, but only for the items you marked in #2.

**Return** by either **Email:** [small.group@blueshieldca.com](mailto:small.group@blueshieldca.com) or **Mail:** Small Group (1-100 employees), P.O. Box 3008, Lodi, CA 95241-1912

## 1 Group identification

Current group legal name	Blue Shield group ID number	Requested effective date for changes
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## 2 Which changes are you making?

Select all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Employer address  | <input type="checkbox"/> Part-time employee eligibility              |
| <input type="checkbox"/> Employer contacts   | <input type="checkbox"/> Medical plans <sup>1</sup>                  |
| <input type="checkbox"/> Employer name, DBA, Federal Tax ID number, SIC, legal entity type | <input type="checkbox"/> Additional selections                       |
| <input type="checkbox"/> Employer waiting period   | <input type="checkbox"/> Specialty benefits – Dental <sup>2</sup>    |
| <input type="checkbox"/> Continuation of coverage – status                                 | <input type="checkbox"/> Specialty benefits – Vision <sup>2</sup>    |
| <input type="checkbox"/> Continuation of coverage – administrator                          | <input type="checkbox"/> Specialty benefits – Life/AD&D <sup>2</sup> |
|  | <input type="checkbox"/> Employer contributions                      |

<sup>1</sup>  Submit the Multiple Subscriber Change Spreadsheet for existing Off-Exchange plan membership in lieu of individual enrollment forms when making renewal changes to current medical elections. This form is available on Broker Connection.

<sup>2</sup>  Add dental      Add specialty product(s) for the first time to existing Blue Shield Medical and ALL currently enrolled employees and dependents will elect specialty coverage. They will automatically be enrolled, and no forms will be required (except for multiple of salary or graded life plans, and to designate life beneficiaries).  
 Add vision  
 Add Life/AD&D

Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents electing coverage. (Refusal of coverage is only allowed for contributory plans.)

## 3A Employer address

Provide the group's new information, where applicable.

Principal business address – number and street (no P.O. box)\*

City	State	ZIP code
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Billing address (if different from above)

City	State	ZIP code
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\* **The principal business address is where Blue Shield will send all paper notices and correspondence;** however, the group may choose to have the bill sent to a different address. The principal business address means the principal business address registered with the Secretary of the State of California. If a principal business address is not registered with the state or is registered solely for purposes of service of process and is not a substantial worksite for the group's business, then provide the business address within the state where the greatest number of employees work.

### 3B Group contact information

We are a digital-first company – email is a **mandatory** field so that we can best serve you.

#### Primary contact – (There can be only one primary contact per group account)

<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		
<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		

#### Employer Connection Plus contact – must also be an authorized contact. (There can be only one Employer Connection Plus contact)

<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		
<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		

#### Secondary contact – (There can be multiple additional contacts per group account)

<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		
<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		

#### Billing contact

<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		
<input type="checkbox"/> Add	<b>Name</b>	<b>Email</b>
<input type="checkbox"/> Delete		

### 3C Employer name, DBA, federal tax ID number, SIC, legal entity type

#### 1. Provide the group's new information

Group legal name	Federal tax ID (TID) number
Doing business as (DBA)	Standard Industry Classification (SIC) and industry description

Choose one legal entity type:

- S-Corporation  
 C-Corporation  
 Partnership or LP  
 Sole proprietor  
 LLC  
 Non-profit  
 Other (specify)

#### 2. Select one option – either 2A simple name change or 2B comprehensive business change. Answer related questions and provide required documentation to [small.group@blueshieldca.com](mailto:small.group@blueshieldca.com).

