blue of california

Small Business Enrollment Spreadsheet Guide

For 1/1/2026 and Later Effective Dates

Rev 1/1/2026

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Introduction

Businesses applying for new small group coverage are required to complete, sign, and date Blue Shield's Master Group Application (MGA). Employees who are enrolling in or refusing the small group coverage must complete, sign, and date Blue Shield's Employee Enrollment Form or Refusal of Coverage.

Blue Shield offers a Small Business Enrollment Spreadsheet that brokers and general agents can use to submit the information from the paper forms.

Benefits of use

- When the spreadsheet is submitted, group (when MGA tab is completed) and 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.
- The spreadsheet contains validations that identify missing data and data errors so that they can be corrected prior to submission.
- Because processing time is shorter, once the group has been approved, member ID cards are generated more quickly.

Submission

General information

- 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 used for new group submissions only.
    - Renewals, plan changes, adding products, and member adds/deletions **cannot** be processed with the spreadsheet
- The spreadsheet includes an MGA tab for the Master Group Application and an Enrollment Form tab for the Employee Enrollment Forms and Refusals of Coverage.
    - In the Employer Enrollment Tool new group submission process, only the Enrollment Form can be submitted.

    - In the ShieldLink new group submission process, the Enrollment Form can be submitted with or without the MGA tab completed; however, the spreadsheet cannot be submitted with only the MGA tab completed.
- 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 under the same submission.
    - If an employee or dependent was omitted from the submitted spreadsheet, a paper Employee Enrollment Form or Refusal of Coverage form must be submitted for that individual.
- A spreadsheet that is missing a Social Security number for an employee cannot be loaded into our system.
    - If the group employs an employee without a Social Security number, that employee and any dependents should be left off of the spreadsheet and his paper Employee Enrollment Form and/or Refusal of Coverage should be included with the group submission and spreadsheet. When submitting the group, include a cover sheet that explains why both a spreadsheet and paper forms are being submitted.
- If a group is eligible to file a combined state tax return with **more than three** subsidiary or affiliated companies, the enrollment spreadsheet cannot be utilized for the MGA.
    - Submit the paper MGA instead and attach a cover letter or other document providing the additional company names and indicate whether they are to be included in coverage.

User responsibilities

- Since the Blue Shield Master Group Application (when MGA tab is utilized), and Employee Enrollment Form and Refusal of Coverage forms (when Enrollment Form tab is utilized) 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.
- If the spreadsheet MGA tab is being utilized, data should not be entered into the MGA tab until the authorized group representative has signed and dated the Master Group Application.
- Data should not be entered into the Enrollment Form tab until the employee has signed and dated the Employee Enrollment Form or, if applicable, the Refusal of Coverage form

- 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 MGA, enrollment or refusal form upon request.

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.

Version acceptability

- Periodic updates will be made to keep the spreadsheet in sync with the 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 Enrollment 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 *Enrollment* tab

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.

Accessing the spreadsheet

Go to Broker Connection and select **Small Business**, then **Forms and Applications** to access the spreadsheet.

Small Business forms and applications | Blue Shield of CA Broker (blueshieldca.com)

Sending the spreadsheet and group documents to Blue Shield

- Ensure the membership data on the Enrollment Spreadsheet is protected when sending it 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.
- Refer to the **New group enrollment checklist** in the Small Group Underwriting Guidelines for additional new group submission documents

Completing the spreadsheet

Functionality and formatting

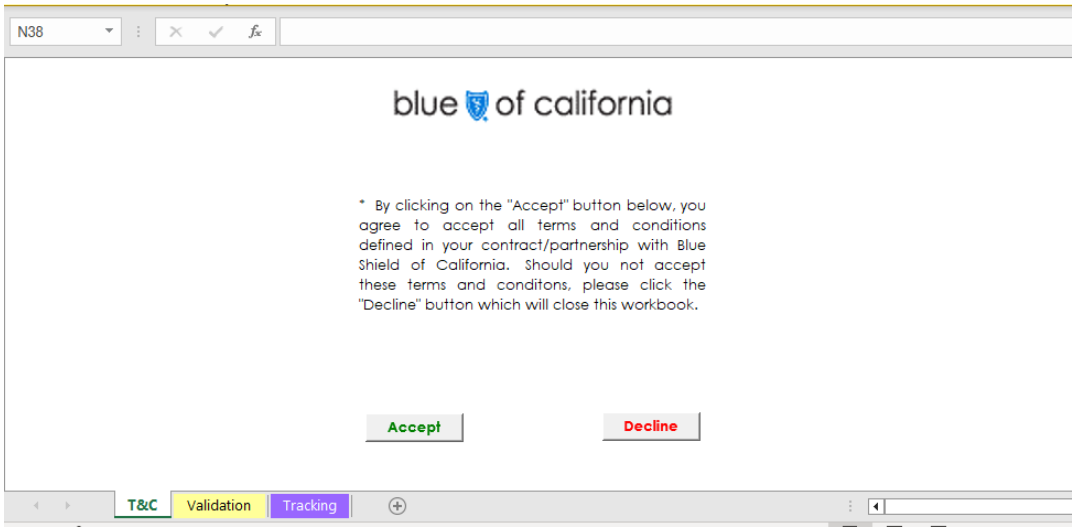
- The fields and columns on the spreadsheet are fixed. Do not delete any rows or columns.
- Fields highlighted in yellow are required; however, all information provided in the group and/or member enrollment forms should be entered into the spreadsheet whether or not the specific field is highlighted yellow.
- Fields highlighted in orange are optional fields and may be left blank when the corresponding fields on the MGA or Employee Enrollment Form are 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.
- Error messages display when formatting is incorrect. Data must be corrected before the spreadsheet is submitted.
- On the Enrollment Form tab, an individual should be listed on the spreadsheet only once. Adding multiple lines for the same individual will cause errors.
    - **Note:** An individual may be listed twice if he/she is an employee who is refusing coverage as an employee and is enrolling as a dependent of his/her spouse who is also an eligible employee of the group.
- 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.).
- Emails must be formatted with an "@" and a period ("."). An email address that is not in the proper format will cause an error.
    - Example: JoeSmith@nomail.net
- When there are drop-down menu options, select from the menu rather than typing information free-form.
- Do not use the "Export to .CSV" button on the *Enrollment Form* tab. It is for internal use only.
- On the Enrollment Form tab, there are ***Quick Links*** 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.

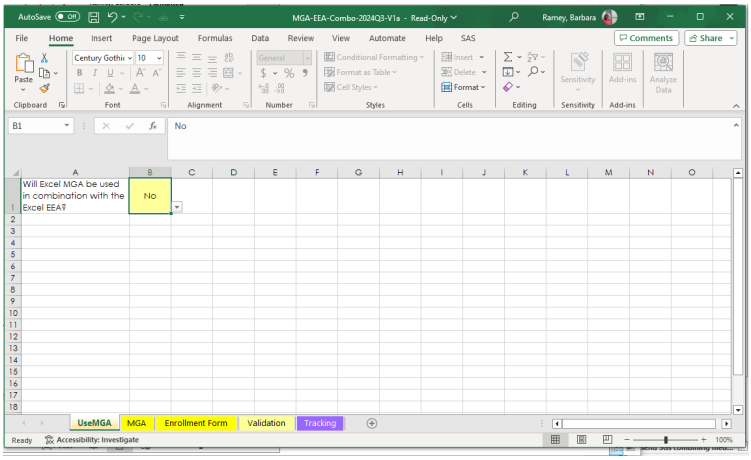
T&C tab

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



- Click the ***Accept*** button to proceed

Once the Terms and Conditions are accepted, the *Use MGA* tab will be visible.



- Select either *Yes* or *No* to indicate whether the MGA will be submitted in the Enrollment Spreadsheet
  - When *Yes* is selected and the MGA tab is completed, only the plans chosen by the group will display in the Enrollment Form tab drop-down options of selectable plans, thereby eliminating the risk of selecting plans not offered by the group.

- When *Yes* is selected and the MGA tab is completed, the group name, group tax ID, group address, group contact, and group contact phone number will automatically carry over to the Enrollment Form tab

MGA tab

This tab contains columns that correspond to the paper MGA form.

- Column B: MGA sections
- Column C: MGA questions
- Columns D and E: Group's answers

Additional columns provide instructions, rules, and spreadsheet logic.

➢ Enter group information as it appears on the completed and signed Master Group Application and follow the specific instructions below for each column.

