Small Business Master Group Application

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

Effective January 1, 2020

Section 1 – Company information – All fields are mandatory. Please type or print clearly in black ink.

1 Full legal business name of group | Requested coverage effective date

Doing business as (DBA), if applicable:

2 Billing address: Number, street, city, state, ZIP (if providing P.O. Box, also complete number 3 below)

3 Physical address (if different from above) | County location of physical address

Business street address where most of your employees work (if different from the physical address)

4 Primary group contact name (only designated contact can access group information) | Title

Phone number | Fax number

Email address (required):

☐ **Check here to register the primary group contact for online account access.**

Note: Online account access may be established to view and/or manage the group account. Once registered, account access may be delegated to the group's broker or other individuals within the organization, as identified by the primary group contact. For more information, please visit **blueshieldca.com/employer**.

Secondary group contact name | Title

Phone number | Email address

5 Legal entity type: ☐ S-Corporation ☐ C-Corporation ☐ Partnership ☐ Sole proprietor ☐ LLC ☐ Non-profit ☐ Other (specify) _____

Federal Tax Identification (TID) number _____ Does your group have multiple TID numbers? ☐ Yes ☐ No

If yes, provide the Federal Employer TID number for the plan sponsor: _____

List the primary products/services of your business | Standard industry classification code(s) (SIC Code)

Prior group health carrier	**Start/end date**	**Coverage still in force?** ☐ **Yes** ☐ **No**

6 Is the company currently covered by or have they previously been covered by Blue Shield of California? ☐ Yes ☐ No If yes, please provide Blue Shield Group ID and/or termination date: Blue Shield Group ID _____ Termination date _____

7 Is the group intending to offer Blue Shield alongside another carrier's plan? ☐ Yes ☐ No

Carrier name	**Number of employees:**	Open enrollment dates **From:**	**To:**

Does the group have any subsidiary or affiliated companies? ☐ Yes ☐ No

Subsidiary or affiliated company name(s)	Include in coverage?	Eligible to file a combined state tax return?
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

Are all employees covered by workers' compensation to the extent required by law? ☐ Yes ☐ No

Section 2 – Eligibility (All fields are mandatory.)

8 There are three different definitions of "employee" that are used in small group health coverage, and determine employee counts for different purposes. Blue Shield asks the group to read these definitions and provide the information requested using the definitions provided below. We rely on the information provided by the group in determining group and employee eligibility for coverage. Please contact us if you have questions or need clarification.

1. All employees – Determine the total number of all employees employed by the group by adding together all employees including full-time, part-time, eligible employees, FTE, and FTE Equivalent, etc.

2. Full-time employee (FTE) and FTE Equivalent – An FTE and FTE Equivalent is defined in Section 4980H(c)(2) of the Internal Revenue Code and is used to determine if a group is a "small employer" under the Small Group Act. A group must have 1-100 FTEs, including FTE Equivalents, to be eligible for a small group health plan at issuance and renewal, in addition to meeting any applicable underwriting criteria such as contribution and participation requirements.

An FTE is an employee who has on average at least 30 hours of service per week, or at least 130 hours of service total, during a calendar month.

The number of FTE Equivalents is determined as follows: Combine the number of hours of service of all non-full-time employees for the month but do not include more than 120 hours of service per employee. Divide the total number by 120.

3. Eligible employee – This definition is used to determine which employees are eligible to enroll, and remain enrolled, in coverage. An eligible employee is an individual who:

- 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
- 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, when the group meets all small employer eligibility requirements.
- An eligible employee does not include individuals working on a temporary or substitute basis.

Total number of employees
a. Total number of employees (including employed owners/officers)
Total number of eligible employees
b. Total number of eligible full-time employees (including eligible sole proprietors and partners)
c. Total number of eligible part-time employees (if offering coverage to all similarly situated employees)

d. Total number of eligible employees enrolling in coverage:	**e. Total number of eligible employees declining coverage**
Medical coverage:	Medical coverage:
Dental coverage:	Dental coverage:
Vision coverage:	Vision coverage:
Life insurance coverage:	Life insurance coverage:

Total number of FTE and FTE Equivalents – see definition number 2 above for instructions
f. Total number of FTE and FTE Equivalents

9 **Employment-based affiliation and waiting periods –** An employer may impose a bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed 90 days.

