blue of california

Small Business Enrollment Spreadsheet Guide

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Introduction

Blue Shield of California is offering the Enrollment Spreadsheet, a new tool that brokers and general agents may use to:

- Transmit group information from the completed and signed Master Group Application (MGA)
- Transmit enrollment and refusal information for employees and dependents for new group submissions from the completed and signed Employee Enrollment and Refusal of Coverage forms.

How the Enrollment Spreadsheet works and benefits of use

- Information from the completed, signed and dated Blue Shield Master Group Application and Blue Shield Employee Enrollment Forms and Refusals of Coverage is entered into the spreadsheet on the appropriate MGA and Enrollment Form tabs, either manually or through Ease Central.
- When the spreadsheet is submitted along with other group documents, group, employee and dependent records are systematically created instead of being manually data-entered, resulting in quicker group processing.
- The spreadsheet forces completion of fields necessary for underwriting and installation of the group, thereby reducing the time spent on collecting missing information through the "pend" process.
- When both the MGA and Enrollment tabs are utilized, requests for more information and enrollment errors are minimized because the MGA portion dictates some of the drop-down choices in the Enrollment portion.

  Example: Only plans selected by the group per the MGA tab will populate the drop-down choices for the Enrollment tab, ensuring that a plan not offered by the group is not accidentally selected.

- Because processing time is shorter, once Underwriting has approved the group, member ID cards are generated more quickly.

When may the Enrollment Spreadsheet be used?

- The spreadsheet may be used by any broker or general agent to submit new small employer groups applying for medical and/or specialty benefits.
  - Medical groups: One to 100 employees
  - Specialty benefits groups: One to 100 employees for dental and vision plans and two to 100 employees for life insurance
- It is for new group submissions only.

    - Renewals, plan changes, adding products, and member adds/deletions **cannot** be processed with the spreadsheet
- While it is best to utilize the spreadsheet to submit both group (MGA tab) and employee (Enrollment Form tab) information, the following combinations of new group spreadsheets and paper forms are acceptable for new group submissions:
    - MGA spreadsheet with Enrollment Form spreadsheet
    - Enrollment Form spreadsheet with completed and signed paper MGA
    - Completed and signed paper MGA and paper Employee Enrollment and Refusal of Coverage forms

  Note: The MGA spreadsheet **cannot** be submitted without also submitting the completed Enrollment Form spreadsheet.

- An Enrollment spreadsheet that is missing a Social Security number for an employee cannot be loaded into our system
    - Leave the employee and any dependents off the spreadsheet and submit the completed/signed paper Employee Enrollment form
    - Attach a cover sheet explaining that both a spreadsheet and a paper form is being submitted for employee enrollment
- The spreadsheet may be submitted for a group **once only**
    - Once it has been submitted, we cannot process any additional spreadsheets or a revised spreadsheet for the group

What else do I need to know?

Record retention

- Since the Blue Shield Employee Enrollment Form and Refusal of Coverage forms are not physically forwarded to us for retention, brokers, general agents and the employer agree to maintain the completed and signed forms for verification purposes. In accordance with our record retention schedule, forms related to individual employee elections and participation in benefits are to be retained while the individual is entitled to receive benefits and for six years after benefits have been completely distributed.
- The Blue Shield Master Group Application must be completed and signed prior to the delivery of the "MGA" spreadsheet enrollment file of that group's data.

- The Blue Shield Employee Enrollment Forms and Refusal of Coverage forms must be completed and signed prior to the delivery of the spreadsheet enrollment file of that member's data.
- The Blue Shield forms may be maintained in paper or electronic format.
- The broker, general agent, and employer agree to supply us with a copy of the enrollment or refusal form upon request.

By enrolling members via spreadsheet, the broker and general agent (where applicable) agree that the data in the spreadsheet is an accurate and complete representation of the information in the completed and signed Master Group Application, Employee Enrollment Forms, and Refusal of Coverage forms.

Right to audit

- We reserve the right to conduct periodic audits on the data received against the Blue Shield Employee Enrollment Form and Refusal of Coverage forms.

Access to the spreadsheet

- Go to blueshieldca.com/bsca/bsc/wcm/connect/broker/broker_content_en/small-business/resources/forms-and-applications to access the spreadsheet.

Version acceptability

- Periodic updates will be made to keep the spreadsheet synchronized with the paper Master Group Application, Employee Enrollment Form and Refusal of Coverage form. Check our Broker Connection portal regularly to ensure the correct version is being used based on the group effective date.
- The spreadsheet is named to identify:
    - The small group market
    - The quarter and year that the spreadsheet is effective
    - The version number (multiple versions may be released during the year) is displayed on the MGA and Enrollment Form tabs

Microsoft Excel requirements

- MS Excel 2010 or greater is recommended for the spreadsheet.
- MS Excel does not require any special setup or configuration in order to use the Enrollment Spreadsheet.

Ensure that the spreadsheet will load into our system

When a spreadsheet cannot be loaded into our system, paper forms will be required, and the information will be manually data-entered by Blue Shield.

Follow these rules to help ensure your spreadsheet will load into our system. The spreadsheet can only be loaded **one-time**. Failure to load or formatting issues may require submission of the paper forms.

- The MGA information **cannot** be submitted via the **MGA** tab in the spreadsheet **unless** the employee information is also being submitted on the **Enrollment Form** tab.
- If you are using the **MGA** tab the following fields **must** be completed, in the proper format:
    - Effective Date
    - Group Name
    - Tax ID Number
    - Group ZIP Code
    - Broker Tax ID Number
    - Authorization and signature
- Follow the "formatting instructions" found below. Improperly formatted information (examples: Tax ID exceeds 10 digits; use of symbols/ characters) will prevent the spreadsheet from loading into our system.

Completing the spreadsheet

1. Review the "General information and formatting instructions" below.
2. Once you possess completed and signed Employee Enrollment forms, Refusal of Coverage forms, and Master Group Application, review and accept the Terms and Conditions on the **Terms and Conditions** tab
3. Answer the question on the **UseMGA** tab
4. Follow the instructions below for completing the **MGA** and/or **Enrollment Form** tabs.