Application information	
MGA tab column name	**Instruction**
Requested coverage effective date	Completion of this field is required. ➢ Enter the requested coverage effective date. Refer to **Functionality and formatting.**
SECTION 1A EMPLOYER INFORMATION	
MGA tab column name	**Instruction**
Full legal business name of group	Completion of this field is required. ➢ Enter the Group legal name. Refer to **Functionality and formatting.**

SECTION 1A EMPLOYER INFORMATION (continued)

MGA tab column name	Instruction
Federal Tax Identification (TID) number	Completion of this field is required. ➢ Enter the Federal Tax ID (TID) number. Refer to **Functionality and formatting.**
Doing business as (DBA), if application	➢ Enter the DBA if indicated on the MGA. Refer to **Functionality and formatting.**
Principal business address in California – number and street (no P.O. box) Street	Completion of this field is required. ➢ Enter the principal business address street number and street name. P.O. Box numbers are not acceptable. Refer to **Functionality and formatting.**
City	Completion of this field is required. ➢ Enter the principal business address city.
State	Completion of this field is required. ➢ Select the appropriate two-letter state abbreviation from the drop-down options.
ZIP Code	Completion of this field is required. ➢ Enter the principal business address 5-digit ZIP Code

SECTION 1A EMPLOYER INFORMATION (continued)

MGA tab column name	Instruction
Billing address: (if different from above) Street	Completion of the billing address fields is required only when it differs from the principal business address. ➢ Enter the billing address street number and street name or billing address P. O. Box number. Refer to **Functionality and formatting.**
City	➢ Enter the billing address city.
State	➢ Select the appropriate two-letter state abbreviation from the drop-down options.
ZIP Code	➢ Enter the billing address 5-digit ZIP Code.
Location of group headquarters (if different from "Principal business address in California" above) Street	Completion of the group headquarters fields is required only when the headquarters address differs from the principal business address. ➢ Enter the headquarters street number and street name. P.O. Box numbers are not acceptable. Refer to Functionality and formatting.
City	➢ Enter the headquarters city.
State	➢ Select the appropriate two-letter state abbreviation from the drop-down options if located in the United States.

SECTION 1A EMPLOYER INFORMATION (continued)

MGA tab column name	Instruction
ZIP Code	➢ Enter the headquarters 5-digit ZIP Code if located in the United States.
Country	➢ Enter the headquarters country

SECTION 1B GROUP SIZE AND OUT OF STATE EMPLOYEES

MGA tab column name	Instruction
Total # of current FTE and FTE Equivalents	Completion of this field is required. ➢ Enter the total current FTE and FTE Equivalent employee count.
If current count is >100, how many employed in prior calendar quarter?	Completion of this field is required when the MGA indicates the total *current* FTE and FTE Equivalent employee count is greater than 100. ➢ Enter the number of FTE and FTE Equivalent employees employed in the prior calendar *quarter*.
If prior calendar quarter count is >100 how many employed in prior calendar year?	Completion of this field is required when the MGA indicates the number of FTE and FTE Equivalent employees employed in the prior calendar *quarter* is greater than 100. ➢ Enter the number of FTE and FTE Equivalent employees employed in the prior calendar *year.*
Total # of FTE and FTE Equivalents employed out of state?	Completion of this field is required. ➢ Enter the total number of FTE and FTE Equivalent employees employed outside of California.

SECTION 1B GROUP SIZE AND OUT OF STATE EMPLOYEES (continued)

MGA tab column name	Instruction
Total FTE and FTE Equivalent employed out of state during the prior calendar quarter?	Completion of this field is required when the MGA indicates the total current FTE and FTE Equivalent employees employed out of state is one or more. ➢ Enter the number of FTE and FTE Equivalent employees employed outside of California during the prior calendar *quarter.*
Total FTE and FTE Equivalent employed out of state during the prior calendar year?	Completion of this field is required when the MGA indicates the total FTE and FTE Equivalent employees employed out of state during the prior calendar *quarter* is one or more. ➢ Enter the number of FTE and FTE Equivalent employees employed outside of California during the prior calendar *year.*

SECTION 1C GROUP CONTACT INFORMATION

MGA tab column name	Instruction
Primary group contact: First Name	Completion of this field is required. ➢ Enter the first name of the Primary group contact. Refer to **Functionality and formatting.**

SECTION 1C GROUP CONTACT INFORMATION (continued)

MGA tab column name	Instruction
Primary group contact: Last Name	Completion of this field is required. ➢ Enter the last name of the Primary group contact. Refer to **Functionality and formatting.**
Title	➢ Enter the Primary group contact title.
Phone number	➢ Enter the Primary group contact phone number. Refer to **Functionality and formatting.**
Email address (required):	Completion of this field is required. ➢ Enter the Primary group contact email address. Refer to **Functionality and formatting.**
Secondary group contact: First Name	➢ Enter the Secondary group contact first name. Refer to **Functionality and formatting.**
Secondary group contact: Last Name	➢ Enter the Secondary group contact last name. Refer to **Functionality and formatting.**
Title	➢ Enter the Secondary group contact title.

SECTION 1C GROUP CONTACT INFORMATION (continued)

MGA tab column name	Instruction
Phone number	➢ Enter the Secondary group contact phone number. Refer to **Functionality and formatting.**
Email address	➢ Enter the Secondary group contact email address. Refer to **Functionality and formatting.**
Check here to register the primary group contact for online account access.	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 1D LEGAL ENTITY TYPE

MGA tab column name	Instruction
Legal entity type:	Completion of this field is required. ➢ Select from the drop-down options: • *S-Corporation* • *C-Corporation* • *Partnership* • *Sole Proprietorship* • *LLC* • *Non-profit* • *Other* Select "Partnership" for all types of partnerships (e.g., LLP, LP)
If "Other", please specify:	Completion of this field is required when "Other" is selected as the legal entity type. ➢ Enter the "other" legal entity type.

SECTION 1E AFFILIATED COMPANIES AND SUBSIDIARIES

MGA tab column name	Instruction
Do the owners of this company have common ownership with any other company and is eligible to file a combined state tax return with that company or companies? (Answering no to this question means that the group has certified that this company is not eligible to file a combined state tax return with any other company.)	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 1E AFFILIATED COMPANIES AND SUBSIDIARIES (continued)

MGA tab column name	Instruction
Subsidiary or affiliated company name(s)	Completion of this field is required when the MGA indicates the group is eligible to file a combined state tax return with one or more subsidiary or affiliated companies. ➢ Enter up to three subsidiary or affiliated company name(s). If there are more than three companies, the MGA tab of the spreadsheet cannot be utilized and the paper MGA must be submitted with the additional company names listed.
Include in coverage?	Completion of this field is required for each subsidiary or affiliated company name indicated in column D. ➢ In column E, select from the drop-down options: • *Yes* • *No*

SECTION 2A PREVIOUS AND CURRENT COVERAGE

MGA tab column name	Instruction
If the group has had or currently has medical coverage, who was/is the most recent carrier(s)?	➢ Enter the name of the current or most recent carrier. Refer to **Functionality and formatting.**
Is the group intending to offer Blue Shield alongside another carrier?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 2A PREVIOUS AND CURRENT COVERAGE (continued)	
MGA tab column name	**Instruction**
If yes, carrier name:	Completion of this field is required when the group is intending to offer Blue Shield alongside another carrier. ➢ Enter the name of the other carrier. Refer to **Functionality and formatting.**
Number of employees enrolled:	Completion of this field is required when the group is intending to offer Blue Shield alongside another carrier. ➢ Enter the number of employees (must be less than 100) enrolled/enrolling with the other carrier.
SECTION 2B CONTINUATION COVERAGE	
MGA tab column name	**Instruction**
Is the group currently subject to Cal-COBRA? (2-19 eligible employees, employed 50% working days in previous calendar year; or if not in the business during the previous calendar year, during the previous calendar quarter?)	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No* **Note:** The group can be subject to Cal-COBRA or COBRA but not both.
Is the group currently subject to Federal COBRA? (20+ total employees, employed 50% working days in previous calendar year.)	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No* **Note:** The group can be subject to Cal-COBRA or COBRA but not both.

SECTION 2B CONTINUATION COVERAGE (continued)

MGA tab column name	Instruction
Number of current COBRA/Cal-COBRA enrollees?	➢ Enter the number of current COBRA and Cal-COBRA enrollees.
How many employees and/or family members are in a COBRA/Cal-COBRA election period?	➢ Enter the number of employees and/or family members who are in a COBRA/Cal-COBRA election period.
Are enrollment forms attached for all enrollment COBRA/Cal-COBRA participants?	➢ Select from the drop-down options: • *Yes* • *No*

SECTION 3A EMPLOYEE COUNTS

MGA tab column name	Instruction
Total # of employees	Completion of this field is required. ➢ Enter the total number of employees.
Total # of eligible full-time employees (including eligible sole proprietors and partners)	Completion of this field is required. ➢ Enter the total number of eligible full-time employees.
Is the group offering coverage to part-time employees?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Total # of eligible part-time employees (if offering coverage to all similarly situated employees)	Completion of this field is required when the group is offering coverage to eligible part-time employees. ➢ Enter the total number of eligible part-time employees.

