MASTER APPLICATION FOR LARGE GROUP EMPLOYERS

COMPANY INFORMATION

Exact Legal Name of Company:		"Doing Business As" (DBA):	
Street Address	City	State	Zip Code
Billing Address (if different from above):	City	State	Zip Code
Tax ID:	SIC Code:	Type of Business:	Years in Business:

Key Contacts

HR Manager: Phone: ( ) E-mail:

Billing: Phone: ( ) E-mail:

☐ **GO PAPERLESS!** By selecting this option you will receive all Plan documents via e-mail, including contracts and invoices. Thank you for helping MediExcel Health Plan's green initiative.

CA Coverage Health Insurance Carrier(s):	Name of Current Workers' Comp Carrier:	
Those not covered by Workers' Comp (List names and why):	Premium Billing Reference: ☐ Bill One Location ☐ Bill Multiple Locations	
Other Health Insurance Plans Offered:	Requested Effective Date:	Rate Structure: ☐ 3-Tier ☐ 4-Tier

PLAN SPECIFICATIONS

MediExcel Health Plan Offering:

☐ Value Plan 5 ☐ Value Plan 10 ☐ Value Plan 20

☐ Plan QEP ☐ Plan MEP

Enrolling in MediExcel Dental Plan: ☐ Yes ☐ No

If yes, choose Dental Plan option: ☐ D100 ☐ D200

OWNER/CORPORATE INFORMATION

Company is a: ☐ Sole Proprietor ☐ Partnership or LLC ☐ Corporation ☐ Non-Profit

REQUIRED ENROLLMENT INFORMATION

Total # of Employees: ____	Total # of Benefit Eligible Employees: ____	Total # Enrolling in MediExcel Health Plan: ____	Total # Enrolling in other Employer Sponsored Plans:___	Total # Declining Coverage: _____

Are all eligible employees subject to withholding as on a W-2 Form? ☐ Yes ☐ No

If no, please explain: _____

REQUIRED COBRA INFORMATION

Is your group currently subject to **Federal COBRA**? ☐ Yes ☐ No

(Employed 20 or more total employees during at least 50% of the working days in the previous calendar year)

Number of existing COBRA or Cal-COBRA participants: _____

Number of hours required per week to be eligible for benefits:

Full-time EE's: ☐ 30 hours ☐ 40 hours

☐ Other _____

Do you want to cover part-time employees that work 20-29 hours?

☐ Yes ☐ No ☐ Other _____

Employer Contribution Levels:

Employee _____% or $ Dependent _____% or $

Waiting Period for New Hires and Rehires

1st of the month following _____ days (for new hires). 1st of the month following _____ days for (rehires).

Domestic Partner Coverage (please check one) – Domestic Partner must also meet MediExcel Health Plan's dependent eligibility requirements as contractually defined:

☐ Yes Coverage: California State Registered (both partners have filed a Declaration of Domestic Partnership with the State of California. Both partners must be the same sex.

☐ No No Coverage for Domestic Partner

Leave of Absence:
Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence. (Maximum 3 months) ☐ None ☐1 month ☐ 2 months ☐ 3 months

Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence (Maximum 6 months) ☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

EMPLOYER HEALTH QUESTIONNAIRE (Complete **ONLY** if 10 EE's or less are enrolling)
Please answer the following questions to the best of your knowledge for your employees and/or dependents enrolling in MediExcel Health Plan, including any COBRA participants.

1) Is there any enrolling employee, dependent of an employee, or person who will be covered under this plan who has received an excess of $20,000 in medical care expenses in the last 2 years? ☐ Yes ☐ No

2) Is there any enrolling employee, dependent of an employee, or person to be covered under this plan who is unable to work or attend school due to an injury or illness? ☐ Yes ☐ No

3) Are there any enrolling dependent children incapable of self-support because of a physical or mental disability? ☐ Yes ☐ No

4) Are there any employees, dependents of an employee, or person(s) to be covered under this plan being treated or been hospitalized for any of the following: heart disease, kidney disorder, stroke, cancer, AIDS, AIDS Related Complex (ARC), diabetes, respiratory diseases, or any mental or nervous conditions? ☐ Yes ☐ No

FOR EACH QUESTION ANSWERED "YES," PLEASE EXPLAIN TO THE BEST OF YOUR ABILITY:

QUESTION #____: _____

QUESTION #____: _____

RESPONSIBILITIES FOR DISTRIBUTION OF THE SUMMARY OF BENEFITS AND COVERAGE ("SBC") TO PARTICIPANTS, BENEFICIARIES OR ELIGIBLE EMPLOYEES**:**

MediExcel Health Plan**:**

- Upon application: as part of any written application materials provided by MediExcel Health Plan
- Upon request

Employer Group**:**

- All other SBC delivery requirements including, but not limited to, delivery to special enrollees, delivery to enrollees added to the Plan after open enrollment and newly eligible employees

Application is hereby made for a MediExcel Health Plan Group Subscriber Agreement. This is an application only. Issuance of a Group Subscriber Agreement is subject to receipt of first month's premium and review and approval by MediExcel Health Plan. All eligible employees and dependents will be offered this benefit package. If accepted, the employer agrees to make required payroll deductions based upon the contributions established herein for all employees who enroll in this plan. The applicant also agrees to notify all eligible employees of their ability to enroll in the plan after their waiting period.

_____ _____/_____ _____
X Signature of Company Officer or Owner **Print Name and Title** **Date**

REQUIRED BROKER / GENERAL AGENCY INFORMATION

Broker Agency:

Broker Name:

Tax ID: **License #:**

General Agency (please check one): **Yes** ☐ **No** ☐

General Agency Name:

_____ _____ _____
X **Broker/Agent Signature** **Broker/Agent Name (Print)** **Date**