General information and formatting instructions

- The fields and columns on the spreadsheet are fixed. Do not delete any rows or columns on the **MGA** or **Enrollment Form** tabs
- Fields highlighted in yellow are required
- Fields highlighted in orange are optional fields and may be left blank
- Fields highlighted in gray do not require data; however, some field requirements are determined by values entered into the spreadsheet and will change color accordingly

- In the **Enrollment Form** tab, fields will be highlighted in red if data in the field is not formatted correctly. Data will need to be corrected before the spreadsheet is submitted.
- In the **MGA** tab, you'll see a formatting error message by scrolling to the right of the field
- An individual should be listed only once on the **Enrollment Form** tab. Adding multiple lines for the same individual will cause errors.
    - **Note:** An individual may be shown twice if he/she is an employee who is refusing coverage as an employee/ but will be enrolling as a dependent of his/her spouse that is also working at the company.
- All dates must be in MM/DD/YYYY format
- Social Security numbers, phone numbers and tax ID numbers should be entered without parentheses or dashes
- Social Security numbers with a leading zero must be entered with a leading single quote mark (')
    - Example**:** Social Security number 012-34-5678 should be entered as '012345678.
- Names of individuals, businesses, insurance carriers, streets, and cities should be entered without symbols (hyphens, accent marks, apostrophes, etc.)
- An email address that is not in the proper format will cause an error
    - Examples: Omitting the "@" or ".com" or ".net"
- When there are drop-down menu options, select from the menu rather than typing information free-form or pasting information cut from another source
    - Not using the drop-down values will prevent an employee and his dependents from being loaded into our system and paper Employee Enrollment and/or Refusal of Coverage forms will be required and information will be manually data-entered
- Do not use the "Export to .CSV" button on the **Enrollment Form** tab or the "Export MGA to .CSV and .PDF" button on the MGA tab. They are for Blue Shield internal use only.

Terms and Conditions tab

- The spreadsheet opens on the *Terms and Conditions (T&C)* tab

- Click the **Accept** button to proceed
- Once the Terms and Conditions are accepted, the **UseMGA, MGA, and Enrollment Form** tabs will be visible.

UseMGA tab

- After agreeing to the Terms and Conditions, the spreadsheet opens the **UseMGA** tab. The purpose of this tab is to indicate whether the group information (the **MGA** tab) will be entered in conjunction with employee enrollment and refusal information (the **Enrollment Form** tab) and your answer is **required**.
    - If you will be entering both MGA and employee information, use the drop-down menu to select "yes"
        - This ensures that options not offered by the group will not be displayed for enrollees and will reduce enrollment errors.
    - If you will not be entering the MGA information, use the drop-down menu to select "no". Please note that if "no" is selected but the **MGA** is still then used with the **Enrollment Form**, the Group Name will not transfer over to the Enrollment Form tab.
- After answering the question on the **UseMGA** tab, move to the **MGA** and/or **Enrollment Form** tab, depending on whether you are submitting only employee information or both employee and group information.

Instructions for completing the MGA Tab

Entering data on the MGA tab

Section 1 – Company information		
Question	**Field name**	**Instruction**
1	Full legal business name of group	Enter the group name as it appears on the Master Group Application

		Do not add or include any special characters (hyphens, accent marks, apostrophes, periods etc.)
	Requested coverage effective date	Enter the requested effective date of coverage. All dates must be in MM/DD/YYYY format.
	Doing business as (DBA), if applicable	Enter the group's DBA (Doing Business As) name as it appears on the Master Group Application Do not add or include any special characters (hyphens, accent marks, apostrophes, periods etc.)
2	Billing address	Enter the group's billing address as it appears on the Master Group Application. If providing a P. O. Box address, a physical address under question number 3 must also be completed.
3	Physical address	Completion of this field is required when the group's physical address differs, or a P.O. Box was provided for the billing address. Enter the group's physical street address (no P. O. Box addresses). Select the county for the physical address by using the drop-down menu.
	Business street address where most of your employees' work	Completion of this field is required when the group's location where most employees work differs from the physical address Enter the group's business street address where most of the employees' work (if different from the physical address. No P. O. Box addresses.

4	Primary group contact	Complete the following fields for the group's primary contact. • *First name* • *Last name* • *Title* • *Phone number* • *Fax number* • *Email address*
	Primary group contact Online account access	Select from the drop-down options to register the primary group contact for online account access.
	Secondary group contact	Complete the following fields for the group's primary contact. • *First name* • *Last name* • *Title* • *Phone number* • *Email address*
5	Legal entity type	Use this field to identify the legal entity type of the group by selecting from the drop-down options. **Note:** entity type of *Other* is for an entity not already listed in the options. If this drop-down option is selected, the type must be specified in the "Other" field.
	Federal Tax Identification (TID) number	Enter the group's Federal Employer Tax Identification (TID) number. The number must be a 9-digit string.
	Does your group have multiple TID numbers?	Select from the drop-down options. If yes, please provide the Federal Employer TID number for the plan sponsor.
	1st primary product/service of your business	Enter the primary products and/or services for the group's business.
	1st Standard Industry Classification code	Enter the primary Standard Industry Classification (SIC) code that corresponds with the product/service of the group.

		Note: *Use OSHA website* hyperlink appears as a courtesy to access the OHSA (Occupational Safety and Health Administration) website to verify or obtain the correct corresponding SIC code.
	2nd primary product/service of your business	Completion of this field is only necessary when there is more than one product and/or service provided by the group. Enter the secondary products and/or services for the group's business.
	2nd Standard Industry Classification code	Completion of this field is only necessary when there is more than one product and/or service with a separate Standard Industry Classification (SIC) code provided by the group. Enter the secondary Standard Industry Classification (SIC) code that corresponds with the product/service of the group.
	Prior group health carrier	Use this field to answer if the group has had prior group health coverage. If the group has not had prior health coverage with another carrier, leave this field blank. If they have had prior group health coverage, please complete the following fields: • *Prior group health carrier* (carrier name) • *Start date* • *End date*

		Answer if the coverage is still in force by selecting from the drop-down options.
6	Is the company currently covered by or have they previously been covered by Blue Shield of California?	Select from the drop-down options. If yes, please provide the following information: • *Blue Shield Group ID* • *Termination date*
7	Is the group intending to offer Blue Shield alongside another carrier's plan?	Select from the drop-down options. If yes, please provide the following information: • *Carrier name* • *Number of employees* • *Open enrollment dates (from/start date and to/end date)*

	Does the group have any subsidiary or affiliated companies?	Select from the drop-down options.
		