SECTION 3A EMPLOYEE COUNTS (continued)

MGA tab column name	Instruction
Medical coverage: Total # of eligible employees enrolling in coverage Total # of eligible employees refusing coverage	Completion of these fields is required when the group is offering medical coverage. ➢ Enter the total number of eligible employees enrolling in the medical coverage in **column D**. ➢ Enter the total number of eligible employees refusing the medical coverage in **column E**, including "0" if none are refusing. **Note:** Number of employees enrolling in medical plus number of employees refusing medical must equal the total number of eligible employees.
Dental coverage: Total # of eligible employees enrolling in coverage Total # of eligible employees refusing coverage	Completion of these fields is required when the group is offering dental coverage. ➢ Enter the total number of eligible employees enrolling in the dental coverage in **column D**. ➢ Enter the total number of eligible employees refusing the dental coverage in **column E**, including "0" if none are refusing. **Note:** Number of employees enrolling in dental plus number of employees refusing dental must equal the total number of eligible employees.

SECTION 3A EMPLOYEE COUNTS (continued)

MGA tab column name	Instruction
Vision coverage: Total # of eligible employees enrolling in coverage Total # of eligible employees refusing coverage	Completion of these fields is required when the group is offering vision coverage. ➢ Enter the total number of eligible employees enrolling in the vision coverage in **column D**. ➢ Enter the total number of eligible employees refusing the vision coverage in **column E**, including "0" if none are refusing. **Note:** Number of employees enrolling in vision plus number of employees refusing vision must equal the total number of eligible employees.
Life insurance coverage: Total # of eligible employees enrolling in coverage Total # of eligible employees refusing coverage	Completion of these fields is required when the group is offering life insurance. ➢ Enter the total number of eligible employees enrolling in the life insurance in **column D**. ➢ Enter the total number of eligible employees refusing the life insurance in **column E**, including "0" if none are refusing. **Note:** Number of employees enrolling in life insurance plus number of employees refusing life insurance must equal the total number of eligible employees.

SECTION 3B GROUP ELIGIBILITY

MGA tab column name	Instruction
Is the group actively engaged in business or service? A "Yes" answer means the business currently provides goods or services. A "No" answer means the business does not currently provide goods or services.	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Was the group formed primarily for the purpose of buying health coverage? A "Yes" answer means the business was established solely to obtain healthcare coverage, not to provide goods or services. A "No" answer means the business was established solely to provide goods or services.	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Did the group employ 1-100 employees on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, and in which a bona fide employer-employee relationship exists?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Does your group employ at least one W-2 ("common law") employee listed on the employer's DE 9C, who meets the definition of an "eligible employee", who isn't the sole proprietor, a partner of the partnership, or their spouse or registered domestic partner?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 4 ADDITIONAL GROUP INFORMATION

MGA tab column name	Instruction
Are all full-time eligible employees being offered health coverage? (Employees who waive coverage on the grounds that they have group coverage through another employer are not counted as eligible employees for purposes pertaining to participation.)	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Do all employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health services?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Are all employees covered by workers' compensation to the extent required by law?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Does the group employ both union and non-union employees?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Has the group used employees leased from a Professional Employer Organization (PEO) within the past six weeks? A leased employee is employed and paid by the PEO. When the PEO performs administrative services only, such as payroll processing, the employees are not leased.	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 4 ADDITIONAL GROUP INFORMATION (continued)

MGA tab column name	Instruction
If yes, are you canceling this leasing arrangement and hiring employees?	Completion of this field is required when the group used employees leased from a PEO within the past six weeks. ➢ Select from the drop-down options: • *Yes* • *No*
Is the group a spinoff?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
Is the group a startup?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 5 EMPLOYER ORIENTATION AND WAITING PERIODS

MGA tab column name	Instruction
Choose One of the following options.	Completion of this field is required. ➢ Select from the drop-down options: • *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*
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?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 6 NOTICES AND ELECTRONIC DISTRIBUTION OF MATERIALS

MGA tab column name	Instruction
Summary 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 into **http:www.blueshieldca.com/policies** 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 http://www.blueshieldca.com/sbpd to distribute to employees. 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.**	Information cannot be entered in this field.

SECTION 7A MEDICAL PLANS

MGA tab column name	Instruction
PPO plans Choose 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 Choose all Full PPO Network plans or select from individual plans below HSA-compatible HDHP plans – Full PPO AND Tandem PPO Networks Choose all HSA-compatible HDHP plans or select from individual plans below Tandem PPO plans – Tandem PPO Network Choose all Tandem PPO plans or select from individual plans below	There are three options for selecting the plans indicated on the MGA: 1. **Choose all PPO plans** button ➢ Click this button to add every Small Business Off-Exchange PPO plan to the spreadsheet 2. Three **Choose all** buttons for different categories of PPO plans: **Full PPO Network**, **HSA-compatible HDHP**, and **Tandem PPO Network** ➢ Click the appropriate category button to add every Small Business Off-Exchange PPO plan in that category to the spreadsheet 3. **Individual plan selections** in columns C, D, and E ➢ To select individual **Full PPO Network** plans, click the down arrow located to the right of **column C** and select the plan from the drop-down options. • Continue this process on each row in the column until all of the Full PPO plans have been added. ➢ To select individual **HSA-compatible HDHP** plans, click the down arrow located to the right of **column D** and select the plan from the drop-down options. • Continue this process on each row in the column until all of the HSA-compatible plans have been added. (Continued on next page)

SECTION 7A MEDICAL PLANS (continued)

MGA tab column name	Instruction
	➢ To select individual **Tandem PPO Network** plans, click the down arrow located to the right of **column E** and select the plan from the drop-down options. • Continue this process on each row in the column until all of the Tandem PPO plans have been added.
HMO plans Choose from the Access+ HMO Network, the Local Access+ HMO Network, and the Trio ACO HMO Network Choose ALL plans OR Access+ plans – Access+ HMO Network Choose all Access+ HMO plans Or select from individual plans below: Trio HMO plans – Trio ACO HMO Network Choose all Trio HMO plans Or select from individual plans below: Local Access+ plans – Local Access+ HMO Network Choose all Local Access+ HMO plans Or select from individual plans below:	There are three options available for selecting the plans indicated on the MGA: 1. A **Choose ALL plans** button ➢ Click this button to add every Small Business Off-Exchange HMO plan from all three HMO networks to the spreadsheet 2. Three **Choose all** buttons: one for Access+ HMO® plans, one for Trio HMO plans, and one for Local Access+ HMO® plans ➢ Click the applicable button to add every Small Business Off-Exchange plan in the specified network to the spreadsheet 3. **Individual plan selections** in columns C, D, and E ➢ To select individual **Access+ HMO®** plans, click the down arrow located to the right of **column C** and select the plan from the drop-down options. Continue this process on each row in the column until all of the Access+ (Continued on next page)

SECTION 7A MEDICAL PLANS (continued)

MGA tab column name	Instruction
	HMO® plans indicated on the MGA have been added. ➢ To select individual **Trio HMO** plans, click the down arrow located to the right of **column D** and select the plan from the drop-down options. • Continue this process on each row in the column until all of the Trio HMO plans indicated on the MGA have been added. ➢ To select individual **Local Access+ HMO®** plans, click the down arrow located to the right of **column E** and select the plan from the drop-down options. • Continue this process on each row in the column until all of the Trio HMO plans indicated on the MGA have been added.

SECTION 7A MEDICAL PLANS (continued)

MGA tab column name	Instruction
Mirror Plans Choose up to all 13 plans Mirror Plans Choose all Mirror plans or select from individual plans below:	There are two options available for selecting the plans indicated on the MGA: 1. **Choose all Mirror plans** button ➢ Click this button to add every Small Business Mirror plan to the spreadsheet 2. **Individual plan selections** in column C ➢ To select individual Mirror plans, click the down arrow located to the right of **column C** and select the plan from the drop-down options. • Continue this process on each row in the column until all of the Mirror plans indicated on the MGA have been added. **Note:** Plans from the Mirror Package cannot be offered alongside plans from the Off-Exchange Package.

SECTION 7B ADDITIONAL SELECTIONS

MGA tab column name	Instruction
If you selected an HDHP plan, you may choose to make HealthEquity your HAS administrator. Choosing HealthEquity means Blue Shield shares eligibility and claims data for a seamless experience. If you do not select HealthEquity, please work directly with your own administrator.	Completion of this field is required when the group is applying for one or more HSA-compatible HDHP plans. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 7B ADDITIONAL SELECTIONS (continued)

MGA tab column name	Instruction
If selected, a rider for assisted reproductive technology benefit will be added to all medical plans for the entire group. This rider can be offered with either an Off-exchange or a Mirror plan package, HMO and PPO.	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 8A SPECIALTY BENEFITS – DENTAL

MGA tab column name	Instruction
The group may select from one of the plan options	➢ Select from the drop-down options: • *Single* • *Dual choice* • *Triple choice*

SECTION 8A SPECIALTY BENEFITS – DENTAL (continued)

MGA tab column name	Instruction
If "Triple Choice" is selected, please choose combo	Completion of this field is required when the MGA indicates the Triple Choice dental plan option. ➢ Select the combination of plan types from the drop-down options: • *2 Dental HMO plans and 1 Dental PPO plan* • *3 Dental HMO plans* • *2 Dental PPO plans and 1 Dental HMO plan* **Note:** To offer 2 Dental PPO plans and 1 Dental HMO plan: • The group must also offer Blue Shield medical plans • Both of the 2 Dental PPO plans must either have an orthodontic benefit or not have an orthodontic benefit.
Select Plan(s) Dental HMO plans Dental PPO plans and Voluntary Dental PPO Plans	➢ Click the down arrow located to the right of **column C** (Dental HMO plans) and/or **column D** (Dental PPO plans and Voluntary Dental PPO plans), then select the plan from the drop-down options. ➢ For Single option, select one plan. ➢ For Dual option, select two plans. ➢ For Triple option, select three plans.