Please note: If the employer imposes an orientation period when completing an enrollment form for a new employee, the "date of hire" is the first day after completion of the orientation period.

9a.	**Employer orientation period** – In addition to the waiting period, does the employer impose an orientation period for new employees?	☐ Yes	☐ No
9b.	If yes, is this orientation period 30 days or less?	☐ Yes	☐ No

9c. **Employer waiting period** – The group may select 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 partial-billed when electing the 91st day waiting period)

9d.	Does the group intend to offer coverage to employees currently in the employer waiting period for the original effective date of the group contract (i.e., one-time waiver of employer waiting period)?	☐ Yes	☐ No

9	**9e.** Number of employees currently in the group's waiting period?		
	9f. Are all full-time eligible employees being offered health coverage?	☐ Yes	☐ No
	9g. If the response to 9f is no, please provide the specific class/group for whom coverage is being offered.		
	9h. Are all full-time eligible employees being offered coverage actively working an average of 30 hours per week?	☐ Yes	☐ No
	9i. Will the group offer coverage to permanent employees who work at least 20 hours but not more than 29 hours per week?	☐ Yes	☐ No
	9j. Are there any out-of-state employees?	☐ Yes	☐ No
	9k. If yes, how many full-time and full-time equivalent employees are out-of-state?		
	9l. How will ongoing enrollment be provided?	Please choose one: ☐ ☐ Blue Shield online EC+ ☐ Paper	

Section 3 – COBRA/Cal-COBRA continuation coverage information (All fields are mandatory.)

10	**Note: Please only answer yes to either 10a. (Cal-COBRA) or 10b. (Federal COBRA).**		
	10a. Is the group currently subject to Cal-COBRA? (Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year, then during the previous calendar quarter.)	☐ Yes	☐ No
	10b. Is the group currently subject to Federal COBRA? (Employed 20 or more total employees on at least 50% of the working days in the previous calendar year.)	☐ Yes	☐ No
	10c. Number of current Cal-COBRA enrollees?		
	10d. How many employees and/or family members are in a Cal-COBRA election period?		
	10e. Number of current COBRA enrollees?		
	10f. How many employees and/or family members are in a COBRA election period?		
	10g. Are enrollment forms attached for all enrolling COBRA/Cal-COBRA participants?	☐ Yes	☐ No

Section 4a – Health plan selection – For groups with one or more enrolling employees, the group may select plans from either the Off-Exchange or Mirror package options, but not both. Plan packages cannot be combined.

11 **Blue Shield of California Off-Exchange Package for Small Business** – The Blue Shield of California Off-Exchange Package is the only package that may be offered alongside another carrier's HMO plan. For groups with one or more enrolling employees offering Blue Shield of California, the group may choose from one up to 48 plans.

PPO plans – Full PPO and HSA-compatible HDHP plans share the full Blue Shield provider network. Tandem PPO plans have a select Blue Shield provider network. You may select any combination of Full PPO Network and Tandem PPO Network plans.

Choose up to all 32 plans from the Full PPO Network (including HDHP plans) and the Tandem PPO Network.