		If yes, complete the following fields for each subsidiary or affiliated company listed:
		• *Subsidiary or affiliated company name(s)*
		• *Include in coverage?*
		  ○ *Yes*
		  ○ *No*
		• *Eligible to file a combined state tax return?*
		  ○ *Yes*
		  ○ *No*

	Are all employees covered by workers' compensation to the extent required by law?	Select from the drop-down options.
Section 2 – Eligibility (All fields are mandatory)		
8	a. Total # of employees	Enter the total number of all employees employed by the group. 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.
	b. Total # of eligible full-time employees (including eligible sole proprietors and partners)	Enter the total number of all eligible full-time employees employed by the group. **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 • 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 or 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. • An eligible employee does not include individuals working on a temporary or substitute basis.
	c. Total # of eligible part-time employees (if offering coverage to similarly situated employees)	Enter the total number of all eligible part-time employees employed by the group.

		Eligible part-time employee meets all the conditions set forth as listed above for full-time eligible employees 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.
	d. Total # of eligible employees enrolling in coverage	Enter the total number of eligible employees enrolling in coverage for each coverage type: • *Medical* • *Dental* • *Vision* • *Life* **Note:** the total number enrolling and the total number declining must equal the total number eligible answered for *8b* and *8c*. Totals must be completed for all fields even if the coverage is not being offered. For example, if not offering dental, enter "0" in the *enrolling in coverage* field and the same number of eligible employees in the *declining coverage* field.
	e. Total # of eligible employees declining coverage	Enter the total number of eligible employees declining coverage for each coverage type: • *Medical* • *Dental* • *Vision* • *Life* **Note:** the total number enrolling and the total number declining must equal the total number eligible answered for *8b* and *8c*.

		Totals must be completed for all fields even if the coverage is not being offered. For example, if not offering dental, enter "0" in the *enrolling in coverage* field and the same number of eligible employees in the *declining coverage* field.
	f. Total # of FTE (full-time employee) and FTE Equivalents	Enter the total number of FTE (full-time employee) and FTE Equivalents. 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.
9a/9b	Employer orientation period	9a. Answer if in addition to the waiting period, does the employer impose an orientation period for

		new employees by selecting from the drop-down options. 9b. If yes, answer if this orientation period is 30 days or less by selecting from the drop-down options. **Note:** if 9a is answered as "Yes", 9b must also be answered with "Yes".
9c	Employer waiting period	Select which waiting period option the employer will offer from the drop-down options. **Note:** Coverage for eligible employees will become effective following completion of the waiting period on the day specified.
9d	Waiver of employer waiting period	Answer whether the group intends to offer coverage to employees currently in the employer waiting period for the original effective date of the group by selecting from the drop-down options.
9e	Number of employees currently in the group's waiting period?	Use this field to answer the number of employees currently in the group's waiting period.
9f/9g	Are all full-time eligible employees being offered health coverage?	9f. Select from the drop-down options. 9g. If the response to 9f is "No", use this field to 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?	Select from the drop-down options.
9i	Will the group offer coverage to permanent employees who work at least 20 hours but not more than 29 hours per week?	Select from the drop-down options.
9j/9k	Are there any out-of-state employees?	9j. Select from the drop-down options.

		9k. If the response to 9*j* is "Yes", use this field to answer the number of out-of-state employees that are eligible for coverage.
9l	Domestic partner coverage	Answer the group offer coverage for opposite-sex domestic partners under the age of 62 years (broad coverage) by select from the drop-down options. **Note:** Coverage for registered same-sex domestic partners and opposite-sex domestic partners where at least one partner is 62 or older and eligible for Social Security based on age (narrow coverage) is included in Blue Shield coverage.
9m	How will ongoing enrollment be provided?	Select from the drop-down options. **Note:** Electronic option is currently not available at this time.
9n	EDI vendor and/or private exchange information	Completion of this section is only required if enrollment changes will be submitted through a private exchange or if the broker is part of the approved EDI maintenance pilot program. Complete the following fields for the EDI vendor information and/or private exchange information: • *EDI vendor name* • *Contact name* • *Contact phone* • *Contact email*
9o	Will enrollment changes be submitted through a private exchange?	Select from the drop-down options. If yes, complete the following field to provide the exchange name.
Section 3 – COBRA/Cal-COBRA continuation coverage information		
10a	Is the group currently subject to Cal-COBRA?	Answer if the group 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 by selecting from the drop-down options. **Note:** Answers to 10a and 10b cannot be the same.
10b	Is the group currently subject to Federal COBRA?	Answer if the group employed 20 or more total employees on at least 50% of the working days in the previous calendar year by selecting from the drop-down options. **Note:** Answers to 10a and 10b cannot be the same.
10c	Number of current Cal-COBRA enrollees?	Enter the number of current Cal-COBRA enrollees.
10d	How many employees and/or family members are in a Cal-COBRA election period?	Enter the number of employees and/or family members that are in a Cal-COBRA election period.
10e	Number of current COBRA enrollees?	Enter the number of current COBRA enrollees.
10f	How many employees and/or family members are in a COBRA election period?	Enter the number of employees and/or family members that are in a COBRA election period.
10g	Are enrollment forms attached for all enrolling COBRA/Cal-COBRA participants?	Select from the drop-down options.
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	PPO plans	Choose up to all 19 plans from the Full PPO Network including HDHP plans and the Tandem PPO Network Select the medical plans by either pressing the corresponding button to populate all the offered medical plans in the indicated section or

		select from the drop-down options to select individual plans. If selecting HSA-compatible HDHP plans, answer if HealthEquity will be offered as the HSA administrator by selecting from the drop-down options.
	HMO plans	*HMO plans* - Choose up to all 12 plans from the Access+ HMO Network and Trio ACO HMO Network OR Choose up to all six plans from the Local Access+ HMO Network. Select the medical plans by either pressing the corresponding button to populate all the offered medical plans in the indicated section or select from the drop-down options to select individual plans. Access+ HMO plans, Local Access+ HMO plans and Trio HMO plans have different provider networks. Access+ HMO plans, which have a full network, and Trio HMO plans, which have a select network, may be offered together. **Note:** Local Access+ HMO plan selections <u>cannot</u> be combined with other HMO plan selections.
	Mirror plans	*Mirror plans* – Choose up to all 7 plans. Select the medical plans by either pressing the corresponding button to populate all the offered medical plans in the indicated section or select from the drop-down options to select individual plans.