##### 2A. Simple name change

1. Select all that apply:

- Filed FBN for new fictitious business DBA  
 Filed amendment/conversion for corporations/partnerships

2. Required documentation:

1. IRS documentation of new name and EIN; or W9 or SS-4
2. Proof of name change showing old and new name, as follows:
1. Amendment and/or Conversion document, filed with CA Secretary Of State (Corporations, Partnerships, LLC only) and/or
  2. Fictitious Business Name (FBN) statement, filed with county (Sole Proprietor, or DBA changes)

### 3C Employer name, DBA, federal tax ID number, SIC, legal entity type (continued)

cont'd

#### 2B. Comprehensive business change

1. Select all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Ownership change                            | <input type="checkbox"/> Adding subsidiary/affiliate business |
| <input type="checkbox"/> Business purchase or sale                   | <input type="checkbox"/> Merger                               |
| <input type="checkbox"/> Entity type change                          | <input type="checkbox"/> Other:                               |
| <input type="checkbox"/> Employees moving to other existing business |   |

2. Additional questions:

**Total current FTE and FTE equivalent** \_\_\_\_\_

If current count is larger than 100, how many employed in prior calendar quarter? \_\_\_\_\_

If prior calendar quarter count is larger than 100, how many employed in prior calendar year? \_\_\_\_\_

**Total current FTE and FTE equivalent employed out of state** \_\_\_\_\_

Total FTE and FTE equivalent employed out of state during the prior calendar quarter \_\_\_\_\_

Total FTE and FTE equivalent employed out of state during the prior calendar year \_\_\_\_\_

3. Required documentation:

1. IRS documentation of new name and EIN; or W9 or SS-4
2. Payroll or W4 for all employees
3. New employees only (if applicable): applications and refusals
4. Documentation supporting the change, such as purchase, merger, or partnership agreements, corporate documentation, or other documentation that has been filed for the specific situation

4. If you selected "Adding subsidiary/affiliate business" above, then fill out the table below

Subsidiary or affiliated company name(s)	Include in coverage?	Eligible to file a combined state tax return?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 4 Employer waiting periods

**Choose one of the following options.** Coverage for eligible employees will become effective following completion of the waiting period on the day specified.

- Effective first of the month following date of hire  
(if hired on the first of the month, coverage will be effective the first of the following month)
- Effective first of the month following 30 days from date of hire
- Effective first of the month following 60 days from date of hire
- Effective on the 91st day following date of hire  
(a group may be partially billed when electing the 91st day waiting period)

## 5A Continuation coverage – status

Complete this section if the employee count has changed to impact whether the group is subject to COBRA or Cal-COBRA requirements. If you are changing your COBRA status, Blue Shield will also change your Medicare Secondary Payer (MSP) status; you do not need to request MSP changes. Please note that Blue Shield must receive COBRA status change requests at the beginning of the calendar year.

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Federal COBRA, OR</b> | As of January 1, 2024, the group has 20+ total employees, employed 50% working days in previous calendar year.  |
| <input type="checkbox"/> <b>Cal-COBRA</b>         | As of January 1, 2024, the group has 2-19 eligible employees, employed 50% working days in previous calendar year; or if not in the business during the previous calendar year, during the previous calendar quarter. |

## 5B Continuation coverage – COBRA third-party administrator

- |                                 |              |
|---------------------------------|--------------|
| <input type="checkbox"/> Add    | Company name |
| <input type="checkbox"/> Delete | Company name |

## 6 Part-time employee eligibility

If you are adding part-time coverage, submit this form along with applications or refusals for all eligible part-time employees. If you are removing part-time coverage, submit this form along with the most recently filed DE-9C.

- Remove part-time coverage  
 Add part-time coverage

**Eligible Employee** – An eligible employee is an employee who:

- **(Full-time)** Is a permanent employee who works on a full-time basis in the conduct of the business of the employer, whose duties are performed at the employer's regular place(s) of business, working an average of 30 hours per work week, and who has met any statutorily authorized waiting period; or
- **(Part-time)** Meets all the conditions set forth in the first bullet except works at least 20 hours but no more than 29 hours at least 50% of the weeks in the previous calendar quarter, the group offers such employees health coverage, and all similarly situated employees are offered such coverage; and
- Receives monetary compensation in the course of employment (shown through W-2); and
- Is a bona fide employee and a bona fide employee/employer relationship exists.
- An eligible employee also includes a sole proprietor, spouse, or Domestic Partner of a sole proprietor, or partners of a partnership, or the spouse or Domestic Partner of a partner of a partnership working on a full-time basis at the employer's regular place(s) of business, working an average of 30 hours per work week or at least 20 hours, but not more than 29 hours on a part-time basis per normal workweek, for at least 50% of the working days in the previous calendar quarter, when the group meets all small employer eligibility requirements.
- An eligible employee does not include individuals working on a temporary or substitute basis.

