CaliforniaChoice®
Your Health. Your Choice.®

721 South Parker, Suite 200, Orange, CA 92868
(800) 558-8003 • www.calchoice.com

Employer Application

Group # _____ (For California*Choice*® use only)

- Please complete using black ink
- Return signed and completed application - and those of employees - to your broker

A Employer Information

Legal Company Name

Date Business Started (MM/DD/YYYY)

CA Federal Tax ID # (9 digits) - NOT Social Security #

DBA Name (Doing Business As)

Exact Nature of Business

SIC Code

Company Structure
☐ Corporation ☐ LLC
☐ S Corporation ☐ Other (Enter below)
☐ Sole Proprietor
☐ Partnership

Owner/President Name

Owner/President Email Address

Contact Name

Contact Job Title

Contact Phone # (XXX) XXX-XXXX

Contact Fax # (XXX) XXX-XXXX

Contact E-mail Address

Billing Address

Suite/Unit #

City | **State** | **ZIP Code** | **County**

☐ Check if Residence

Street Address (if different) (no P.O. Box)

Suite/Unit #

City | **State** CA | **ZIP Code** | **County**

☐ Check if Residence

Worker's Comp Carrier Name (not broker or agency name)

Policy #

Future Renewal Date (MM/DD/YYYY)

Note: Workers' Compensation Coverage must be effective on or prior to the effective date requested with California*Choice*

☐ **We are not covered by Workers' Compensation coverage due to legal exemption under the following checked condition**
100% family-related running business out of home (does not include domestic partners; family members must reside at the same residence)

B Enrollment & Eligibility Information

1. **Requested Effective Date (MM/DD/YYYY)**
2. **How many pay periods per year? (Will be shown on Employer Enrollment Worksheets)** ☐ 12 ☐ 24 ☐ 26 ☐ 48 ☐ 52
3. **Have you employed 20 or more employees during at least 50% of the preceding calendar year? (COBRA)** ☐ Yes ☐ No — **Total # of COBRA Enrollees**
4. **If you answered YES to question #3, do you want your COBRA participants on your bill?** (If yes, you must complete the "Group COBRA Direct Billing" contract) ☐ Yes ☐ No
5. **Have you employed 20 or more employees for 20 or more weeks during the current or preceding year? (TEFRA)** ☐ Yes ☐ No
6. **Average number of total employees (full-time, part-time and seasonal) in the preceding year?**
7. **Does your group currently have group medical coverage?** ☐ Yes ☐ No — **Carrier Name** | **Policy #** | **Termination Date** (MM/DD/YYYY)
8. **Eligible employees must work the following number of hours to qualify** ☐ 20+ hours a week ☐ 30+ hours a week
9. **Waiting Period for new employees is first day of the month following** ☐ Date of Hire ☐ 30 days ☐ 60 Days (NOT to exceed 90 days)
10. **Waiting period applies to** ☐ Future employees (hired after the effective date) ☐ Current and future employees (Current=hired on or prior to effective date) — **# in Waiting Period**
11. **Total number of employees on payroll regardless of hours worked** (including owners, seasonal, etc.)
    Total number of <u>active eligible</u> employees on payroll (including owners, seasonal, etc.)
    Total number of eligible employees <u>applying</u> for medical (including owners, seasonal, etc.)
12. **Number of employees waiving due to** A) Other Group Coverage — B) Other Individual Coverage
13. **Total number of <u>ineligible</u> employees in each of the following categories (write "0" if none)**
    A) Union | B) Part-time | C) Seasonal | D) Temporary | E) Terminated
14. **How many of the employees (including owners) enrolling are related by blood or marriage?**

43878

CC 0201 3/2017 Eff. 4/1/2017

C Metal Tier

Select **ONE** Metal Tier option to offer to your employees:

Single Tier	☐ BRONZE	☐ SILVER	☐ GOLD	☐ PLATINUM
Tiered Choice	☐ BRONZE/SILVER	☐ SILVER/GOLD	☐ GOLD/PLATINUM	

D Premium Contribution Method

CHOOSE ONLY ONE OPTION BELOW

☐ OPTION 1 PERCENTAGE OF COST

STEP 1: Enter the percentage amount you will contribute toward

Employee Premium [ ] % (50% minimum) Dependent Premium [ ] % (write 0 if none)