		Note: Mirrored plans <u>cannot</u> be selected or offered alongside our Off-Exchange plans, or alongside any other carrier's plans.
11a	Infertility benefits rider	Select from the drop-down options. 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 must be offered with all medical plans – PPO and HMO.
11c	Medical plan employer contribution amount	Enter the amount the employer will contribute towards the medical coverage benefit for the employees and dependents. Amount can be either a percentage (%) or a dollar amount ($), but cannot be both. 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. **Note:** the contribution type for the employees and dependents does not have to be the same. Example: employees 50% and dependents $50.
Section 4b – Specialty benefits – dental, vision and life insurance plan selection		
SB1 – Dental Benefits	Dental Benefits	When adding dental coverage for the first time to your existing Blue Shield Small Business benefits

		package, please answer if all currently enrolled employees and dependents that elect the coverage will automatically be enrolled and no forms will be required by selecting from the drop-down options. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing dental coverage.
	Dental plan option selection	Choose which dental plan option will be offered by selecting from the drop-down options. If triple choice option is selected, choose from one of the plan combinations by selecting from the drop-down options.
	Dental plan selection	Select the dental plan(s) by using the drop-down options. Number of plans to be selected will be based on the dental plan option selected in the previous field.
	Dental plan employer contribution amount	Enter the amount the employer will contribute towards the dental coverage benefit for the employees and dependents. Amount can be either a percentage (%) or a dollar amount ($), but cannot be both. 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.

		Note: the contribution type for the employees and dependents does not have to be the same. Example: employees 50% and dependents $5.
SB2 – Vision Coverage	Vision Coverage	When adding vision coverage for the first time to your existing Blue Shield Small Business benefits package, please answer if all currently enrolled employees and dependents that elect the coverage will automatically be enrolled and no forms will be required by selecting from the drop-down options. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing vision coverage.
	Vision plan selection	Select the vision plan by using the drop-down options.
	Vision plan employer contribution amount	Enter the amount the employer will contribute towards the vision coverage benefit for the employees and dependents. Amount can be either a percentage (%) or a dollar amount ($), but cannot be both. The employer must contribute at least 25% of the employee's premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll. **Note:** the contribution type for the employees and dependents does

		not have to be the same. Example: employees 25% and dependents $5.
SB3 – Life/AD&D Insurance	Life/AD&D Insurance	When adding life insurance coverage for the first time to your existing Blue Shield Small Business benefits package, please answer if all currently enrolled employees and dependents that elect the coverage will automatically be enrolled and no forms will be required by selecting from the drop-down options. Otherwise, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing life insurance coverage. (Refusal of coverage is only allowed for contributory plans.)
	Life coverage plan type	Select the life plan type by selecting from the drop-down options. If "basic" or "multiple of salary" is selected, specify the amount by choosing from the drop-down options. If "graded" is selected, specify the number of classes by completing the *Class Name* field and choose the amount for each corresponding class from the drop-down options.
	Dependent life insurance	Select from the drop-down options. If yes, please specify the amount by choosing from the drop-down options.
	Group term life insurance plan employer contribution amount	Enter the amount the employer will contribute towards the life

		insurance benefit for the employees and dependents. Amount can be either a percentage (%) or a dollar amount ($), but cannot be both. For life insurance coverage, the employer must contribute a minimum of 25% of the total employee premium. If a plan is non-contributory (100% paid by the employer), all eligible employees must enroll, no exceptions allowed. **Note:** the contribution type for the employees and dependents does not have to be the same. Example: employees 25% and dependents $5.
Authorization and signature		
13	Authorization and signature	Complete the following fields for the group's authorization: • *Date of signature* • *Group representative first name* • *Group representative last name* • *Group representative title* Answer if the form has been signed by selecting from the drop-down options.
Producer information		
14	Producer information	Complete the following fields with the producer information: • *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* Continue to the end of this section and complete the following fields: • ***Today's date*** • ***Producer first name*** • ***Producer last name***
	Split commission	Select from the drop-down options. If yes, define split by completing the following fields: • *Producer #1 percentage amount* • *Producer #2 percentage amount* If there is a second producer, these additional fields must be completed: • *Name of second producer* • *Second producer tax ID number*
	General agency	Completion of these fields are only necessary when group was submitted through a general agent. Answer the following fields with the general agency information: • *General agency name* • *General agency tax ID number (for commission payments)* • *General agency producer name*

		• *General agency producer email*

Instructions for completing the Enrollment Form Tab

Quick Link and Add Missing Dependent buttons

- *Quick Link* buttons will scroll the spreadsheet to specific sections of the Blue Shield Employee Enrollment Form.
- The *Quick Link* button numbers correspond with the Blue Shield Employee Enrollment Form section.
- The ROC *Quick Link* will scroll the spreadsheet to the Blue Shield Refusal of Coverage fields.

Use the *Add Missing Dependent* button to insert a new row above a selected cell/field to add a dependent that was mistakenly missed. This button may also be used to add a subscriber before the spreadsheet is submitted to us.

- Click on the cell/row below the line where you want to insert an omitted individual and click the *Add Missing Dependent* button
- A new blank row appears above the cell/row you clicked
    - Example: Subscriber Smith on row 17, Subscriber Jones on row 18. To add dependent to Subscriber Smith, click on Subscriber Jones, then click the *Add Missing Dependent* button and a blank row will be inserted immediately below Subscriber Smith, which is the appropriate place for his dependent.

Entering data into the Enrollment Form tab

Step 1 – Enter group information

The following items only need to be completed if "no" was answered under the **UseMGA** tab. If answered "yes, the information will populate from the information completed under the MGA tab.

Group Name			
Group Tax ID			
Group Address			
Group Contact			
Group Contact Phone			

- Refer to the **General information and formatting instructions** above
- Enter the group name as it appears on the Master Group Application
- Enter the group tax ID
- Enter the group address as it appears on the Master Group Application
- Enter the name of the group contact as it appears on the Master Group Application
- Enter the group contact phone number as it appears on the Master Group Application
- **Note:** Do not add any special characters (hyphens, accent marks, apostrophes, periods etc.)

Step 2 – Enter employee and dependent information

- Review the column letter and follow the associated instruction for each field in the chart below.
- If values do not appear in all drop-down menus, follow these steps:
  1) Click on the *File* tab at the top left of the spreadsheet
  2) Click on *Options*
  3) Select *Trust Center* from the menu on the left
  4) Click the *Trust Center Settings* button
  5) Click on *ActiveX Setting* and ensure that the *Enable all controls without restrictions and without prompting* radio button is selected, and then click *OK*
  6) Click on *Macro Setting* and ensure that the *Enable all macros* radio button is selected, and then click *OK*

Application information		
Column	**Field name**	**Instruction**
A	Group tax ID	The tax ID entered in Step 1 above will auto-populate this column.
B	Applicant Type	Use this field to identify each employee and dependent that is enrolling in coverage. Every individual that is enrolling in one or more lines of coverage will be entered on his or her own row. Select the applicant type from the drop-down options. The employee must always be the subscriber.