## 7A Medical plans

For groups with one or more enrolling employee, choose plans from either the Off-Exchange or Mirror plan packages, but not both. Plan packages cannot be combined. Within a plan package, HMO and PPO can be offered together.

### Include an Employee Census listing each employee's plan selection with this form.

When the group is no longer offering plans that have active membership, the group-level changes cannot be completed without an Employee Census listing each employee's plan selection.

**Off-Exchange Package** May be offered with another carrier's HMO plan.

**Mirror Package** Cannot be offered alongside Off-Exchange plans. Can be offered alongside another carrier's plans. These plans "mirror" standardized plans offered through Covered California.

### Blue Shield of California Off-Exchange package for Small Business

**PPO Plans** Full PPO and Tandem PPO have different provider networks.  
Full PPO and Full HSA-compatible High-Deductible Health Plan (HDHP) plans share a full Blue Shield provider network.  
Tandem PPO and Tandem HSA-compatible HDHP plans share a select Blue Shield provider network.  
Choose any combination of Full PPO Network and Tandem PPO Network plans.

Choose ALL PPO plans, OR

Individually choose any number of the plan(s) below:

#### PPO plans – Full PPO Network

- Platinum Full PPO 0/0 OffEx
- Platinum Full PPO 0/10 OffEx
- Platinum Full PPO 250/10 OffEx
- Platinum Full PPO 250/15 OffEx
- Gold Full PPO 0/35 OffEx
- Gold Full PPO 500/30 OffEx
- Gold Full PPO 750/30 OffEx
- Gold Full PPO 1000/35 OffEx
- Silver Full PPO 2000/60 OffEx
- Silver Full PPO 2350/65 OffEx\*
- Silver Full PPO 2550/70 OffEx
- Bronze Full PPO 5500/65 OffEx
- Bronze Full PPO 6250/65 OffEx
- Bronze Full PPO 6500/70 OffEx
- Bronze Full PPO 6850/55 OffEx
- Bronze Full PPO 7500/65 OffEx

#### HSA-compatible HDHP plans – Full PPO Network

- Gold Full PPO Savings 1750/15% HDHP  
PrevRx OffEx
- Silver Full PPO Savings 2300/30% OffEx
- Silver Full PPO Savings 2600/35% HDHP  
PrevRx OffEx
- Bronze Full PPO Savings 5700/40% OffEx
- Bronze Full PPO Savings 7500 OffEx

#### HSA-compatible HDHP plans – Tandem PPO Network

- Gold Tandem PPO Savings 1750/15% HDHP  
PrevRx OffEx
- Silver Tandem PPO Savings 2300/30% OffEx
- Silver Tandem PPO Savings 2600/35% HDHP  
PrevRx OffEx
- Bronze Tandem PPO Savings 5700/40% OffEx
- Bronze Tandem PPO Savings 7500 OffEx

#### Tandem PPO plans – Tandem PPO Network

- Platinum Tandem PPO 0/0 OffEx
- Platinum Tandem PPO 0/10 OffEx
- Platinum Tandem PPO 250/10 OffEx
- Platinum Tandem PPO 250/15 OffEx
- Virtual Blue<sup>SM</sup> Platinum Tandem PPO  
250/20 OffEx
- Gold Tandem PPO 0/35 OffEx
- Gold Tandem PPO 500/30 OffEx
- Gold Tandem PPO 750/30 OffEx
- Gold Tandem PPO 1000/35 OffEx
- Virtual Blue<sup>SM</sup> Gold Tandem PPO  
1500/45 OffEx
- Silver Tandem PPO 2000/60 OffEx
- Silver Tandem PPO 2350/65 OffEx\*
- Silver Tandem PPO 2550/70 OffEx
- Virtual Blue<sup>SM</sup> Silver Tandem PPO  
2700/75 OffEx
- Bronze Tandem PPO 5500/65 OffEx
- Bronze Tandem PPO 6250/65 OffEx
- Bronze Tandem PPO 6500/70 OffEx
- Bronze Tandem PPO 6850/55 OffEx
- Bronze Tandem PPO 7500/65 OffEx
- Virtual Blue<sup>SM</sup> Bronze Tandem PPO  
7500/75 OffEx