STEP 2: Apply contribution toward A*, B*, C*, D, E, F or G. (*If no HMO plan available to Employee, contribution will be based on lowest cost PPO plan)

A. ☐ Lowest cost HMO within the Metal Tier(s) selected.

B. ☐ HMO/HSP/EPO

Specific Health Plan: (select one benefit plan from the Metal Tier(s) selected in Section C)

*HSA Qualified High Deductible Plan

	Anthem Blue Cross	Health Net	Kaiser Permanente	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE	☐ EPO A ☐ EPO B*	☐ HSP A	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO B* ☐ HMO D*	☐ HMO A ☐ HMO B*	☐ HMO B* ☐ HMO C	☐ HMO B ☐ HMO C* ☐ HMO D*
SILVER	☐ HMO A ☐ EPO A ☐ EPO B*	☐ HSP A	☐ HMO B ☐ HMO C ☐ HMO D*	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C*
GOLD	☐ HMO A	☐ HMO A ☐ HMO B ☐ HSP A	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D*
PLATINUM	☐ HMO A	☐ HMO A	☐ HMO A	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B

C. ☐ HMO

Lowest cost benefit plan in HMO: (select one benefit level from the Metal Tier(s) selected in Section C)

	BRONZE	***SILVER***	***GOLD***	***PLATINUM***
HMO	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C

D. ☐ PPO

Specific Health Plan: (select one benefit plan from the Metal Tier(s) selected in Section C)

	Anthem Blue Cross	Health Net	Kaiser Permanente	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE							
SILVER	☐ PPO A ☐ PPO B						
GOLD	☐ PPO A ☐ PPO B ☐ PPO C ☐ PPO D						
PLATINUM							

E. ☐ PPO

Lowest cost benefit plan in PPO: (select one benefit level from the Metal Tier(s) selected in Section C)

	BRONZE	***SILVER***	***GOLD***		***PLATINUM***
PPO		☐ PPO A ☐ PPO B	☐ PPO A ☐ PPO B	☐ PPO C ☐ PPO D	

F. ☐ Lowest cost PPO within the Metal Tier(s) selected.

G. ☐ Any HMO, HSP, EPO or PPO plan selected by employee.

(CONTINUED ON NEXT PAGE)

D Premium Contribution Method (Cont.)

☐ OPTION 2 EMPLOYER FIXED DOLLAR AMOUNT

Enter the dollar amount(s) you will contribute toward any plan selected by the employee. (Employer must pay for at least 50% of each Employee's lowest cost premium)

$ _____ for Employee

$ _____ for Dependents (write 0 if none)

OR $ _____ Combined amount for Employee and Dependents

☐ OPTION 3 EMPLOYEE FIXED DOLLAR AMOUNT

STEP 1: Enter the dollar amount(s) the employee will contribute toward

$ _____ Employee Cost

$ _____ Additional for Spouse

$ _____ Additional for child(ren)

$ _____ Additional for Family

If you do not make an additional contribution for dependents enter "NA"

STEP 2: Apply contribution toward A or B

A. ☐ HMO/HSP/EPO

Specific Health Plan: ➡ (select one benefit plan from the Metal Tier(s) selected in Section C)

*HSA Qualified High Deductible Plan

	Anthem Blue Cross	Health Net	Kaiser Permanente	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE	☐ EPO A ☐ EPO B*	☐ HSP A	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO B* ☐ HMO D*	☐ HMO A ☐ HMO B*	☐ HMO B* ☐ HMO C	☐ HMO B ☐ HMO C* ☐ HMO D*
SILVER	☐ HMO A ☐ EPO A ☐ EPO B*	☐ HSP A	☐ HMO B ☐ HMO C ☐ HMO D*	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C*
GOLD	☐ HMO A	☐ HMO A ☐ HMO B ☐ HSP A	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D*
PLATINUM	☐ HMO A	☐ HMO A	☐ HMO A	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B

B. ☐ PPO

Specific Health Plan: ➡ (select one benefit plan from the Metal Tier(s) selected in Section C)

	Anthem Blue Cross	Health Net	Kaiser Permanente	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE							
SILVER	☐ PPO A ☐ PPO B						
GOLD	☐ PPO A ☐ PPO B ☐ PPO C ☐ PPO D						
PLATINUM							

Please be advised that Employee Enrollment Application forms are available in the following languages: Spanish, Chinese, Korean, Tagalog, Vietnamese and Russian - please contact your broker or California*Choice*® . Some translations in these languages are also available to your employees on an on-going basis as well as interpretation services in 150 different languages. California*Choice* would be glad to give you copies of the Employee Enrollment Application Form in the "threshold languages" of the Plan(s) your employees select. Please contact us or your broker to receive these.