SECTION 8B SPECIALTY BENEFITS – VISION*

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

MGA tab column name	Instruction
The group may select from one of the plan options	➢ Select from the drop-down options: • *Single* • *Dual Choice*
Select plan(s)[1]: Ultimate Vision for Small Business Preferred Vision for Small Business Basic Vision for Small Business [1] Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.	➢ Click the down arrow located to the right of **column C** (Ultimate Vision for Small Business), **column D** (Preferred Vision for Small Business), and/or **column E** (Basic Vision for Small Business) then select the plan(s) from the drop-down options. ○ For Single option, select one plan. ○ For Dual option, select two plans.

SECTION 8C SPECIALTY BENEFITS – LIFE AD&D*

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

MGA tab column name	Instruction
Select type of life coverage Life plan types	➢ Select from the drop-down options: • *Basic* • *Multiple of Salary* • *Graded* **Note:** Select "Basic" when the MGA indicates "Flat"

SECTION 8C SPECIALTY BENEFITS – LIFE AD&D* (continued)

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

MGA tab column name	Instruction
If "Basic", specify amount:	The number of eligible employees employed by the group determines the Basic life plans that are available for selection in the spreadsheet. ➢ Click the down arrow located to the right of **column D** then select the Basic/Flat plan from the drop-down options.
If "Multiple of Salary", specify Multiplier/Max amount	The number of eligible employees employed by the group determines the Multiple of Salary life plans that are available for selection in the spreadsheet. ➢ Click the down arrow located to the right of **column D** then select the Multiple of Salary plan from the drop-down options.
If "Graded", specify # of classes:	➢ Select the number of employee classes from the drop-down options: • *2* • *3* • *4*
Class Name	➢ Enter the class name in **column C**. On the MGA, Class Name is found in the "Provide class description" column of the Graded Life table.

SECTION 8C SPECIALTY BENEFITS – LIFE AD&D* (continued)

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

MGA tab column name	Instruction
Plan Description/Flat Amount	➢ For each class name entered in column C, click the down arrow to the right of column D to select the Basic/Flat or Multiple of Salary plan for that class.
Dependent life insurance	➢ Select from the drop-down options: • *Yes* • *No*
If "Yes", select amount:	The number of eligible employees employed by the group and the employee benefit amount determines the coverage amounts that can be selected for dependents. ➢ Select the dependent term life insurance benefit amount from the drop-down options.

SECTION 9 EMPLOYER CONTRIBUTIONS

MGA tab column name	Instruction
Indicate **medical plan** employer contribution amount here (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): For employees % $ For dependents % $	Completion of these fields is required when the group offers medical coverage. **Employees:** ➢ Enter the employer contribution for employee medical coverage: • A percentage (%) in column D, **or** • A defined dollar amount ($) in column E. **Dependents:** ➢ Enter the employer contribution for dependent medical coverage: • A percentage (%) in column D, **or** • A defined dollar amount ($) in column E.
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 % $ For dependents % $	Completion of these fields is required when the group offers dental coverage. **Employees:** ➢ Enter the employer contribution for employee dental coverage: • A percentage (%) in column D, **or** • A defined dollar amount ($) that is equal to or greater than 50% of the total employee rates in column E. **Dependents:** ➢ Enter the employer contribution for dependent dental coverage: • A percentage (%) in column D, **or** • A defined dollar amount ($) in column E. •

SECTION 9 EMPLOYER CONTRIBUTIONS (continued)

MGA tab column name	Instruction
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 % $ For dependents % $	Completion of these fields is required when the group offers vision coverage. **Employees:** ➢ Enter the employer contribution for employee vision coverage: • A percentage (%) in column D, **or** • A defined dollar amount ($) that is equal to or greater than 25% of the total employee rates in column E. **Dependents:** ➢ Enter the employer contribution for dependent vision coverage: • A percentage (%) in column D, **or** • A defined dollar amount ($) in column E.
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 % $ For dependents % $	**Employees** Completion of these fields is required when the group offers life insurance. ➢ Enter the employer contribution for Employee life/AD&D insurance: • A percentage (%) in column D, **or** • A defined dollar amount ($) that is equal to or greater than 25% of the total employee rates in column E. **Dependents** ➢ Enter the employer contribution for dependent life insurance: • A percentage (%) in column D, **or** • A defined dollar amount ($) in column E.

SECTION 10A PRODUCER INFORMATION (to be completed by producer or general agent)

MGA tab column name	Instruction
Agency name	Completion of this field is required. ➢ Enter the Producer Agency name (as associated to Tax ID Number field). Refer to **Functionality and formatting.**
Tax ID number (for commission payments)	Completion of this field is required. ➢ Enter the Producer Agency's Tax ID number for commission payments. Refer to **Functionality and formatting.**
Producer name (agent who wrote the group)	Completion of this field is required. ➢ Enter the name of the Producer who wrote the group. Refer to **Functionality and formatting.**
Producer CDI license number	Completion of this field is required. ➢ Enter the CDI license number of the Producer who wrote the group. Refer to **Functionality and formatting.**
Producer email	Completion of this field is required. ➢ Enter the Producer email address. Refer to **Functionality and formatting.**

SECTION 10A PRODUCER INFORMATION (to be completed by producer or general agent) (continued)

MGA tab column name	Instruction
Producer phone number	Completion of this field is required. ➢ Enter the Producer phone number. Refer to **Functionality and formatting.**
Producer street address (P.O. Box not acceptable)	Completion of this field is required. ➢ Enter the Producer street address, which cannot be a P.O. Box. Refer to **Functionality and formatting.**
City	Completion of this field is required. ➢ Enter the Producer city. Refer to **Functionality and formatting.**
State	Completion of this field is required. ➢ Select the appropriate two-letter state abbreviation for the Producer address from the drop-down options.
ZIP code	Completion of this field is required. ➢ Enter the 5-digit ZIP code for the Producer address.
Does the producer have a delegate contact?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*

SECTION 10A PRODUCER INFORMATION (to be completed by producer or general agent) (continued)

MGA tab column name	Instruction
Producer contact	Completion of this field is required when the producer has a delegate contact. ➢ Enter the Producer contact first and last names.
Producer contact email	Completion of this field is required with the Producer has a delegate contact. ➢ Enter a valid email address for the Producer contact. Refer to **Functionality and formatting.**
Is this a split commission?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
If yes, define split: Producer #1 % Producer #2 %	Completion of this field is required if the commission is being split between the writing producer (Producer #1) and another producer (Producer #2). ➢ Enter the percentage of the commission that will be paid to Producer #1 on row 213. ➢ Enter the percentage of the commission that will be paid to Producer #2 on row 214.

SECTION 10A PRODUCER INFORMATION (to be completed by producer or general agent) (continued)

MGA tab column name	Instruction
2nd producer name	Completion of this field is required when the commission is being split between the writing producer (Producer #1) and another producer (Producer #2). ➢ Enter the first and last name of Producer #2. Refer to **Functionality and formatting.**
2nd producer tax ID	This information is required when the commission is being split between the writing producer (Producer #1) and another producer (Producer #2). ➢ Enter the second Producer tax ID. Refer to **Functionality and formatting.**

SECTION 10B PRODUCER SIGNATURE

MGA tab column name	Instruction
I assisted the applicant in completing and submitting this application, consistent with the terms of my Producer Agreement with Blue Shield of California. I certify that, to the best of my knowledge and belief, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the application understood the explanation. **Important Notice:** If you willfully state as true any material fact you know to be false, you are subject to a civil penalty of up to twenty thousand dollars ($20,000) pursuant to California Health and Safety Code Section 1389.8, in addition to any applicable penalties or remedies available under current law. I certify that I have and will retain the completed application on file and that the group representative has reviewed and signed the completed application. I acknowledge that the group authorization to proceed with this application for coverage has been collected and is on file and that the information I am providing is an accurate representation of the information in the signed form(s).	Completion of this field is required. The Enrollment Spreadsheet (MGA tab) should not be submitted until the Producer has checked the attestation box on the MGA (Section 10B) and signed and dated the MGA. ➢ Select from the drop-down options to indicate whether the attestation box has been checked on the MGA: • *Yes* • *No*

SECTION 10B PRODUCER SIGNATURE (continued)