		Family members should be listed in the spreadsheet in the order shown above. Spouse, domestic partner and dependent children are listed on the spreadsheet only when they are enrolling in one or more coverages selected by the subscriber. An employee must enroll in coverage in order for his dependent to enroll in that line of coverage. *Other Dependent Child – Guardianship* is a child for whom the employee or spouse/domestic partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction who is not covered for benefits as a subscriber. **Note:** A copy of the court document will be required.
C	Type of Application	Select from the drop-down options. Use *Enroll* for every subscriber and dependent that is enrolling in one or more lines of coverage. Use *ROC* for an employee that is refusing <u>all</u> coverage offered by the employer.
D	Applicant Last Name	Enter the applicant last name.
E	Applicant First Name	Enter the applicant first name.
F	Applicant Middle Initial	This is an optional field.
G	Subscriber SSN	Enter the subscriber's Social Security number (nine digits). Social Security number is required for every subscriber who is enrolling or refusing to enroll. **Note:** If an <u>employee</u> does not have a Social Security number, do not enter that employee or his dependents into the spreadsheet as the spreadsheet will fail to load into our system and the group will be returned to you. Instead, submit that employee's paper Employee

		Enrollment Form along with the Master Group Application, spreadsheet and other necessary group documents.
H	Applicant SSN	Enter the Social Security number (nine digits) for enrolling spouses, domestic partners, children, and other dependent children – guardianship.
Section 1a – Health plan selection		
I	Health Package	If the group is offering medical coverage, select from the drop-down options. If the group is not offering medical coverage, *Health Package* should be left blank. When family members are also enrolling, the *Health Package* is only required on the associated subscriber row as any family members enrolling in health coverage cannot chose a package or plan that differs from the subscriber's package and plan.
J	Health Plan	Select from the drop-down options. Plans listed in the drop-down are based on the *Health Package* selection in column I. When family members are also enrolling, the *Health Plan* is only required on the associated subscriber row as any family members enrolling in health coverage cannot chose a package or plan that differs from the subscriber's package and plan.
Section SB1 – Dental Benefits		
K	Dental Package	If the group is offering dental coverage, select from the drop-down options. If the group is not offering dental coverage, *Dental Package* should be left blank. When family members are also enrolling, the *Dental Package* is only required on the associated subscriber row as any family members enrolling in dental coverage cannot chose a package or plan that differs from the subscriber's package and plan.

L	Dental Plan	Select the plan from the drop-down options. Plans listed in the drop-down are based on the *Dental Package* selection in column K. When family members are also enrolling, the *Dental Plan* is only required on the associated subscriber row as any family members enrolling in dental coverage cannot chose a package or plan that differs from the subscriber's package and plan.
Section SB2 – Vision Coverage		
M	Vision Package	If the group is offering vision coverage, select from the drop-down options. If the group is not offering vision coverage, *Vision Package* should be left blank. When family members are also enrolling, the *Vision Package* is only required on the associated subscriber row as any family members enrolling in vision coverage cannot chose a package or plan that differs from the subscriber's package and plan.
N	Vision Plan	Select the plan from the drop-down options. Plans listed in the drop-down are based on the *Vision Package* selection in column M. When family members are also enrolling, the *Vision Plan* is only required on the associated subscriber row as any family members enrolling in vision coverage cannot chose a package or plan that differs from the subscriber's package and plan.
Section SB3 – Life/AD&D insurance (Underwritten by Blue Shield of California Life & Health Insurance Company [Blue Shield Life])		
O	Life/AD&D Option	If the group is offering life insurance, select from the drop-down options. If the group is not offering life insurance, *Life/AD&D Option* should be left blank. When the employer selects the "flat" life insurance option on the Master Group

		Application, the *Life/AD&D Option* for the employee will be "basic" in the spreadsheet. **Note**: COBRA and Cal-COBRA enrollees are not eligible for life insurance. **Note:** When both spouses or domestic partners are employees and the employer offers dependent life, the employee may enroll as an employee or as a dependent but not both.
P	Employee Life/AD&D Option	Select the plan from the drop-down options. Plans listed in the drop-down are based on the *Life/AD&D Option* selection in column O.
Q	Basic Dependent Life Insurance	Select from the drop-down options. The employee must purchase basic life insurance in order for dependent life insurance to be available.
R	Number of Eligible Dependents	Enter the number of the subscriber's dependents that meet the definition of an eligible dependent. When dependent life insurance is selected, all eligible dependents must be enrolled.
S	Amount of Coverage Requested for Dependents	Select the amount from the drop-down options. Amount of dependent life insurance must match the amount selected on the Master Group Application.
T	Earnings Excluding OT, Bonus	Completion of this field is required only when the Life/AD&D Option (column O) is "Multiple of Salary." Enter the earnings amount that correlates with the *Frequency* selection in column U.
U	Earnings Frequency	Completion of this field is required only when the *Life/AD&D Option* (column O) is "Multiple of Salary." Select the frequency that correlates with the "Earning Excluding OT, Bonus" amount in column T from the drop-down options.

Section 2 – Subscriber information		
V	Subscriber – Home Address	Enter the subscriber's home (physical) street address (no P. O. Box addresses).
W	Subscriber – City	Enter the city of the subscriber's home (physical) address.
X	Subscriber – State	Enter the state of the subscriber's home (physical) address. Use the two-letter state codes (e.g., "CA" for California).
Y	Subscriber – ZIP	Enter the ZIP code of the subscriber's home (physical) address using five digits only.
Z	Mailing Address Same as Home?	Select from the drop-down options.
AA	Subscriber – Mailing Address (If Different)	Completion of this field is required when the subscriber's mailing address differs from the physical home address. Enter the subscriber's mailing address.
AB	Subscriber – Mailing City	Completion of this field is required when the subscriber's mailing address differs from the physical home address. Enter the city of the subscriber's mailing address.
AC	Subscriber – Mailing State	Completion of this field is required when the subscriber's mailing address differs from the physical home address. Enter the state of the subscriber's mailing address. Use the two-letter state codes (e.g., "CA" for California).
AD	Subscriber – Mailing Zip	Enter the ZIP code of the subscriber's mailing address using five digits only.
AE	Subscriber – Work Phone	Enter 10-digit work phone number. This field is required when the selection in column AI (Preferred Method of Contact) is "Work phone."
AF	Subscriber – Home Phone	Enter 10-digit home phone number.