\* The Silver Full PPO 2350/65 OffEx and Silver Tandem PPO 2350/65 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

**HMO Plans** Access+ HMO<sup>®</sup> plans, Local Access+ HMO<sup>®</sup> plans, and Trio HMO plans have different provider networks.  
Local Access+ and Trio are select networks, and Access+ is a full network.  
Access+ and Local Access+ networks may not be offered together.

Choose ALL Trio and Local Access+ plans, OR

Choose ALL Trio and Access+ plans, OR

Individually choose any number of plan(s) below from Trio/Access+ or Trio/Local Access+:

#### Access+ HMO plans –

##### Access+ HMO Network

- Platinum Access+ HMO<sup>®</sup> 0/20 OffEx
- Platinum Access+ HMO<sup>®</sup> 0/25 OffEx
- Platinum Access+ HMO<sup>®</sup> 0/30 OffEx
- Gold Access+ HMO<sup>®</sup> 0/35 OffEx
- Gold Access+ HMO<sup>®</sup> 500/35 OffEx
- Gold Access+ HMO<sup>®</sup> 1000/35 OffEx
- Gold Access+ HMO<sup>®</sup> 1500/35 OffEx
- Silver Access+ HMO<sup>®</sup> 2300/70 OffEx
- Silver Access+ HMO<sup>®</sup> 2750/70 OffEx
- Bronze Access+ HMO<sup>®</sup> 7000/70 OffEx

#### Trio HMO plans –

##### Trio ACO HMO Network

- Platinum Trio HMO 0/20 OffEx
- Platinum Trio HMO 0/25 OffEx
- Platinum Trio HMO 0/30 OffEx
- Gold Trio HMO 0/35 OffEx
- Gold Trio HMO 500/35 OffEx
- Gold Trio HMO 1000/35 OffEx
- Gold Trio HMO 1500/35 OffEx
- Silver Trio HMO 2300/70 OffEx
- Silver Trio HMO 2750/70 OffEx
- Bronze Trio HMO 7000/70 OffEx

#### Local Access+ HMO plans –

##### Local Access+ HMO Network

- Platinum Local Access+ HMO<sup>®</sup> 0/20 OffEx
- Platinum Local Access+ HMO<sup>®</sup> 0/25 OffEx
- Platinum Local Access+ HMO<sup>®</sup> 0/30 OffEx
- Gold Local Access+ HMO<sup>®</sup> 0/35 OffEx
- Gold Local Access+ HMO<sup>®</sup> 500/35 OffEx
- Gold Local Access+ HMO<sup>®</sup> 1000/35 OffEx
- Gold Local Access+ HMO<sup>®</sup> 1500/35 OffEx
- Silver Local Access+ HMO<sup>®</sup> 2300/70 OffEx
- Silver Local Access+ HMO<sup>®</sup> 2750/70 OffEx
- Bronze Local Access+ HMO<sup>®</sup> 7000/70 OffEx

**7A Blue Shield of California Mirror package for Small Business**

cont'd

Note: Cannot be offered alongside Off-Exchange plans. Can be offered alongside another carrier's plans. These plans "mirror" standardized plans offered through Covered California.