MGA tab column name	Instruction
Date (required)	Completion of this field is required. ➢ Enter the date the Producer signed the MGA. Refer to **Functionality and formatting.**
Producer signature (required)	Completion of this field is required. ➢ Indicate whether the Producer signed the MGA by selecting from the drop-down options: • *Yes* • *No*
Producer printed first name (required)	Completion of this field is required. ➢ Enter the Producer's first name. Refer to **Functionality and formatting.**
Producer printed last name (required)	Completion of this field is required. ➢ Enter the Producer's last name. Refer to **Functionality and formatting.**

SECTION 10C GENERAL AGENT INFORMATION

MGA tab column name	Instruction
General Agency name	Completion of this field is required when the MGA indicates there is a General Agent. ➢ Enter the name of the General Agency. Refer to **Functionality and formatting.**
General agency tax ID number (for commission payments)	Completion of this field is required when the MGA indicates there is a General Agent. ➢ Enter the tax ID number. Refer to **Functionality and formatting.**
General agency contact name	Completion of this field is required when the MGA indicates there is a General Agent. ➢ Enter General Agency contact name (first and last). Refer to **Functionality and formatting.**
General agency contact email	Completion of this field is required when the MGA indicates there is a General Agency contact. ➢ Enter the General Agency contact's email address. Refer to **Functionality and formatting.**

SECTION 11 EMPLOYER ATTESTATIONS AND SIGNATURE

MGA tab column name	Instruction
The group representative attests to the following: 1. Each employee to whom coverage is being offered meets the definition of an eligible employee (see Section 3A of this application for reference.) 2. 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, required premium payments have been made, and a group health service contract has been issued. The group representative certifies that, to the best of his/her knowledge and belief, all of the responses provided in this application are true, correct, and complete. 3. 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 follow remedies: Coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the health service contract may be rescinded.	Completion of this field is required. The authorized group representative attests to this information by signing and dating the Master Group Application. The MGA tab should not be submitted until the group representative has signed/dated the MGA. ➢ Select from the drop-down options to indicate whether the group has attested to this information by signing the MGA: • *Yes* • *No*

SECTION 11 EMPLOYER ATTESTATIONS AND SIGNATURE (continued)

MGA tab column name	Instruction
Authorized group representative signature	Completion of this field is required. ➢ Select from the drop-down options to indicate whether the authorized group representative signed the MGA. • *Yes* • *No*
Date	Completion of this field is required. ➢ Enter the date the authorized group representative signed the MGA. Refer to **Functionality and formatting.**
Authorized group representative first name	Completion of this field is required. ➢ Enter the first name of the authorized group representative who signed the MGA. Refer to **Functionality and formatting.**
Authorized group representative last name	Completion of this field is required. ➢ Enter the last name of the authorized group representative who signed the MGA. Refer to **Functionality and formatting.**

SECTION 11 EMPLOYER ATTESTATIONS AND SIGNATURE (continued)	
MGA tab column name	**Instruction**
Authorized group representative title	Completion of this field is required. ➢ Enter the job title for the authorized group representative who signed the MGA. Refer to **Functionality and formatting.**
INTERNAL SALES INFORMATION	
This information is not on the Master Group Application and when applicable will be completed by a Blue Shield account executive, account manager, or sales assistant.	

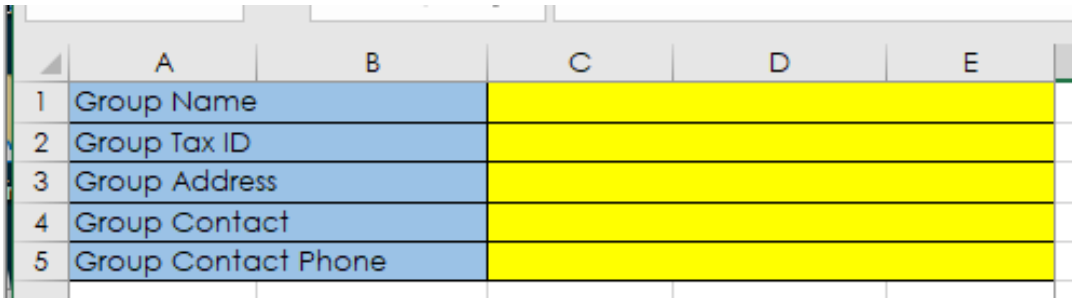
Enrollment Form tab

This tab contains fields that correspond to the paper Employee Enrollment and Refusal of Coverage forms.

Every eligible employee with a Social Security number and every enrolling eligible dependent (spouse, domestic partner, dependent child, dependent child – other) should be listed in the spreadsheet.

All information provided by the employee in the paper forms should be entered into the spreadsheet whether or not completion of the field is required.

Step 1:
Enter group information



Enrollment Form tab (continued)

- Enter the group legal name
- Enter the group federal tax ID number
- Enter the group principal business address in the following format: Address, City, State, ZIP code
- Enter the name of the group primary contact
- Enter the group primary contact phone number

Note: If the MGA tab is being utilized, the group information will automatically populate these fields.

Refer to the **Functionality and formatting** instructions.

Step 2:

Enter employee and dependent information

- Refer to the appropriate section of the Employee Enrollment Form then enter data from the form into the column, row by row, for every eligible employee and their enrolling eligible dependents.
- 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.

Application information (continued)

Column	Field name	Instruction
B	Applicant Type	Completion of this field is required. *Subscriber* must be an employee. Enrolling dependents are entered as a specific dependent type. *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. Dependents should be listed in the spreadsheet in the order shown below. Dependents are entered into 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. ➢ Select from the drop-down options: • *Subscriber* • *Spouse* • *Domestic Partner* • *Dependent Child* • *Other Dependent Child – Guardianship*

Application information (continued)

Column	Field name	Instruction
C	Type of Application	Completion of this field is required. ➢ Select from the drop-down options: • *Enroll* • *ROC* Select *Enroll* for every subscriber and dependent that is enrolling in one or more plans offered by the employer. Select *ROC* for a **subscriber** (employee) who is refusing <u>all</u> plans offered by the employer.
D	Applicant Last Name	Completion of this field is required. ➢ Enter the applicant last name. Refer to **Functionality and formatting.**
E	Applicant First Name	Completion of this field is required. ➢ Enter the applicant first name. Refer to **Functionality and formatting.**
F	Applicant Middle Initial	This is an optional field. ➢ Enter no more than one initial. Refer to **Functionality and formatting.**

Application information (continued)

Column	Field name	Instruction
G	Subscriber SSN	➢ **Subscribers:** enter the subscriber's Social Security number (nine digits). ➢ **Dependents:** the SSN of the subscriber above the dependent row will automatically populate in this field. Refer to **Functionality and formatting.** Social Security number is required for every subscriber who is enrolling or refusing to enroll. **Note:** If an employee 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. In this case, submit the paper Employee Enrollment Form and/or Refusal of Coverage.
H	Applicant SSN	➢ **Subscribers:** the SSN entered in column G will automatically populate column H. ➢ **Dependents:** enter the Social Security number of the dependent who is enrolling. Refer to **Functionality and formatting.**

Section 1a – Health plan selection

Column	Field name	Instruction
I	Health Package	➢ If the group is offering medical coverage, select from the drop-down options: • *Waive* • *Off_Exchange* • *Mirror* ➢ If the group is not offering medical coverage, *Health Package* should be left blank. If the MGA tab was completed, only the *Health Package* selected by the group and *Waive* are displayed in the drop-down menu. When dependents are also enrolling, the *Health Package* is only required on the subscriber row as any dependents enrolling in health coverage cannot chose a package or plan that differs from the subscriber's package and plan.
J	Health Plan	➢ If the employee is enrolling in health coverage, select from the drop-down options. Plans listed in the drop-down are based on the *Health Package* selection in column I. If the MGA tab was completed, only the medical plans offered by the group are displayed in the drop-down menu. When dependents are also enrolling, the *Health Plan* is only required on the subscriber row as any dependents enrolling in health coverage cannot chose a package or plan that differs from the subscriber's package and plan.

Section SB1 – Dental Benefits

Column	Field name	Instruction
K	Dental Package	➢ If the group is offering dental coverage, select from the drop-down options: • *Waive* • *Dental HMO* • *Dental PPO* ➢ If the group is not offering dental coverage, *Dental Package* should be left blank. If the MGA tab was completed, only the *Dental Package* selected by the group and *Waive* are displayed in the drop-down menu. When dependents are also enrolling, the *Dental Package* is only required on the subscriber row as any dependents enrolling in dental coverage cannot chose a package or plan that differs from the subscriber's package and plan.
L	Dental Plan	➢ If the employee is enrolling in dental coverage, select the plan from the drop-down options. Plans listed in the drop-down are based on the *Dental Package* selection in column K. If the MGA tab was completed, only the dental plan(s) offered by the group is displayed in the drop-down menu. When dependents are also enrolling, the *Dental Plan* is only required on the subscriber row as any dependents enrolling in dental coverage cannot chose a package or plan that differs from the subscriber's package and plan.