☐ Choose all PPO plans **OR** individually select plans that the group would like to offer to all future and current employees:

PPO plans – Full PPO Network
- ☐ Platinum Full PPO 0/0 OffEx
- ☐ Platinum Full PPO 0/10 OffEx
- ☐ Platinum Full PPO 250/15 OffEx
- ☐ Gold Full PPO 0/20 OffEx
- ☐ Gold Full PPO 500/30 OffEx
- ☐ Gold Full PPO 750/30 OffEx
- ☐ Gold Full PPO 1200/35 OffEx
- ☐ Silver Full PPO 1800/55 OffEx
- ☐ Silver Full PPO 2300/45 OffEx
- ☐ Bronze Full PPO 5000/70 OffEx
- ☐ Bronze Full PPO 6850/65 OffEx
- ☐ Bronze Full PPO 6500/50 OffEx

HSA-compatible HDHP plans – Full PPO Network
- ☐ Silver Full PPO Savings 2000/25% OffEx
- ☐ Silver Full PPO Savings 2500/35% OffEx
- ☐ Bronze Full PPO Savings 5300/40% OffEx
- ☐ Bronze Full PPO Savings 6900 OffEx

HSA-compatible HDHP plans – Tandem PPO Network
- ☐ Silver Tandem PPO Savings 2000/25% Off/Ex
- ☐ Silver Tandem PPO Savings 2500/35% OffEx
- ☐ Bronze Tandem PPO Savings 5300/40% OffEx
- ☐ Bronze Tandem PPO Savings 6900 OffEx

Tandem PPO plans – Tandem PPO Network
- ☐ Platinum Tandem PPO 0/0 OffEx
- ☐ Platinum Tandem PPO 0/10 OffEx
- ☐ Platinum Tandem PPO 250/15 OffEx
- ☐ Gold Tandem PPO 0/20 OffEx
- ☐ Gold Tandem PPO 500/30 OffEx
- ☐ Gold Tandem PPO 750/30 OffEx
- ☐ Gold Tandem PPO 1200/35 OffEx
- ☐ Silver Tandem PPO 1800/55 OffEx
- ☐ Silver Tandem PPO 2300/45 OffEx
- ☐ Bronze Tandem PPO 5000/70 OffEx
- ☐ Bronze Tandem PPO 6500/50 OffEx
- ☐ Bronze Tandem PPO 6850/65 OffEx

Choosing HealthEquity means Blue Shield shares eligibility and claims data for a seamless experience.

☐ Yes, we will offer HealthEquity as the HSA administrator. If you do not select yes, work directly with your own HSA administrator.

HMO plans – Access+ HMO plans, Local Access+ HMO plans, and Trio HMO plans have different provider networks. Access+ and Trio are select networks and Local Access+ is a full network. Access+ and Local Access+ networks may not be offered together.

Choose up to 16 plans from the Access+ HMO Network and the Trio ACO HMO Network or up to 16 plans from the Local Access+ HMO Network and the Trio ACO HMO Network.

☐ Choose all Trio HMO and Local Access+ HMO plans **OR**
☐ Choose all Trio HMO and Access+ HMO plans **OR**
☐ Individually choose Trio HMO/Access+ HMO or Trio/Local Access+ HMO from below:

Access+ HMO plans – Access+ HMO Network
- ☐ Platinum Access+ HMO® 0/20 OffEx
- ☐ Platinum Access+ HMO® 0/25 OffEx
- ☐ Platinum Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 500/35 OffEx
- ☐ Gold Access+ HMO® 1000/35 OffEx
- ☐ Gold Access+ HMO® 1500/35 OffEx
- ☐ Silver Access+ HMO® 2350/65 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 0/30 OffEx
- ☐ Gold Trio HMO 500/35 OffEx
- ☐ Gold Trio HMO 1000/35 OffEx
- ☐ Gold Trio HMO 1500/35 OffEx
- ☐ Silver Trio HMO 2350/65 OffEx

Local Access+ HMO plans – Local Access+ HMO Network
- ☐ Platinum Local Access+ HMO® 0/20 OffEx
- ☐ Platinum Local Access+ HMO® 0/25 OffEx
- ☐ Platinum Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 500/35 OffEx
- ☐ Gold Local Access+ HMO® 1000/35 OffEx
- ☐ Gold Local Access+ HMO® 1500/35 OffEx
- ☐ Silver Local Access+ HMO® 2350/65 OffEx

Blue Shield of California Mirror Package for Small Business

Mirror package plans cannot be offered alongside our Off-Exchange plan package, or alongside any other carrier's plans.
The plans in these packages "mirror" the standardized plans offered through Covered California. Groups with one or more enrolling employees who select this package may select any number of plans from the options below.
A group has the option of choosing an HMO plan utilizing the Trio ACO HMO provider network along with a PPO plan utilizing the Full PPO Network.