Choose ALL Access+ and Trio HMO and Full PPO plans, OR

Individually choose any number of plan(s) below from Access+ and Trio HMO and/or Full PPO

**Platinum Mirror plans**

- Blue Shield Platinum 90 PPO 0/15 + Child Dental  
 Blue Shield Access+ Platinum 90 HMO® 0/20 + Child Dental  
 Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental

**Gold Mirror plans**

- Blue Shield Gold 80 PPO 350/25 + Child Dental  
 Blue Shield Access+ Gold 80 HMO® 250/35 + Child Dental  
 Blue Shield Trio Gold 80 HMO 250/35 + Child Dental

**Silver Mirror plans**

- Blue Shield Silver 70 PPO 2500/55 + Child Dental  
 Blue Shield Silver 70 HDHP PPO 2300/30% + Child Dental Alt  
 Blue Shield Access+ Silver 70 HMO® 2500/55 + Child Dental  
 Blue Shield Trio Silver 70 HMO 2500/55 + Child Dental

**Bronze Mirror plans**

- Blue Shield Bronze 60 PPO 6300/60 + Child Dental  
 Blue Shield Bronze 60 HDHP PPO 7500/0% + Child Dental Alt  
 Blue Shield Trio Bronze 60 HMO 7000/70 + Child Dental Alt

**7B Additional selections**

Choose any additional selections, as applicable.

**Yes, HealthEquity**

If you selected an HDHP plan, you may choose to make HealthEquity your HSA administrator.

**Remove HealthEquity**

**Choosing HealthEquity means Blue Shield shares eligibility and claims data for a seamless experience.** If you do not select HealthEquity, please work directly with your own HSA administrator.

**Yes, Assisted Reproductive Technology Benefits Rider**

**Remove Assisted Reproductive Technology Benefits Rider from all medical plans**

If selected, a rider for assisted reproductive technology benefits will be added to all medical plans for the entire group. This rider can be offered with either an Off-Exchange or a Mirror plan package, HMO and PPO.

**8A Specialty benefits – dental**

**Include an Employee Census listing each employee's plan selection with this form.**

When the group is no longer offering plans that have active membership, the group-level changes cannot be completed without an Employee Census listing each employee's plan selection.

Choose one dental plan option below:

**Single dental plan option** – Choose any ONE plan below (HMO or PPO), OR

**Dual Choice dental plan option** – Choose any TWO plans below (any combination of HMO or PPO), OR

**Triple Choice dental plan option** – Choose THREE plans below in one of these combinations:

2 Dental HMO and 1 Dental PPO, OR

3 Dental HMO plans, OR

2 Dental PPO plans and 1 Dental HMO plan – This option requires you to offer Blue Shield medical plans. Both of the 2 Dental PPO plans must either have an orthodontic benefit or not have an orthodontic benefit.

**Dental HMO plans**

DHMO Basic

DHMO Standard

DHMO Plus

DHMO Deluxe

DHMO Voluntary

**Dental PPO plans**

Bronze DPPO/\$1000/MAC

Bronze DPPO/\$1000/MAC/Child Only Ortho

Bronze DPPO/\$1500/MAC

Bronze DPPO/\$1500/MAC/Child Only Ortho

Silver DPPO/\$1500/MAC

Silver DPPO/\$1500/MAC/Adult+Child Ortho

Silver DPPO/\$1500/U90

Silver DPPO/\$1500/U90/Adult+Child Ortho

Gold DPPO/\$1500/MAC

Gold DPPO/\$1500/MAC/Adult+Child Ortho

Gold DPPO/\$2000/MAC

Gold DPPO/\$2000/MAC/Adult+Child Ortho

Gold DPPO/\$1500/U90

Gold DPPO/\$1500/U90/Adult+Child Ortho

Gold DPPO/\$2000/U90

Gold DPPO/\$2000/U90/Adult+Child Ortho

Platinum DPPO/\$2500/U90

Platinum DPPO/\$2500/U90/Adult+Child Ortho

Platinum DPPO/\$3000/U90

Platinum DPPO/\$3000/U90/Adult+Child Ortho

Platinum DPPO/\$5000/U90

Platinum DPPO/\$5000/U90/Adult+Child Ortho

Diamond DPPO/\$3000/U95

Diamond DPPO/\$3000/U95/Adult+Child Ortho

Diamond DPPO/\$5000/U95

Diamond DPPO/\$5000/U95/Adult+Child Ortho

**8A Voluntary Dental PPO plans\*\***

- cont'd
- |   |  |
|---|--|
| <input type="checkbox"/> Bronze Voluntary DPPO/\$1000/MAC | <input type="checkbox"/> Bronze Voluntary DPPO/\$1000/MAC/Child Only Ortho |
| <input type="checkbox"/> Bronze Voluntary DPPO/\$1500/MAC | <input type="checkbox"/> Bronze Voluntary DPPO/\$1500/MAC/Child Only Ortho |