Section SB2 – Vision Coverage

Column	Field name	Instruction
M	Vision Package	➢ If the group is offering vision coverage, select from the drop-down options: • *Waive* • *Ultimate* • *Preferred* • *Basic* ➢ If the group is not offering vision coverage, *Vision Package* should be left blank. If the MGA tab was completed, only the *Vision Package* selected by the group and *Waive* are displayed in the drop-down menu. When dependents are also enrolling, the *Vision Package* is only required on the subscriber row as any dependents enrolling in vision coverage cannot chose a package or plan that differs from the subscriber's package and plan.
N	Vision Plan	➢ If the employee is enrolling in vision coverage, select the plan from the drop-down options. Plans listed in the drop-down are based on the *Vision Package* selection in column M. If the MGA tab was completed, only the vision plans selected by the group is displayed in the drop-down menu. When dependents are also enrolling, the *Vision Plan* is only required on the subscriber row as any dependents 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])

Column	Field name	Instruction
O	Life/AD&D Option	➢ If the group is offering life insurance, select from the drop-down options: • *Waive* • *Basic* • *Multiple of Salary* • *Graded* ➢ If the group is not offering life insurance, *Life/AD&D Option* should be left blank. If the MGA tab was completed, only the *Life /AD&D Option* selected by the group and *Waive* are displayed in the drop-down menu. 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.

Section SB3 – Life/AD&D insurance (Underwritten by Blue Shield of California Life & Health Insurance Company [Blue Shield Life]) (continued)

Column	Field name	Instruction
P	Employee Life/AD&D Option	➢ If the employee is enrolling in life insurance, 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. If the MGA tab was completed, only the option(s) selected by the group is displayed in the drop-down menu. **Note:** If the group is offering life insurance in a graded schedule, ensure that the plan selection is appropriate for the subscriber job classification.
Q	Basic Dependent Life Insurance	Completion of this field is required when the employee is enrolling in life insurance and the group is offering Dependent Life Insurance. ➢ Select from the drop-down options: • *Yes* • *No* **Note:** The employee must enroll in life insurance in order for dependent life insurance to be available.
R	Number of Eligible Dependents	Completion of this field is required when the answer in column Q is *Yes.* Enter the number of the subscriber's eligible dependents.

Section SB3 – Life/AD&D insurance (Underwritten by Blue Shield of California Life & Health Insurance Company [Blue Shield Life]) (continued)

Column	Field name	Instruction
S	Amount of Coverage Requested for Dependents	➢ Select the group's Dependent Life Insurance plan from the drop-down options. If the MGA tab was completed, only the Dependent Life benefit selected by the group will be displayed in the drop-down menu.
T	Earnings Excluding OT, Bonus	Completion of this field is required 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 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: • *Hourly* • *Weekly* • *Monthly* • *Yearly*

Section 2 – Subscriber information

Column	Field name	Instruction
V	Subscriber – Home Address	➢ Enter the subscriber's home (physical) street address (no P. O. Box). Refer to **Functionality and formatting.**

Section 2 – Subscriber information (continued)

Column	Field name	Instruction
W	Subscriber – City	➢ Enter the city of the subscriber's home (physical) address. Refer to **Functionality and formatting.**
X	Subscriber – State	➢ Select the appropriate two-letter state abbreviation for the subscriber's home address from the drop-down options.
Y	Subscriber – ZIP	➢ Enter the 5-digit ZIP code of the subscriber's home (physical) address.
Z	Mailing Address Same as Home?	➢ Select from the drop-down options: • *Yes* • *No* When *Yes* is selected, the subscriber's "Home" address will automatically populate columns AA, AB, AC, and AD.
AA	Subscriber – Mailing Address (If Different)	Completion of this field is required when the answer in column Z is *No*. ➢ Enter the subscriber's street or P.O. Box mailing address. Refer to **Functionality and formatting.**
AB	Subscriber – Mailing City	Completion of this field is required when the answer in column Z is *No*.. ➢ Enter the city of the subscriber's mailing address. Refer to **Functionality and formatting.**

Section 2 – Subscriber information (continued)

Column	Field name	Instruction
AC	Subscriber – Mailing State	Completion of this field is required when the answer in column Z is *No*. ➢ Select the appropriate two-letter state abbreviation for the subscriber's mailing address from the drop-down options.
AD	Subscriber – Mailing Zip	Completion of this field is required when the answer in column Z is *No*. ➢ Enter the 5-digit ZIP code of the subscriber's mailing address.
AE	Subscriber – Cell Phone	➢ Enter 10-digit cell phone number. Refer to **Functionality and formatting.**
AF	Subscriber – Landline Phone	➢ Enter 10-digit home phone number. Refer to **Functionality and formatting.**
AG	Language Preference	➢ Select from the drop-down options: • *EN01 – English* • *SP01 – Spanish* • *CH01 – Chinese* • *VI01 – Vietnamese* • *NS01 – Not selected*
AH	Consent to Telephone Communications	➢ Select from the drop-down options: • *Yes* • *No*

Section 2 – Subscriber information (continued)

Column	Field name	Instruction
AI	Subscriber – Email Address	Completion of this field is required when the selection in column AJ (Preferred Method of Contact) is *Electronic*. ➢ Enter a valid email address. Refer to **Functionality and formatting.**
AJ	Preferred Method of Contact	➢ Select from the drop-down options: • *Electronic* • *Paper*
AK	Subscriber – Date of Birth	Completion of this field is required. ➢ Enter the subscriber's date of birth. Refer to **Functionality and formatting.**
AL	Subscriber – Gender	Completion of this field is required. ➢ Select from the drop-down options: • *Male* • *Female*
AM	Subscriber – Marital Status	Completion of this field is required. ➢ Select from the drop-down options: • *Single* • *Married* • *Domestic Partner*
AN	Are you of Hispanic or Latino origin?	➢ Select from the drop-down options: • *Yes* • *No* • *1003 – Unknown* • *1024 - Declined*

Section 2 – Subscriber information (continued)

Column	Field name	Instruction
AO	If "Yes", please select one	➢ Select from the drop-down options: • *1000 – Cuban* • *1026 – Guatemalan* • *1001 – Mexican, Mexican American, Chicano* • *1002 – Puerto Rican* • *1025 – Salvadoran* • *1022 – 2 or more Ethnicities* • *1021 – Other Hispanic, Latino, Spanish*
AP	Which race(s) do you identify with? (select one)	➢ Select from the drop-down options: • *1000 – American Indian or Alaska Native* • *1001 – Asian Indian* • *1002 - Black or African American* • *1020 - Cambodian* • *1003 – Chinese* • *1004 – Filipino* • *1005 – Guamanian or Chamorro* • *1018 – Hmong* • *1006 – Japanese* • *1007 – Korean* • *1019 – Laotian* • *1008 – Native Hawaiian* • *1011 – Samoan* • *1012 – Vietnamese* • *1013 – White* • *1015 – 2 or more races* • *1014 – Other* • *1017 – Declined* • *1016 – Unknown*

Section 2 – Subscriber information (continued)

Column	Field name	Instruction
AQ	Date of Hire	Completion of this field is required. ➢ Enter the subscriber's date of hire. Refer to **Functionality and formatting.**
AR	Subscriber – Job Title	Completion of this field is required. ➢ Enter the subscriber's job title in 80 characters or less.
AS	Job Classification	Completion of this field is required when the *Life/AD&D Option* (column O) is *Graded*. ➢ Enter the appropriate classification number (e.g., 1, 2, 3, 4) or description (e.g., Officers, Managers, Sales, Clerical) per the Master Group Application.
AT	Do you have any eligible dependent children under the age of 26?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No*
AU	How many?	Completion of this field is required when the answer in column AT is *Yes*. ➢ Enter the number of eligible dependents under the age of 26.
AV	How many are enrolling?	This field is required when the answer to column AT is *Yes*. ➢ Enter the number of eligible dependents under the age of 26 that are enrolling.