Platinum Mirror plans
- ☐ Blue Shield Trio Platinum 90 HMO 0/15 + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental

Gold Mirror plans
- ☐ Blue Shield Trio Gold 80 HMO 250/25 + Child Dental
- ☐ Blue Shield Gold 80 PPO 250/25 + Child Dental

Silver Mirror plans
- ☐ Blue Shield Trio Silver 70 HMO 2250/50 + Child Dental
- ☐ Blue Shield Silver 70 PPO 2250/50 + Child Dental

Bronze Mirror plans
- ☐ Blue Shield Bronze 60 PPO 6300/65 + Child Dental

11a. Note: Summary of Benefits and Coverage (SBC) forms are available for all health plans. These forms summarize coverage and benefits for all plans in a uniform manner. Log in to **blueshieldca.com/sbc** to review SBC forms for any plan prior to submitting an application. Once the group's application for coverage is approved, download the SBC form(s) for benefit plans specific to your group at **bscadocs.com/sbc** to distribute to employees.

11b. Indicate medical plan employer contribution amount here:
For employees _____% or $ _____ For dependents _____% or $ _____

The employer must contribute either (1) at least 50% of the total employee rates, or (2) a defined contribution of a minimum of $100 per employee (or the cost of the total employee rates, whichever is less). If 100% of the employee's premium is paid by the employer, all eligible employees must enroll in coverage.

11c. Optional benefit – A rider for infertility benefits may be offered with either the Blue Shield of California Off-Exchange Package for Small Business or with the Blue Shield of California Mirror Package for Small Business. If selected, it will be added to all medical plans – PPO and HMO.
☐ Infertility benefits rider

Section 4b – Specialty benefits – dental,* vision,* and life insurance* plan selection

11 **Section SB1 – Dental benefits**

Dental plan options – The group may offer Blue Shield dental coverage with or without a medical plan.

☐ When adding dental coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees and dependents elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing dental coverage.

The group may select from one of the plan options below.

☐ **Single Dental Plan Option**

☐ **Dual Choice Dental Plan Option** – Please select any two plans from the options below.

☐ **Triple Choice Dental Plan Option** – Available with or without a Blue Shield medical plan. Please select three plans from the options below in one of the following combinations:

☐ 2 Dental HMO plans and 1 Dental PPO plan	☐ 3 Dental HMO plans

The following Triple Choice Dental Plan option is only available when purchased with a Blue Shield medical plan:

☐ 2 Dental PPO plans and 1 Dental HMO plan (The two Dental PPO Plans must have the same Orthodontic benefit.)