\*\* Voluntary Dental plans require one eligible, enrolling employee. The voluntary plans include a 12-month waiting period on major services and orthopedic services (ortho plan)

**8B Specialty benefits – vision\***

**Include an Employee Census listing each employee’s plan selection with this form.**

When the group is no longer offering plans that have active membership, the group-level changes cannot be completed without an Employee Census listing each employee’s plan selection.

Choose one vision plan option below:

- Single vision plan option – choose any ONE plan below, OR  
 Dual Choice vision plan option – choose any TWO plan options below:

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Basic Vision for Small Business (12-24-24)
<input type="checkbox"/> Ultimate Vision Plus 0/0/150/150	<input type="checkbox"/> Preferred Vision Plus 0/0/150/150	<input type="checkbox"/> Basic Vision Plus 0/0/150/150
<input type="checkbox"/> Ultimate Vision 0/0/150	<input type="checkbox"/> Preferred Vision 0/0/150	<input type="checkbox"/> Basic Vision 0/0/150
<input type="checkbox"/> Ultimate Vision Plus 10/25/150/150	<input type="checkbox"/> Preferred Vision Plus 10/25/150/150	<input type="checkbox"/> Basic Vision Plus 10/25/150/150
<input type="checkbox"/> Ultimate Vision 10/25/150	<input type="checkbox"/> Preferred Vision 10/25/150	<input type="checkbox"/> Basic Vision 10/25/150
<input type="checkbox"/> Ultimate Vision 0/0/120	<input type="checkbox"/> Preferred Vision 0/0/120	<input type="checkbox"/> Basic Vision 0/0/120
<input type="checkbox"/> Ultimate Vision 10/25/120	<input type="checkbox"/> Preferred Vision 10/25/120	<input type="checkbox"/> Basic Vision 10/25/120
<input type="checkbox"/> Ultimate Vision Voluntary 10/25/150 <sup>1</sup>	<input type="checkbox"/> Preferred Vision Voluntary 10/25/120 <sup>1</sup>	<input type="checkbox"/> Basic Vision Voluntary 10/25/120 <sup>1</sup>

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

<sup>1</sup> Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

**8C Specialty benefits – Life/AD&D\***

When a group of 10+ eligible lives is adding Life and AD&D insurance for the first time, the Life and AD&D composite-rate quote that displays both the term life rate and the AD&D rate is required to be included with this form.

Choose the life plan design and coverage amount from the benefit amount table below, then select the plan(s):

**Benefit amount table** (use to find benefit amount or maximum benefit for your plan type)

Number of eligible employees	Flat	Multiple of salary	Basic dependent life
	If benefit is within a range, pick any increment of \$5,000.	Minimum benefit is always \$15,000. 1x or 2x annual salary up to the below maximums.	Dependent life benefit must not be more than 50% of the employee benefit. Spouse/domestic partner and children must be covered for the same benefit amount.
2-9	\$15,000 – \$50,000	\$30,000 or \$50,000	\$1,000 or \$2,000 or \$3,000 or \$4,000 or \$5,000
10-24	\$15,000 – \$100,000	\$50,000 – \$300,000 for 1x annual salary and \$50,000 – \$500,000 for 2x annual salary	
25-50	\$15,000 – \$150,000	\$50,000 – \$300,000 for 1x annual salary and \$50,000 – \$500,000 for 2x annual salary	\$1,000 or \$2,000 or \$3,000 or \$4,000 or \$5,000 or \$7,500 or \$10,000 or \$20,000
51-100	\$15,000 – \$150,000 or \$175,000 or \$200,000	\$50,000 – \$300,000 for 1x annual salary and \$50,000 – \$600,000 for 2x annual salary	

Employee Life/AD&D requires two eligible, enrolling employees.