Section 2 – Subscriber information (continued)

Column	Field name	Instruction
AW	Are you a full-time employee?	➢ Select from the drop-down options: • *Yes* • *No*
AX	Are you a part-time employee?	➢ Select from the drop-down options: • *Yes* • *No* If the MGA tab was completed, the group does not offer coverage to part-time employees, and this question answered *Yes*, the field will turn red to identify the part-time employee as ineligible.
AY	If no, are you an existing COBRA participant or enrolling due to a COBRA qualifying event?	Completion of this field is required when columns AW and AX are both answered "no." ➢ Select from the drop-down options: • *Yes* • *No*

Section 3 – HMO physician/Dental HMO provider assignment

Column	Field name	Instruction
AZ	Should Blue Shield designate a provider?	This field must be completed for each **subscriber** and **dependent** who is enrolling in a medical HMO plan and/or a dental HMO plan. ➢ Select from the drop-down options: • *Yes* • *No*

Section 3 – HMO physician/Dental HMO provider assignment (continued)

Column	Field name	Instruction
BA	Medical HMO Personal Physician Name	Answers are required in columns BA, BB, BC and BD when a **subscriber** is enrolling in an HMO medical plan and answered *No* in column AZ. **Note:** This information is entered for dependents in Section 4 of the Enrollment Spreadsheet. ➢ Enter the subscriber's medical HMO primary care physician name, PCP ID number and IPA/Medical Group name. A list of available providers can be found at Find a Doctor, Dentist, Hospital, Vision, Urgent Care, Pharmacy, Health - Blue Shield of California (blueshieldca.com).
BB	PCP ID	
BC	IPA/MG Name	
BD	Existing medical patient?	➢ Select from the drop-down options: • *Yes* • *No*
BE	Dental HMO Provider Name	Answers are required in columns BE, BF, BG, and BH when a **subscriber** is enrolling in an HMO dental plan and answered *No* in column AZ. **Note:** This information is entered for **dependents** in Section 4 of the Enrollment Spreadsheet. ➢ Enter the dental HMO provider name, provider number and dental group name. A list of available dental providers can be found at Find a Doctor, Dentist, Hospital, Vision, Urgent Care, Pharmacy, Health - Blue Shield of California (blueshieldca.com).
BF	Dental Provider Number	
BG	Dental Group Name	

Section 3 – HMO physician/Dental HMO provider assignment (continued)

Column	Field name	Instruction
BH	Existing dental patient?	➢ Select from the drop-down options: • *Yes* • *No*

Section 4 – Dependent information (complete one row for each enrolling dependent)

Column	Field name	Instruction
BI	All dependents same race & ethnicity as subscriber?	➢ Select from the drop-down options: • *Yes* • *No*
BJ	Dependent – Are you of Hispanic or Latino origin?	➢ Select from the drop-down options: • *Yes* • *No* • *1003 – Unknown* • *1024 – Declined*
BK	Dependent –If "Yes", please select one	➢ Select from the drop-down options: • *1000 – Cuban* • *1026 - Guatemalan* • *1001 – Mexican, Mexican American, Chicano* • *1002 – Puerto Rican* • *1025 – Salvadoran* • *1022 – 2 or more Ethnicities* • *1021 – Other Hispanic, Latino, Spanish*

Section 4 – Dependent information (complete one row for each enrolling dependent) (continued)

Column	Field name	Instruction
BL	Dependent – Which race(s) do you identify with? (select one)	➢ Select from the drop-down options: • *1000 – American Indian or Alaska Native* • *1001 – Asian Indian* • *1002 – Black or African American* • *1020 – Cambodian* • *1003 – Chinese* • *1004 – Filipino* • *1005 – Guamanian or Chamorro* • *1018 – Hmong* • *1006 - Japanese* • *1007 – Korean* • *1019 – Laotian* • *1008 – Native Hawaiian* • *1011 – Samoan* • *1012 – Vietnamese* • *1013 – White* • *1015 – 2 or more Races* • *1014 – Other* • *1017 – Declined* • *1016 - Unknown*
BM	Dependent Gender	Completion of this field is required for each dependent enrolling in coverage. ➢ Select from the drop-down options: • *Male* • *Female*

Section 4 – Dependent information (complete one row for each enrolling dependent) (continued)

Column	Field name	Instruction
BN	Enroll in all products selected by subscriber?	Completion of this field is required for each dependent enrolling in coverage. ➢ Select from the drop-down options: • *Yes* • *No*
BO	Dependent – Date of Birth	Completion of this field is required for each dependent enrolling in coverage. ➢ Enter the dependent's date of birth. Refer to **Functionality and formatting.**
BP	Dependent address same as subscriber's?	Completion of this field is required for each dependent enrolling in coverage. ➢ Select from the drop- down options: • *Yes* • *No* When the answer is column BP is *Yes*, the subscriber's home address will automatically populate columns BQ, BR, BS, and BT.
BQ	Dependent – Address	Completion of this field is required when column BP is answered *No*. ➢ Enter the enrolling dependent's address. Refer to **Functionality and formatting.**

Section 4 – Dependent information (complete one row for each enrolling dependent) (continued)

Column	Field name	Instruction
BR	Dependent – City	Completion of this field is required when column BP is answered *No*. ➢ Enter the enrolling dependent's city. Refer to **Functionality and formatting.**
BS	Dependent – State	Completion of this field is required when column BP is answered *No*. ➢ Select the appropriate two-letter state abbreviation for the dependent's address from the drop-down options.
BT	Dependent – ZIP	Completion of this field is required when column BP is answered *No*. ➢ Enter the enrolling dependent's 5-digit ZIP code.
BU	Dependent – Communication Preference	➢ Select from the drop-down options: • *Electronic* • *Paper*
BV	Dependent – Email	When the dependent communication preference in column BU is "electronic", dependent email address is required. ➢ Enter the dependent 's email address. Refer to **Functionality and formatting.**

Section 4 – Dependent information (complete one row for each enrolling dependent) (continued)

Column	Field name	Instruction
BW	Dependent – HMO Personal Physician Name	Answers are required in columns BW, BX, BY, and BZ when a **dependent** is enrolling in an HMO medical plan, and answered *No* in column AZ ("Should Blue Shield designate a provider?"). A list of available providers can be found at Find a Doctor, Dentist, Hospital, Vision, Urgent Care, Pharmacy, Health - Blue Shield of California (blueshieldca.com) ➢ Enter the medical HMO primary care physician name, provider number and IPA name.
BX	Dependent – PCP ID	
BY	Dependent – IPA Name	
BZ	Dependent – Existing medical patient?	➢ Select from the drop-down options: • *Yes* • *No*
CA	Dependent – Dental HMO Provider Name	Answers in columns CA, CB, CC and CD are required when a **dependent** is enrolling in an HMO dental plan, and answered *No* in column AZ ("Should Blue Shield designate a provider?"). A list of available providers can be found at Find a Doctor, Dentist, Hospital, Vision, Urgent Care, Pharmacy, Health - Blue Shield of California (blueshieldca.com) ➢ Enter the HMO dental provider name, provider number and dental group name.
CB	Dependent – Dental Provider Number	
CC	Dependent – Dental Group Name	
CD	Dependent – Existing dental patient?	➢ Select from the drop-down options: • *Yes* • *No*

Section 5 – Other Health Plan Information

Column	Field name	Instruction
CE	Any prior coverage in the past 6 months?	**Note:** The questions in Section 5 are answered on the **subscriber row** only. ➢ Select from the drop-down options: • *Yes* • *No* **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?"
CF	If prior coverage, list prior carrier name	➢ Enter the current or prior carrier name. Field is limited to 80 characters. **Note:** On the Employee Enrollment Form, this field is "If yes, specify carrier"
CG	Type of Coverage	➢ Select from the drop-down options: • *Group* • *Individual* • *Medicare* • *Covered Calif/State Exchange* • *Other*
CH	Policy ID Number	➢ Enter the policy ID number for the current or prior coverage.
CI	Date Prior Coverage Began	➢ Enter the date that current or prior coverage began. Refer to **Functionality and formatting.**

Section 5 – Other Health Plan Information (continued)

Column	Field name	Instruction
CJ	Date Prior Coverage Ended	➢ Enter the date that current coverage will end or the date that prior coverage ended. Refer to **Functionality and formatting.**
CK	Family Member with Prior Coverage	➢ Enter the names of all of the enrolling family members (limited to 100 characters) who are currently or were previously enrolled in the health coverage.

Section 6 – Medicare Information

Column	Field name	Instruction
CL	Are you or any dependents currently covered by Medicare?	➢ Select from the drop-down options: • *Yes* • *No*
CM	If "Yes" to current Medicare coverage, do you have Part A?	➢ Select from the drop-down options: • *Yes* • *No*
CN	Part A Effective Date	Completion of this field is required when the answer in column CM is *Yes*. ➢ Enter the Medicare Part A effective date. Refer to **Functionality and formatting.**
CO	If "yes" to current Medicare coverage, do you have Part B?	➢ Select from the drop-down options: • *Yes* • *No*

Section 6 – Medicare Information (continued)

Column	Field name	Instruction
CP	Part B Effective Date	Completion of this field is required when the answer in column CO is *Yes*. ➢ Enter the Medicare Part B effective date. Refer to **Functionality and formatting.**
CQ	Is Medicare eligible due to end stage renal disease?	➢ Select from the drop-down options: • *Yes* • *No*
CR	What was the first date of dialysis treatment?	Completion of this field is required when the answer in column CQ is *Yes*. Enter the date of the first dialysis treatment. Refer to **Functionality and formatting.**
CS	Type of Dialysis	This field is required when the answer in column CQ is *Yes*. ➢ Select from the drop-down options: • *Hemo* • *Self-dialysis (peritoneal)*
CT	If kidney transplant, provide date	Completion of this field is optional. ➢ Enter the date of the kidney transplant. Refer to **Functionality and formatting.**