E Statement of Compliance

I understand that no coverage will become effective until notified by the California*Choice*® Underwriting Department. I hereby certify that all information contained in the employer and employee applications are true and correct to the best of my knowledge.

I understand that California*Choice* will not consider my group approved until the funds have been received for our first month's premium payment. If such funds are not received or cannot be processed, my group will NOT be considered approved and will be terminated as of the original requested effective date. If such a termination is made, any expenses that may have been incurred due to utilization by our employees of health care services offered by a California*Choice* plan or carrier will not be the responsibility of California*Choice*, the health plan or carrier.

I understand that no alterations can be made to this section and that it must be signed exactly as stated. I have read and understand the following statements and confirm that my group complies with all the rules and regulations of the California*Choice* Program.

- Our Home Office is located in California.
- A majority (51+%) of our eligible employees reside in California.
- I will maintain all participation requirements including all eligible employees (as noted in the California*Choice* Underwriting Guidelines).
- California*Choice* coverage will be offered to all eligible employees on a uniform basis.
- All employees enrolling are currently working the minimum number of hours per week to be considered eligible (as noted in Section B) to enroll for California*Choice* coverage.

I understand that once California*Choice* coverage is approved, group policy changes cannot be implemented until the next Renewal (Anniversary Date). These changes shall include, but are not limited to COBRA provisions, minimum hours worked per week, and premium contribution amounts.
I understand the plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
I understand that once membership information is transmitted to the elected health plans, our group coverage effective date cannot be changed nor can our coverage be terminated until after the first month of coverage.
I understand that no alterations can be made to this section and that it must be signed exactly as stated.
I understand that the above statements are subject to audit at any time.
I understand that the above qualifications must be maintained in order for my group to continue coverage through California*Choice*.
I agree to provide California*Choice* with any and all information necessary to prove the above statements.
I understand that if I am unable to provide the requested information, all California*Choice* benefits will terminate 15 days following notice of termination, and employees will be held responsible for all services and charges incurred through California*Choice* program providers.
I understand that any persons, business, or health plan that suffers a loss because of false declarations contained in this Employer Application may have cause to bring civil action against our company to recover their losses.
I understand that premium payments are to be received by California*Choice* by the statement due date and if payment is not received by the due date, my group will be subject to a 10% late fee.
I understand that all California Applicants will be subject to Binding Arbitration (see Employee Application).

Owner/Partner Signature	Print Name	Date (MM/DD/YYYY)	Company Name

Signature of Broker of Record	Print Name	Date (MM/DD/YYYY)

(continued on next page)

E Statement of Compliance *(continued)*

To be completed by BROKER:

General Agent/PPGA Name (if applicable)

Broker Name (please print) **Must be broker name - not agency**

Co-broker Name (please print)

Phone # (XXX) XXX-XXXX | Fax # (XXX) XXX-XXXX

Phone # (XXX) XXX-XXXX | Fax # (XXX) XXX-XXXX

Commissions payable to | % Commission if split

Commissions payable to | % Commission if split

I certify that the employer applying for coverage through the California*Choice*® Program has met all participation requirements. Agent/Producer/Broker Attestation - To be completed by the agent/broker

1. To the best of my knowledge, the information on this application is complete and accurate.
2. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
3. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
4. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize California*Choice* to attribute such additions or changes to me.
5. I have advised the employer, in easy-to-understand language, that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until California*Choice* reviews and approves the application and the employer receives a written notice from California*Choice*. The employer understood my explanation.
6. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from California*Choice* shall be paid to an agent/producer/broker not appointed/approved by California*Choice*.
7. I have advised the client not to terminate any existing coverage until receiving written notification from California*Choice* that the coverage being applied for by this application is accepted.
8. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.
9. I understand that if any portion of this statement signed by me is willfully false, I may be subject to civil penalties as authorized under California Health and Safety Code Section 1389.8 and Insurance Code Section 10119.3: if I willfully state as true any material fact that I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000.