\* Life/AD&D Insurance is underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

**8C** **Select plans** – Choose one employee plan option: Flat, Multiple of salary, or Graded. Determine if you also want to offer dependent life. If offering dependent life, the group must also offer Employee Life/AD&D.

cont'd

	1. Select plan(s)	2. Provide benefit details	Description
<b>Employee</b>	<input type="checkbox"/> Flat	Benefit amount: \$ _____	All employees are covered at the same flat amount (up to the maximum amount).
	<input type="checkbox"/> Multiple of salary	<input type="checkbox"/> 1x salary or <input type="checkbox"/> 2x salary Up to a maximum benefit of: \$ _____	All employees are covered for the same multiple of salary at one or two times annual salary (up to the maximum amount). Benefit amounts are rounded to the next highest \$1,000.
	<input type="checkbox"/> Graded	Make selections in the "Graded life table" below	Employees are covered by class (up to four), defined with different levels of benefits. Classes can be either flat or multiple of salary, and this selection can vary for each class.
<input type="checkbox"/> <b>Dependent</b>		Benefit amount: \$ _____	Only available to employees electing Life/AD&D. Benefits for children ages 14 days to six months are 10% of total benefit, with no coverage for infants from birth to 14 days. AD&D is not available for dependents.

**Graded life table** (use only if choosing a graded plan). Provide a class description and choose one plan option, Flat or Multiple of Salary, for each class. Plan choices may vary by class. The benefit amount for each class must be no more than 2.5 times that of the next lower class.

Provide class description	Flat		Multiple of salary	
	Up to four classes	Provide benefit amount	Select salary multiplier	Provide maximum benefit amount
<b>Class 1</b>		\$ _____	<input type="checkbox"/> 1x or <input type="checkbox"/> 2x	\$ _____
<b>Class 2</b>		\$ _____	<input type="checkbox"/> 1x or <input type="checkbox"/> 2x	\$ _____
<b>Class 3</b>		\$ _____	<input type="checkbox"/> 1x or <input type="checkbox"/> 2x	\$ _____
<b>Class 4</b>		\$ _____	<input type="checkbox"/> 1x or <input type="checkbox"/> 2x	\$ _____

**9 Employer contributions**

How much will the group contribute for each product selected? Only one contribution for Employee and one contribution for Dependent may be selected for each product category.

<b>Medical</b>	Employee: _____% or \$ _____	Employer must contribute either (1) at least 50% of employee's total premium, or (2) a defined contribution minimum of \$100 per employee (or the cost of total employee premiums, whichever is less). If employer pays 100% employee premium, all eligible employees must enroll in coverage.
	Dependent: _____% or \$ _____	
<b>Dental</b>	Employee: _____% or \$ _____	Employer must contribute at least 50% of employee's total premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll in coverage.
	Dependent: _____% or \$ _____	
<b>Vision</b>	Employee: _____% or \$ _____	Employer must contribute at least 25% of employee's total premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll in coverage.
	Dependent: _____% or \$ _____	
<b>Basic Term Life and AD&amp;D</b>	Employee: _____% or \$ _____	Employer must contribute at least 25% of employee's total premium (Voluntary life is not an option). If 100% is paid by the employer (non-contributory), all eligible employees must enroll in coverage.
	Dependent: _____% or \$ _____	



## 10 Employer representative attestations and signature

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By signing below, the group representative attests to the following:

1. The group understands that no requested change(s) will be effective until Blue Shield has processed this request and assigned an effective date. The group or the group's broker will be notified by Blue Shield of the change, or Blue Shield can be contacted for confirmation.
2. The person signing this form must be an existing authorized group contact on file with Blue Shield.
3. For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

X

\_\_\_\_\_  
Authorized group representative signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized group representative printed name

\_\_\_\_\_  
Authorized group representative printed title

## 11 General agent information

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General agency name

General agency tax ID number (for commission payments)

\_\_\_\_\_  
General agency producer name

\_\_\_\_\_  
General agency producer email