		This field is required when the selection in column AI (Preferred Method of Contact) is "Home phone."
AG	Language Preference	Select from the drop-down options.
AH	Subscriber – Email Address	Enter a valid email address. This field is required when the selection in column AI (Preferred Method of Contact) is "Email."
AI	Preferred Method of Contact	Select from the drop-down options.
AJ	Subscriber – Date of Birth	Enter the subscriber's date of birth.
AK	Subscriber – Gender	Select from the drop-down options.
AL	Subscriber – Marital Status	Select from the drop-down options.
AM	Date of Hire	Enter the subscriber's date of hire.
AN	Subscriber – Job Title	Enter the subscriber's job title in 80 characters or less.
AO	Job Classification	This field is required when the *Life/AD&D Option* (column O) is "Graded." Enter the appropriate classification number (e.g., I, II, II, IV) or description (e.g., Clerical, Management) per the Master Group Application.
AP	Do you have any eligible dependent children under the age of 26?	Select from the drop-down options.
AQ	How many?	This field is required when the answer in column AP is "yes." Enter the number of eligible dependents under the age of 26.
AR	How many are enrolling?	This field is required when the answer to column AP is "yes." Enter the number of eligible dependents under the age of 26 that are enrolling.
AS	Are you a full-time employee?	Select from the drop-down options.

AT	Are you a part-time employee?	Select from the drop-down options.
AU	If no, are you an existing COBRA participant or enrolling due to a COBRA qualifying event?	This field is required when columns AS and AT are both answered "no." Select from the drop-down options.
Section 3 – HMO physician/Dental HMO provider assignment		
AV	Should Blue Shield designate a provider?	This field is required when the medical plan is an HMO plan and/or the dental plan is a DHMO plan. Select from the drop-down options.
AW	Medical HMO Personal Physician Name	Answers in columns AW, AX, AY and AZ are required when the answer to column AV is "no." A list of available providers can be found at blueshieldca.com/fap/app/find-a-doctor.html. Enter the medical HMO primary care physician name, provider number and IPA name.
AX	Provider Number	
AY	IPA (Independent Practice Association) Name	
AZ	Existing medical patient?	Select from the drop-down options.
BA	Dental HMO Provider Name	Answers in columns BA, BB, BC, and BD are required when the answer to column AV is "no." A list of available dental providers can be found at blueshieldca.com/fap/app/find-a-doctor.html. Enter the dental HMO provider name, provider number and dental group name.
BB	Dental Provider Number	
BC	Dental Group Name	
BD	Existing dental patient?	Select from the drop-down options.
Section 4 – Dependent information (complete one row for each enrolling dependent)		
BE	Dependent - Gender	Select from the drop-down options.
BF	Enroll in all products selected by subscriber?	Select from the drop-down options.
BG	Dependent – Date of Birth	Enter the dependent's date of birth.

BH	Dependent address same as subscriber's?	This field is required for each dependent enrolling in coverage. Select from the drop-down options. The subscriber's address will auto-populate columns BI, BJ, BK and BL for every dependent with a "yes" answer in column BH.
BI	Dependent – Address (if different from subscriber)	When column BH is answered "no" for a specific enrolling dependent, column BI is a required field. Enter the enrolling dependent's address.
BJ	Dependent – City	When column BH is answered "no" for a specific enrolling dependent, column BJ is a required field. Enter the enrolling dependent's city.
BK	Dependent – State	When column BH is answered "no" for a specific enrolling dependent, column BK is a required field. Enter the enrolling dependent's state. Use the two-letter state codes (e.g., "CA" for California).
BL	Dependent – Zip	When column BH is answered "no" for a specific enrolling dependent, column BK is a required field. Enter the enrolling dependent's ZIP code using five digits only.
BM	Dependent – HMO Physician Name	Answers in columns BM, BN, BO, and BP are required when the answer to column AV is "no." A list of available providers can be found at blueshieldca.com/fap/app/find-a-doctor.html. Enter the medical HMO primary care physician name, provider number and IPA name.
BN	Dependent – Provider Number	
BO	Dependent – IPA Name	
BP	Dependent – Existing medical patient?	Select from the drop-down options.

BQ	Dependent – Dental HMO Provider Name	Answers in columns BQ, BR, BS and BT are required when the answer to column AV is "no". A list of available providers can be found at blueshieldca.com/fap/app/find-a-doctor.html. Enter the dental HMO provider name, provider number and dental group name.
BR	Dependent – Dental Provider Number	
BS	Dependent – Dental Group Name	
BT	Dependent – Existing dental patient?	Select from the drop-down options.
Section 5 – Other Health Plan Information		
BU	Any prior coverage in the past 6 months?	Select from the drop-down options. **Note**: On the Employee Enrollment Form, this question is "Does any person applying for coverage currently have health coverage or previously had health coverage at any time in the past six (6) months?"
BV	If prior coverage, list prior carrier name	Enter the current or prior carrier name. Field is limited to 80 characters.
BW	Type of Coverage	Select from the drop-down options.
BX	Policy ID Number	Enter the policy ID number for the current or prior coverage.
BY	Date Prior Coverage Began	Enter the date that current or prior coverage began.
BZ	Date Prior Coverage Ended	Enter the date that current coverage will end or the date that prior coverage ended.
CA	Family Member with Prior Coverage	Enter the names of all of the enrolling family members who are currently or were previously enrolled in the health coverage identified in column BU.
Section 6 – Medicare Information		
CB	Are you or any dependents currently covered by Medicare?	Select from the drop-down options. **Note**: Copies of the individuals' Medicare cards must be included in the new group submission.
CC	If "Yes" to current Medicare coverage, do you have Part A?	This field is required with the answer in column CB is "yes." Select from the drop-down options.

CD	Part A Effective Date	This field is required when the answer in column CC is "yes." Enter the Medicare Part A effective date.
CE	If "yes" to current Medicare coverage, do you have Part B?	This field is required when the answer in column CB is "yes." Select from the drop-down options.
CF	Part B Effective Date	This field is required when the answer in column CE is "yes." Enter the Medicare Part B effective date..
CG	Is Medicare eligible due to end stage renal disease?	Select from the drop-down options.
CH	What was the first date of dialysis treatment?	This field is required when the answer in column CG is "yes." Enter the date of the first dialysis treatment.
CI	Type of Dialysis	This field is required when the answer in column CG is "yes." Select the type of dialysis from the drop-down options.
CJ	If kidney transplant, provide date	Enter the date of the kidney transplant.
Section 7 – COBRA/Cal-COBRA Group continuation coverage (Completed only when enrolling in COBRA or Cal-COBRA group continuation coverage)		
CK	Are you enrolling in COBRA or Cal-COBRA?	Select from the drop-down options.
CL	Employee/Subscriber Blue Shield ID Number	Enter the employee/subscriber Blue Shield ID number if applicable.
CM	Original Qualifying Event Date	Enter the date of the original qualifying event.
CN	Qualifying Event Reason	Select from the drop-down options.
Section 8 – Disclosure of personal and health information/Acknowledgement and signature		
CO	Signature of Employee	Answer if the form has been signed by the employee by selecting from the drop-down options.