Dental HMO plans

☐ DHMO Basic	☐ DHMO Standard	☐ DHMO Plus	☐ DHMO Deluxe	☐ DHMO Voluntary

Dental PPO plans

☐ Smile[SM] Value 50/1500/No Ortho/MAC/NR	☐ Smile[SM] Plus Gold 50/1500/Ortho/U80
☐ Smile[SM] 50/1500/No Ortho/MAC/NR	☐ Smile[SM] Plus Gold 50/1500/No Ortho/U80
☐ Smile[SM] Plus 50/1500/Ortho/MAC/NR	☐ Smile[SM] Plus Gold 50/1500/Ortho/U80/ADV
☐ Smile[SM] Basic 75/1000/No Ortho/MAC/NR	☐ Smile[SM] Plus Gold 50/1500/Ortho/U90/ADV
☐ Smile[SM] Basic 50/1000/No Ortho/MAC	☐ Smile[SM] Plus Gold 50/1500/No Ortho/U90/ADV
☐ Smile[SM] Basic 50/1000/Ortho/U85	☐ Smile[SM] Plus Gold 50/2500/Ortho/U90/ADV
☐ Smile[SM] Plus 50/1500/No Ortho/MAC	☐ Smile[SM] Plus Gold 50/2500/No Ortho/U90/ADV
☐ Smile[SM] Plus 50/1500/No Ortho/MAC/WP*	☐ Ultimate Dental PPO for Small Business 50/2000/MAC/NR
☐ Smile[SM] Deluxe 50/1500/Ortho/MAC/NR	☐ Ultimate Dental Plus PPO for Small Business 50/2000/MAC/NR
☐ Smile[SM] Deluxe 2000 50/2000/No Ortho/MAC/NR	☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U80
☐ Smile[SM] Deluxe Plus 2000 50/2000/Ortho/MAC/NR	☐ Ultimate Dental PPO for Small Business 50/2000/Lifetime Ortho/U90
☐ Smile[SM] Deluxe Gold 50/1500/Ortho/U85/NR	☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90
☐ Smile[SM] Plus Gold 50/1500/Ortho/U85/NR	

Voluntary Dental PPO Plans*

☐ Smile[SM] Basic Voluntary 75/1000/No Ortho/MAC/NR	☐ Smile[SM] Basic Voluntary 50/1500/Ortho/U80
☐ Smile[SM] Basic Voluntary 50/1000/No Ortho/MAC	☐ Smile[SM] Basic Voluntary 50/1000/No Ortho/U80 (No Wait)†

Indicate dental plan employer contribution amount here:

For dental coverage, the employer must contribute at least 50% of the employee's premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

For employees _____% or $ _____ For dependents _____% or $ _____

* Voluntary dental plans require a minimum of one (1) enrolling, eligible employee.
† This Voluntary plan does not include Waiting Periods submission of proof of any prior coverage is not required.
ADV stands for Advantage and incentivize members to use INN providers. NR stands for No Rollover.

11 Section SB2 – Vision coverage

Vision coverage* – The group may offer Blue Shield vision coverage with or without a medical plan.

☐ When adding vision coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees and dependents elect the coverage; they will automatically be enrolled and no forms will be required. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing vision coverage.

The group may select from one of the 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)**
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Basic Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Basic Vision 0/0/150
☐ Ultimate Vision Plus 10/25/150/120	☐ Preferred Vision Plus 10/25/150/120	☐ Basic Vision Plus 10/25/150/120
☐ Ultimate Vision 10/25/150	☐ Preferred Vision 10/25/150	☐ Basic Vision 10/25/150
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 0/0/120	☐ Basic Vision 0/0/120
☐ Ultimate Vision 10/25/120	☐ Preferred Vision 10/25/120	☐ Basic Vision 10/25/120
☐ Ultimate Vision Voluntary 10/25/150†	☐ Preferred Vision Voluntary 10/25/120†	☐ Basic Vision Voluntary 10/25/120†

Indicate vision plan employer contribution amount here:

For vision coverage, the employer must contribute a minimum of 25% of the total employee premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

For employees _____% or $ _____ For dependents _____% or $ _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
† Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

Section SB3 – Life/AD&D insurance

Group term life insurance* – Requires a minimum of two eligible employees.

The group may offer Blue Shield group term life and AD&D insurance coverage with or without a medical plan.

☐ When adding flat life insurance coverage for the first time to your existing Blue Shield Small Business benefits package, please check this box if all currently enrolled employees elect the coverage; they will automatically be enrolled and no forms will be required (except for multiple of salary or graded plans). Otherwise, please complete an enrollment, refusal of coverage, or subscriber change request form for all eligible employees. (Refusal of coverage is only allowed for contributory plans.)

The group may select from one of the plan options and coverage amounts below. Benefit amounts are available in $5,000 increments between the designated guaranteed issue benefit amounts listed.