Broker Signature | Date (MM/DD/YYYY)

Co-Broker Signature | Date (MM/DD/YYYY)

Optional Benefits Application

Company Name _____

F Dental Insurance — SmileSaver℠ (Prepaid)/Ameritas† (PPO)

† When electing dental coverage, the undersigned employer hereby applies for membership in the Bankers Life Nebraska Preferred Trust.

Step 1: Select one plan offering

*PPO plans with Ortho are only available to groups with 5 or more eligible employees

- ☐ All buy-up dental plans: Prepaid 1000 & 3000, PPO 3000, 3500, 4000 & 5000 WITHOUT Ortho
- ☐ All buy-up dental plans: Prepaid 1000 & 3000, PPO 3000, 3500*, 4000* & 5000* WITH Ortho
- ☐ Voluntary Prepaid 3000

Groups electing PPO 3000, PPO 3500, PPO 4000 or PPO 5000 with 10 or more employees qualify for takeover benefits by submitting the following:
1) Group's most recent prior dental billing statement;
2) Statement from 12 months prior to effective date;
3) and 24 months prior showing Ortho for Ortho takeover

Step 2: Complete numbers 1-6 below for buy up dental plans only

(Do not complete for Voluntary Prepaid 3000)

1. Total number of employees applying for dental coverage _____
2. Total number of COBRA eligibles applying for dental coverage _____
3. Percentage of employee-only premium paid by Employer _____ *% (Employer must pay a minimum of 50%)*
4. Percentage of dependent premium paid by Employer _____ *% (write 0 if none)*
5. Employer contribution is based on plan *(Check one box only)* ☐ Prepaid 1000 ☐ Prepaid 3000 ☐ PPO 3000 ☐ PPO 3500 ☐ PPO 4000 ☐ PPO 5000
6. Does your group currently have dental? ☐ Yes ☐ No If yes, carrier name _____

G Voluntary Vision — EyeMed†/VSP†

†When electing vision coverage, the undersigned employer hereby applies for membership in the Bankers Life Nebraska Preferred Trust. Provided by Ameritas.

☐ Check this box if you would like to offer Voluntary Vision to your employees. Employees are responsible for 100% of this cost if they enroll in this coverage.

H ChiroPlus — Landmark Healthplan, Inc.

CHOOSE ONE PLAN ONLY ☐ Chiropractic Only ☐ Chiropractic & Acupuncture

I Life Insurance — Assurity Life Insurance Company

☐ **OPTION 1:** Flat Amount
Select a Flat amount for all employees

1. Amount $ _____
2. # of eligible employees _____

◄CHOOSE ONE OPTION ONLY►

Guaranteed Issue Amounts available for both Options

Eligible Employees	Minimum	Maximum
1-10	$10,000	$25,000
11-25	$10,000	$50,000
26-50	$10,000	$75,000
51-100	$10,000	$100,000

Amounts in between available in increments of $5,000

100% of all eligible employees (whether enrolling or waiving medical) must enroll for life coverage.

***Employees must fall under classification to qualify for specified amount ➡**

☐ **OPTION 2:** Scheduled Amount
Select up to 4 amounts with the highest being NO MORE THAN 2.5 X the lowest.
(amounts must be in increments of $5,000)

	Life Amount	Employee Classification* (i.e. management, executives, etc.)
$		
$		
$		
$		

J Section 125 — Premium Only Plan — CONEXIS Benefit Administrators (a division of WageWorks)

1. Name of Company President, Principal, or Partners _____
2. Name of Corporate Secretary (if applicable) _____
3. Plan Number (usually 501) _____ *(If not indicated, 501 will be used)*
4. State of Incorporation or Domicile (if applicable) _____
5. Company Structure ☐ Corporation ☐ Sole Proprietorship ☐ LLC ☐ S Corporation ☐ Partnership ☐ Other _____
6. Premium payments may be elected for ☐ Medical ☐ Dental ☐ Vision ☐ Other _____
7. Last day of first Plan year (MM/DD/YYYY) _____
(If not indicated, last day of medical plan year will be used)
Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date.

Participation Limitations - P.O.P. rules require that all participants in the plan be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore, are ineligible to participate in the P.O.P.
IMPORTANT: Read the information provided in the California*Choice*® Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Employer Signature _____ **Print Name** _____ **Date (MM/DD/YYYY)** _____