		There should never be a "no" answer in this column as the employee's signature is required before his/her information can be entered into the spreadsheet. Refer to the **Record retention** section.
CP	Date	Enter the date that the employee signed the Employee Enrollment Form.
Refusal of Coverage Form		
CQ	Are all eligible family members enrolling?	Select from the drop-down options.
CR	Date of Birth	Enter the subscriber's date of birth.
CS	Hire Date	Enter the month, day and year that the subscriber was hired.
CT	State of Residence	Enter the two-letter code for the subscriber's state of residence (e.g., CA for California).
CU	Marital Status	Select from the drop-down options.
CV	Job Title	Enter the subscriber's job title in 80 characters or less.
CW	Are you a FT employee – 30 or more hours per week?	Select from the drop-down options.
CX	Are you a PT employee – 20-29 hours per week?	Select from the drop-down options.
CY	Declining Medical Coverage	**Subscriber row:** Select who is declining medical coverage from the drop-down options. Select "The following dependents only" when some of the dependent children are enrolling in medical and some are not or when the spouse/domestic partner is declining medical along with some, but not all, of the dependent children. **Dependent (Spouse/Domestic Partner, Dependent Child, Other Dependent Child – Guardianship) rows:** When "The following dependents only" is selected in column CY/subscriber row, the drop-down options in column CY for each dependent row will change to: • *Yes*

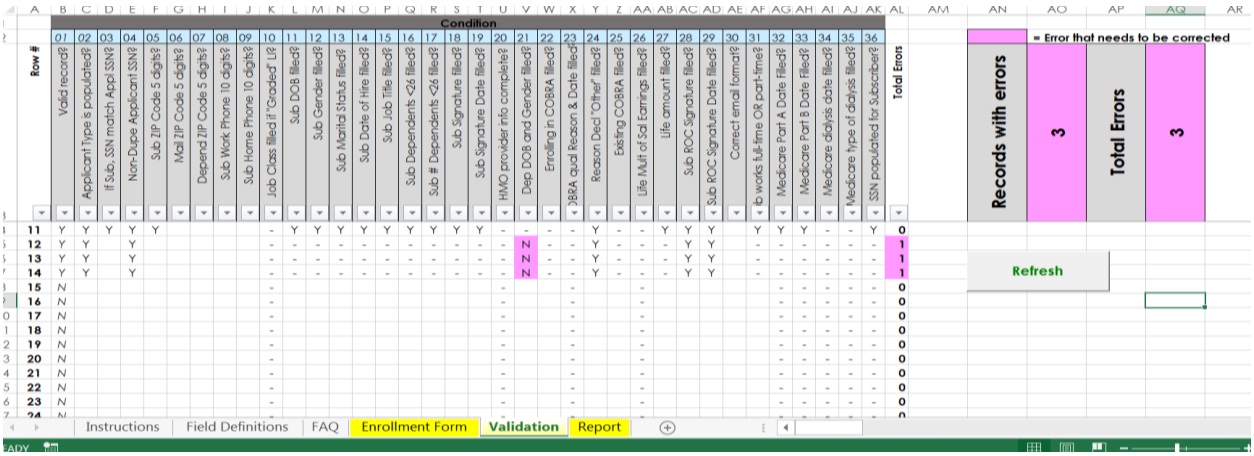
		• *No* Select "Yes" for each dependent that is declining to enroll in medical (Yes, I am declining medical coverage). Select "No" for each dependent that is enrolling in medical coverage (No, I am not declining medical coverage).
CZ	Reason for Declining Medical	Select from the drop-down options.
DA	Reason for Declining (Other) – Medical	This field is required when the answer in column CZ is "Other." Enter the "other" reason for declining medical coverage in 80 characters or less. • Example: "Cost" **Note:** Do not use any special characters such as apostrophes in words like "don't."
DB	If covered by another medical carrier, please name carrier	Enter the name of the medical carrier in 80 characters or less. This field is optional.
DC	Member ID at Medical Carrier	Enter the medical ID number if covered by another medical carrier. This field is optional.
DD	Declining Dental Coverage	**Subscriber row:** Select who is declining dental coverage from the drop-down options. Select "The following dependents only" when some of the dependent children are enrolling in dental and some are not, or when the spouse/domestic partner is declining dental along with some, but not all, of the dependent children. **Dependent (Spouse/Domestic Partner, Dependent Child, Other Dependent Child – Guardianship) rows:** When "The following dependents only" is selected in column DD/subscriber row, the drop-down options in column DD for each dependent row will change to:

		• *Yes* • *No* Select "Yes" for each dependent that is declining to enroll in dental (Yes, I am declining dental coverage). Select "No" for each dependent that is enrolling in dental (No, I am not declining dental coverage).
DE	Reason for Declining Dental	Select from the drop-down options.
DF	Reason for Declining (Other) – Dental	When "Other" is selected in column DE, enter the "other" reason for declining dental. • Example: "Cost" **Note:** Do not use any special characters such as apostrophes in words like "don't."
DG	If covered by another dental carrier, please name carrier	Enter the name of the dental carrier in 80 characters or less. This field is optional.
DH	Member ID at Dental Carrier	Enter the dental ID number if covered by another dental carrier. This field is optional.
DI	Declining Vision Coverage	**Subscriber row:** Select who is declining vision coverage from the drop-down options. Select "The following dependents only" when some of the dependent children are enrolling in vision and some are not, or when the spouse/domestic partner is declining vision along with some, but not all, of the dependent children. **Dependent (Spouse/Domestic Partner, Dependent Child, Other Dependent Child – Guardianship) rows:** When "The following dependents only" is selected in column DI/subscriber row, the drop-down options in column DI for each dependent row will change to: • *Yes* • *No*