Benefit amount:
2-9 eligible employees: $15,000, $35,000 or $50,000
10-24 eligible employees: $15,000-$100,000
25-50 eligible employees: $15,000-$150,000
51-100 eligible employees: $15,000-$150,000 or $175,000 or $200,000, $250,000*, $300,000*

* The benefit amounts of $250,000 and $300,000 are only available with a multiple of salary plan and not for flat amount plans.

☐ **Flat amount** – All employees are covered at the same flat amount (up to a maximum benefit amount). $ _____

☐ **Multiple of salary** – All employees are covered for the same multiple of salary at a 1 or 2 times annual salary (up to maximum benefit amount). Benefit amounts established by salary are rounded to the next highest $1,000. ____ times salary, maximum $ _____

☐ **Graded** – Employees are covered by class (up to 4), defined with different levels of benefits. The benefit amount for each class must be no more than 2.5 times that of the next lower class.

- ☐ 1. Class description _____ amount $ _____
- ☐ 2. Class description _____ amount $ _____
- ☐ 3. Class description _____ amount $ _____
- ☐ 4. Class description _____ amount $ _____

☐ **Dependent life insurance** – Coverage amounts listed are per dependent, and are only available for employees electing life insurance. The maximum dependent benefit may not be more than 50% of the employee benefit. Benefits for children age 14 days to 6 months are 10% of the total benefit, and there is no coverage for infants from birth to 14 days. AD&D insurance coverage is not available for dependents.
(Choose one): ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $20,000

Indicate group term life insurance plan employer contribution amount here:

For life insurance coverage, the employer must contribute a minimum of 25% of the total employee premium. If 100% is paid by the employer (non-contributory), all eligible employees must enroll.

For employees _____% or $ _____ For dependents _____% or $ _____

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

Section 5 – Electronic distribution of *Evidence of Coverage* (EOC) and notices

12 The group is responsible for the prompt distribution of the *Evidence of Coverage* booklets and other required coverage notices ("required materials") to covered employees. Electronic versions of required materials are emailed directly to the group administrator.

For printed versions of required materials, please contact us at **(800) 559-5905**.

Authorization and signature (All fields are mandatory.)

13 This is an application for coverage. The group understands that no contract for coverage will exist until Blue Shield has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted and a group health service contract has been issued. The group representative certifies that, to the best of his or her knowledge and belief, all of the responses provided in this application are true, correct and complete. By signing below, the group also understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of issuance of coverage, Blue Shield may pursue one of the following remedies: Coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the health service contract may be rescinded.

Authorized group representative signature	Date
Group representative name (please print)	
Group representative title (please print)	

Producer information (To be completed by producer or general agent. All fields are mandatory.)

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Agency name		Tax ID number (for commission payments)	
Producer name (agent who wrote the group)		Producer CDI license number	
Producer email			Producer phone number
Producer contact		Producer contact email	
Producer street address (P.O. Box not acceptable)			
City		State	ZIP code
Is this a split commission? ☐ Yes ☐ No	If yes, define split Producer number 1 _____ % Producer number 2 _____ %	Name of second producer Second producer tax ID number	
General agency name		General agency tax ID number (for commission payments)	
General agency producer name		General agency producer email	

Today's date (required)	Producer signature (required)	Producer print name (required)
_____	X_____	_____

I certify that, to the best of my knowledge and belief, all responses given above are true, correct, and complete.

Items to be completed internally by Blue Shield	
Blue Shield account executive	Phone number
Blue Shield account manager	Phone number
Blue Shield sales assistant	Phone number

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services
Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、ＩＤカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند.برای دریافت کمک،با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید.برای دریافت کمک بیشتر، به CA Dept. of Insurance(اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید.Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo bááh ílínígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hóló̱o̱doo nínízingo éí bíighah. Naaltsoos naanin——áhájeehígí shich'į' yíidooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866)346-7198jį' hodíilnih. Hózhó shíká anáá'doowoł nínízingo éí díí béeso ách'a̱a̱h naa'nil bił haz'á̱a̱jį' 1-800-927-4357jį' hodíilnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian