



MASTER APPLICATION FOR SMALL 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:	
<input type="checkbox"/> 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 <u>not</u> covered by Workers' Comp (List names and why):		Premium Billing Reference: <input type="checkbox"/> Bill one locations <input type="checkbox"/> Bill Multiple Locations	
Other Health Insurance Plans Offered:		Requested Effective Date:	

PLAN SPECIFICATIONS

MediExcel Health Plan Offering:	Enrolling in Dental Plan:	If yes, choose tier level:
<input type="checkbox"/> Ultra-Platinum Plan (P5) <input type="checkbox"/> Platinum Plus Plan (P20) <input type="checkbox"/> Platinum Mirror Plan (PM) <input type="checkbox"/> Gold Mirror Plan (GM)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D100 <input type="checkbox"/> D200	<input type="checkbox"/> 3-Tier <input type="checkbox"/> 4-Tier

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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, please explain: _____				

REQUIRED COBRA INFORMATION

Is your group currently subject to **Cal-COBRA**? Yes No
 (Employed 2-19 employees during at least 50% of the working days in the previous calendar year or previous quarter if not in business in the previous calendar year, and are not subject to Federal COBRA)

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: <input type="checkbox"/> 30 hours <input type="checkbox"/> 40 hours <input type="checkbox"/> Other _____ Do you want to cover part-time employees that work 20-29 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____	Employer Contribution Levels: Employee _____% or \$ Dependent _____% or \$
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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

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