Section 7 – COBRA/Cal-COBRA Group continuation coverage

Column	Field name	Instruction
CU	Are you enrolling in COBRA or Cal-COBRA?	➢ Select from the drop-down options: • *Yes* • *No*
CV	Employee/Subscriber Blue Shield ID Number	➢ Enter the employee/subscriber Blue Shield ID number if applicable. Refer to **Functionality and formatting.**
CW	Original Qualifying Event Date	Completion of this field is required when the answer in column CU is *Yes*. Enter the date of the original Qualifying Event. Refer to **Functionality and formatting.**
CX	Qualifying Event Reason	Completion of this field is required when the answer in column CU is *Yes*. ➢ Select from the drop-down options • *Termination or reduction in hours due to disability* • *Divorce or legal separation* • *Entitlement to Medicare by covered employee* • *Attainment of maximum age for a dependent child* • *Death of covered employee* • *Termination of domestic partnership*

Section 8 – Disclosure of personal and health information/ acknowledgement and signature

Column	Field name	Instruction
CY	Signature of Employee	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No* Select *Yes* when the employee signature is present. **Note:** 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.
CZ	Date	Completion of this field is required. ➢ Enter the date that the employee signed the Employee Enrollment Form. Refer to **Functionality and formatting.**

Refusal of Coverage Form

Completion of this section is required in the following scenarios:

- Subscriber refused all coverage offered by the group (*ROC* **Type of Application**)
- Subscriber refused some coverage offered by the group (*Enroll* **Type of Application**)
- Subscriber refused some or all coverage for dependents (*Enroll* **Type of Application**)

Refusal of Coverage Form (continued)

Column	Field name	Instruction
DA	Are all eligible family members enrolling?	Completion of this field is required. ➢ Select from the drop-down options: • *Yes* • *No* Select *No* when: • The Subscriber has eligible dependents who are not enrolling in any of the Subscriber's plans • The Subscriber has eligible dependent(s) who are enrolling in some, but not all of the Subscriber's plans
DB	Date of Birth	Completion of this field is required when the subscriber's **Type of Application** is *ROC* (employee is refusing all coverage offered by the employer). Enter the subscriber's date of birth. Refer to **Functionality and formatting.**
DC	Hire Date	Completion of this field is required when the subscriber's **Type of Application** is *ROC* (employee is refusing all coverage offered by the employer). ➢ Enter the month, day and year that the subscriber was hired. Refer to **Functionality and formatting.**

Refusal of Coverage Form (continued)

Column	Field name	Instruction
DD	State of Residence	Completion of this field is required when the subscriber's **Type of Application** is *ROC* (employee is refusing all coverage offered by the employer). ➢ Select the appropriate two-letter abbreviation for the subscriber's state of residence .
DE	Marital Status	Completion of this field is required when the subscriber's **Type of Application** is *ROC* (employee is refusing all coverage offered by the employer). Select from the drop-down options: *Single* *Married* *Domestic partner*
DF	Job Title	Completion of this field is required when the subscriber's **Type of Application** is *ROC* (employee is refusing all coverage offered by the employer). Enter the subscriber's job title in 80 characters or less.
DG	Are you a FT employee – 30 or more hours per week?	Completion of this field is required when the subscriber's **Type of Application** is *ROC* (employee is refusing all coverage offered by the employer). Select from the drop-down options: *Yes* *No*

Refusal of Coverage Form (continued)

Column	Field name	Instruction
DH	Are you a PT employee – 20-29 hours per week?	Completion of this field is required when the subscriber's **Type of Application** is *ROC* (employee is refusing all coverage offered by the employer). Select from the drop-down options: *Yes* *No*

Refusal of Coverage Form (continued)

Column	Field name	Instruction
DI	Declining Medical Coverage	Completion of this field is required when the Refusal of Coverage indicates that the employee is declining medical coverage for themselves, a spouse/domestic partner, or any or all dependent children. **Subscriber row:** ➢ Select from the drop-down options: • *Myself and all dependents* • *My spouse/domestic partner only* • *My children only* • *My spouse/domestic partner and children* • *The following dependents only* **Dependent rows:** When *The following dependents only* is selected in column DI on the **subscriber row**, the drop-down options for each **dependent row** will change. ➢ Select from the drop-down options: • *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).

Refusal of Coverage Form (continued)

Column	Field name	Instruction
DJ	Reason for **Employee** Declining Medical	➢ Select from the drop-down options: • *Enrolling as a dependent of an employee on this group health plan* • *Covered by this employer's other health plan (through another carrier)* • *Covered by another employer's health plan, including COBRA or Cal-COBRA coverage* • *Covered by an individual/family health plan* • *Covered by Government program* • *Other reasons*
DL	Declining Dental Coverage	**Subscriber row:** ➢ Select from the drop-down options: • *Myself and all dependents* • *My spouse/domestic partner only* • *My children only* • *My spouse/domestic partner and children* • *The following dependents only* **Dependent rows:** When *The following dependents only* is selected in column DL **subscriber row**, the drop-down options for each **dependent row** will change. ➢ Select from the drop-down options: • *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).

Refusal of Coverage Form (continued)

Column	Field name	Instruction
DM	Reason for Employee declining Dental	➢ Select from the drop-down options: • *Enrolling as a dependent of an employee on this group dental plan* • *Covered by another employer's dental plan, including COBRA or Cal-COBRA dental coverage* • *Other*
DO	Declining Vision Coverage	**Subscriber row:** ➢ Select from the drop-down options: • *Myself and all dependents* • *My spouse/domestic partner only* • *My children only* • *My spouse/domestic partner and children* • *The following dependents only* **Dependent rows:** When "The following dependents only" is selected in column DO **subscriber row**, the drop-down options for each **dependent row** will change. ➢ Select from the drop-down options: • *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).

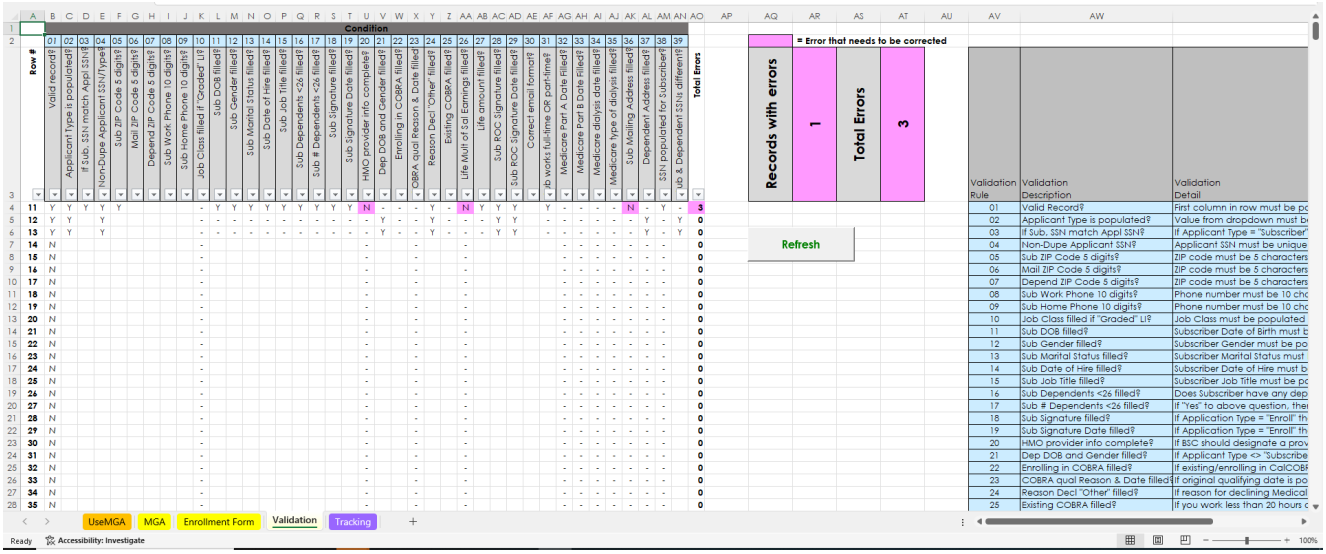
Refusal of Coverage Form (continued)

Column	Field name	Instruction
DP	Reason for Employee declining Vision coverage	➢ Select from the drop-down options: • *Enrolling as a dependent of an employee on this group vision plan* • *Covered by another employer's vision plan, including COBRA or Cal-COBRA vision coverage* • *Other*
DR	Declining Life Coverage	➢ Select from the drop-down option: • *Myself and all dependents*
DS	Reason for Employee declining Life coverage	➢ Select from the drop-down options: • *Covered by another employer's life insurance coverage through your spouse/domestic partner or parent* • *Cost of coverage* • *Do not need or do not want coverage*
DU	ROC Signature of Employee	Completion of this field is required when any coverage offered by the employer is being refused. ➢ Select from the drop-down options: • *Yes* • *No* 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.
DV	Date	Enter the date that the employee signed the Refusal of Coverage form. Refer to **Functionality and formatting.**

Refusal of Coverage Form (continued)

Column	Field name	Instruction
FA	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.

Validations Tab



- The spreadsheet contains formatting validations for 39 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 displayed across the top of the screen.
  - ➢ Correct invalid data ("N") highlighted in pink before submitting the enrollment form.
- 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.

Tracking tab

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

Frequently asked questions

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 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.**

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.