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

Routine:	Phone: ( )	E-mail:	Text: ( )
Billing:	Phone: ( )	E-mail:	Text: ( )
Executive:	Phone: ( )	E-mail:	Text: ( )

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 Medical Plan Offering:	Enrolling in Dental Plan: ☐ Yes ☐ No
☐ Value Plan 5 ☐ Value Plan 10 ☐ Value Plan 20	☐ D100 ☐ D200 ☐ 3-Tier ☐ 4-Tier
☐ Plan QEP ☐ Plan MEP	

OWNER/CORPORATE INFORMATION

Company is a: ☐ Sole Proprietor ☐ Partnership or LLC ☐ Corporation

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 **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: ____

Dependent Coverage: MediExcel Health Plan will default Coverage to include spouse, domestic partner and children to age 26, unless checked below. Please be advised you may be subject to federal penalties for excluding Coverage to Dependents. Note that offering Dependent Coverage does not require employer contribution. ☐ **No Dependent Coverage**	**Employer Contribution Levels:** Employee _____% or $ Dependent _____% or $

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 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 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 employees, dependents of employees, or person(s) to be covered under this plan who are currently pregnant? ☐ Yes ☐ No

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

5) 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 # ____________________

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/Owner ____________________ Print Name/Title ____________________ Date ____________

REQUIRED BROKER / GENERAL AGENCY INFORMATION

Broker Agency:

Broker Name:

Tax ID: **License #:** **Telephone #:**

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

General Agency Name:

X Broker/Agent Signature ____________________ Broker/Agent Name (Print) ____________________ Date ____________