		Select "Yes" for each dependent that is declining to enroll in vision (Yes, I am declining vision coverage). Select "No" for each dependent that is enrolling in vision (No, I am not declining vision coverage).
DJ	Reason for Declining Vision Coverage	Select from the drop-down options.
DK	Reason for Declining (Other) – Vision	When "Other" is selected in column DJ, enter the "other" reason for declining vision. Example: "Cost" **Note:** Do not use any special characters such as apostrophes in words like "don't."
DL	If covered by another vision carrier, please name carrier	Enter the name of the vision carrier in 80 characters or less. This field is optional.
DM	Member ID at Vision Carrier	Enter the vision ID number if covered by another vision carrier. This field is optional.
DN	Declining Life Insurance Coverage	If the employee is declining to enroll in life insurance offered by the employer, select the drop-down option.
DO	Reason for Declining Life Insurance Coverage	Select from the drop-down options.
DP	Reason for Declining (Other) – Life	When "Other" is selected in column DO, enter the "other" reason for declining life insurance. Example: "No need for life insurance" **Note:** Do not use any special characters such as apostrophes in words like "don't."
DQ	If covered by another life carrier, please name carrier	Enter the name of the life insurance carrier in 80 characters or less. This field is optional.
DR	Member ID at Life Carrier	Enter the life insurance ID number if covered by another life insurance carrier. This field is optional.
DS	ROC Signature of Employee	Answer if the form has been signed by the employee by selecting from the drop-down options.

		There should never be a "no" answer in this column as the employee's signature is required before his/her refusal of coverage information can be entered into the spreadsheet. (Refer to the **Record retention** section.)
DT	Date	Enter the date that the employee signed the Refusal of Coverage form.
EN	Comment/Follow-up	This column is provided for your convenience for free-form notes and reminders. The information remains in the spreadsheet and is not loaded as part of the application data.

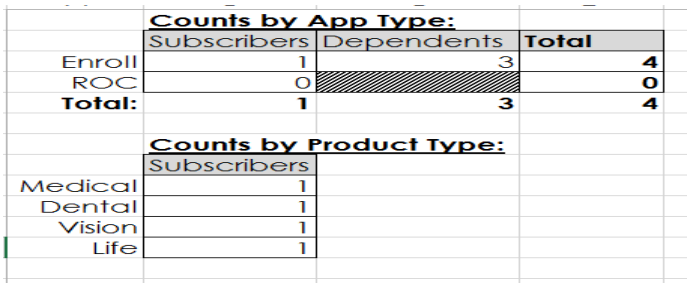
Step 3 – Validate enrollment information
Validations Tab



- The spreadsheet contains formatting validations for 36 fields for each member record. The *Validation* tab displays the data validations ("Y" - valid/ "N" - invalid) for each member record (row number). The specific fields being validated are across the top of the screen. Invalid data ("N") will be highlighted in pink and should be corrected before the enrollment form is submitted for faster processing.
- Use the *Refresh* button to realign the *Validation* cells after the *Add Missing Dependent* is used in the Enrollment Form. It will ensure that the correct rows are being referenced.
- If there is a validation error for missing SSN for a subscriber, either the SSN must be filled in before the spreadsheet is submitted, or, if the subscriber does not have an SSN, he must be removed from the spreadsheet before it is submitted, and his paper Employee Enrollment Form or Refusal of Coverage form must be submitted along with the spreadsheet.

Step 4 – Review the employee counts

Reports tab



	Counts by App Type:		
	Subscribers	Dependents	Total
Enroll	1	3	4
ROC	0		0
Total:	**1**	**3**	**4**

	Counts by Product Type:
	Subscribers
Medical	1
Dental	1
Vision	1
Life	1

- Review the information on the *Reports* tab before submitting the spreadsheet and compare it to the information on the Master Group Application to ensure that all eligible employees and dependents are accounted for in the spreadsheet.
- The Counts by App Type tracks the number of subscribers (eligible employees) that are listed in the spreadsheet as enrolling in coverage or refusing all coverage.
- The "total" number of subscribers that are "Enroll" and "ROC" Application Types should equal the number of eligible employees that are listed on the Master Group Application, thereby accounting for every eligible employee as either enrolling or refusing coverage.
- Note that if any Employee Enrollment Forms or Refusal of Coverage forms are submitted, the "total" number of subscribers will differ from the MGA eligible employee count by the number of employees submitting paper forms.

Send the file and accompanying group documents to Blue Shield

- Ensure the information and membership data on the MGA and Enrollment Spreadsheet is protected when sending to us. Secure email is the preferred method for sending sensitive files to us.
- Send the spreadsheet through the channel you currently use. Our email box for new groups is SGUW-NewBusiness@blueshieldca.com.
- Remember to include all documents required for a new group and paper Employee Enrollment Forms/Refusal of Coverage forms for any eligible employees that do not have a Social Security number. Include a cover sheet that explains why enrollment is being submitted using both the spreadsheet and paper forms.

Tracking tab

The *Tracking* tab is for our internal use only.

Frequently asked questions

Q: Can I submit the spreadsheet using the MGA tab only?
A: No. The only submission options are MGA spreadsheet with Enrollment Form spreadsheet, Enrollment Form spreadsheet with completed and signed paper MGA or completed and signed paper MGA and paper Employee Enrollment and Refusal of Coverage forms.

Q: Can I upload the spreadsheet if a dependent doesn't have a Social Security number?
A: Yes. The *Validation* tab will show an error for missing SSN, but the spreadsheet can still be loaded.

Q: Can I filter on the colored cells in the spreadsheet?
A: Yes. The spreadsheet can be filtered by color, but only with Excel version 2013 or later. Earlier Excel versions will not allow a filter by color option

Q: Can I submit my new small group membership enrollment via EDI (ANSI 834 file) instead of using the enrollment spreadsheet.
A: No. For a new group, we can receive small business membership enrollment only through the Enrollment Spreadsheet or paper Employee Enrollment Form and Refusal of Coverage forms.

Q: Does the spreadsheet contain HIPAA Privacy information?
A: Yes. Please ensure the membership data on the Enrollment Spreadsheet is protected when sending it to us. Secure email is the preferred method for sending files to us.

Q: Can I lock the Enrollment Spreadsheet with a password to protect HIPAA protected personal information instead of using secure email?
A: Yes. Please send the password in a separate email from the spreadsheet to us.

Q: Do I need to give the file a special name or save it in a particular format before sending it to you?
A: There are no requirements for file naming; however, it is helpful to include the group name and effective date. Save the file as an Excel Macro-Enabled Workbook (*.xlsm) before sending to us. Do not use the "Export to .CSV" button on the **Enrollment Form** tab or the "Export MGA to .CSV and .PDF" button on the **MGA** tab.

Q: What do I do if I already submitted the Enrollment Spreadsheet to you, but I need to add another member?
A: Once the Enrollment Spreadsheet has been submitted, it is final. A paper Blue Shield Employee Enrollment Form and/or Refusal of Coverage form must be submitted for that employee.