



CALIFORNIA

Small Business Employer Group Application

Effective October 1, 2005

SMALL BUSINESS GROUP APPLICATION

Source Code	Tracking #
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Important: Please Print or Type All Sections in Black Ink

Legal Name of Group/DBA		Phone ()	Fax ()	E-mail Address
Address		City	County	State
<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other:		Start Date of Business		Employer Tax ID#
Executive/Employer Contact		Title	Phone ()	E-mail Address
Administrative/Service Contact		Title	Phone ()	E-mail Address
Billing Contact		Title	Phone ()	E-mail Address
Billing Address		City	State	ZIP
List Current Medical Carrier(s):	Years with Carrier:	List Current Dental and/or Vision Carrier(s):	Years with Carrier:	

Are you subject to a local living wage law? Yes No

Did you have health care coverage for the employees under the local living wage law prior to January 1, 2003? Yes No

Are you subject to ERISA regulations? Yes No Do you currently have a workers' compensation policy in force? Yes No

Type of Business	SIC Code	List current workers' compensation carrier:
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Are all employees covered under workers' compensation? Yes No If no, please state reason:

Please list the name and job title of all individuals to be included for medical coverage not eligible for workers' compensation:

Name	Title	E-mail Address
Name	Title	E-mail Address

Total number of **eligible employees enrolling** in PacifiCare: Medical: Dental: Vision: Life:

Number of eligible employees waiving medical coverage: _____	Number of permanent full-time (30+ hours per week) employees: _____	Number of permanent full-time (30+ hours per week) employees who work or reside outside of CA : _____
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Please complete if offering health care coverage to permanent part-time employees (at least 20 but less than 29 hours per week):	Number of permanent part-time employees: _____	Number of permanent part-time employees who work or reside outside of CA : _____
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Contribution

Medical (Employer: 50% min.) Employee _____% Dependents _____%	Dental (Employer: 50% min.) Employee _____% Dependents _____%	Vision (Employer: 50% min.) Employee _____% Dependents _____%	Life Employee _____% Dependents _____%
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Eligibility

NOTE: Independent contractors whose income is reported on IRS Form 1099, part-time, seasonal and leased employees are ineligible. Eligible employees and rehires must be full-time permanent employees who work at least thirty (30) hours per week or permanent part-time employees who work at least twenty (20) hours per week but not more than twenty-nine (29) hours per week, and the employer offers employees health coverage under a health benefit plan to all similarly situated individuals. In addition, eligible employees must complete the employer's required waiting period of: _____ (max. 6 months).

Rehire Eligibility: 1st of month following _____ months	Total employees in waiting period: _____	How long do you continue paying health care premiums for employees on leave of absence? (max. 6 months): _____
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Continuation Coverage

Please provide details on ALL COBRA participants below. In addition, please provide a list of AB1401 COBRA, Cal-COBRA and/or Senior COBRA enrollees from your current carrier.

Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date

If AB1401 COBRA, Cal-COBRA and/or Senior COBRA enrollees are added after the initial group enrollment, the group may be subject to re-rate.

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Plan Coverage

Requested effective date: (coverage must begin 1st of the month) *Note: PacifiCare SignatureOptionsSM, PacifiCare SignatureIndependenceSM and PacifiCare SignatureFreedomSM plans are underwritten by PacifiCare Life and Health Insurance Company.*

Medical Plans

<p>Stand Alone – Select any plan, except PacifiCare SignatureIndependence</p> <p>Dual Option¹ – Select one PacifiCare SignatureValue or PacifiCare SignatureValue Advantage plan and one of the following plans: any of the PacifiCare SignatureFreedomSM or PacifiCare SignatureOptionsSM plans (except 70–50/2000 (PPO) and 70–50/3500 (PPO))</p> <p>Choice Series² – Select up to 4 PacifiCare SignatureValue, PacifiCare SignatureValue Advantage* and/or PacifiCare SignatureOptions plans, except 70–50/2000 (PPO), 70–50/3500 (PPO) and all HSA-Compatible plans.</p> <p>*PacifiCare SignatureValue plans may not be offered alongside PacifiCare SignatureValue Advantage plans.</p>	<p>PacifiCare SignatureValueSM (HMO)</p> <input type="checkbox"/> 10–30/100 <input type="checkbox"/> 15–30/250a <input type="checkbox"/> 10/500d ³ <input type="checkbox"/> 20–40/500d ³ <input type="checkbox"/> 35/600d ³	<p>PacifiCare SignatureOptionsSM (PPO)</p> <input type="checkbox"/> 15/90–50/250 <input type="checkbox"/> 20/80–60/250 <input type="checkbox"/> 30/70–50/250 <input type="checkbox"/> 35/80–60/500 <input type="checkbox"/> 35/70–50/1000 <input type="checkbox"/> 35/50–50/1000 <input type="checkbox"/> 70–50/2000 ³ (PPO) <input type="checkbox"/> 70–50/3500 ³ (PPO)	<p>PacifiCare SignatureOptionsSM (HSA-Compatible)</p> <input type="checkbox"/> 100–50/5000 <input type="checkbox"/> 80–50/2700 <input type="checkbox"/> 70–50/3500 (HSA-Compatible)	
	<p>PacifiCare SignatureValueSM Advantage (HMO Value)</p> <input type="checkbox"/> 10/500d ³ (HMO Value) <input type="checkbox"/> 35/600d ³ (HMO Value)			<p>PacifiCare SignatureIndependenceSM (Indemnity)</p> <input type="checkbox"/> 80/1000 ⁴
	<p>PacifiCare SignaturePOSSM (POS)</p> <input type="checkbox"/> 15/80–60			<p>PacifiCare SignatureFreedomSM (SDHP)</p> <input type="checkbox"/> 80–50/2000 <input type="checkbox"/> 80–50/2000 with Dental <input type="checkbox"/> 70–50/2000 (SDHP) <input type="checkbox"/> 70–50/2000 with Dental <input type="checkbox"/> 50–50/3000 <input type="checkbox"/> 50–50/3000 with Dental
	<input type="checkbox"/> Age Rates <input type="checkbox"/> Composite Rates (not available for groups purchasing the Choice Series and for groups with less than 16 enrolled employees)			
	<p>Will you self-fund any portion of your employees' cost-sharing by offering a wrap-around plan, such as a Health Reimbursement Account (HRA), in addition to your PacifiCare Small Group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

- Groups must have at least 5 eligible employees enrolling with PacifiCare to purchase this option.
- Groups must have at least 10 eligible employees enrolling with PacifiCare to purchase this option.
- By selecting this plan, the Group has chosen not to offer Infertility Services to its employees. The Group understands that PacifiCare covers Infertility Services in other Small Business plans.
- Must purchase at least one PacifiCare SignatureValue, PacifiCare SignatureValueSM Advantage, PacifiCare SignaturePOS, PacifiCare SignatureOptions or PacifiCare SignatureFreedom plan with this plan.
- Please answer the following question if you are purchasing the PacifiCare SignatureOptions (PPO) 70–50/2000 or 70–50/3500 Plan:

Dental and Vision Plans
Dual Choice Dental: Select one PacifiCare SignatureValue and one PacifiCare SignatureOptions Dental and/or PacifiCare SignatureIndependence plan or PacifiCare SignatureSavings program.

PacifiCare SignatureValue SM (HMO)		PacifiCare SignatureOptions SM (PPO)			PacifiCare SignatureIndependence SM (Indemnity)	
Contributory	Voluntary	Contributory ⁶	Voluntary ⁷	Contributory	Contributory	Voluntary ⁷
<input type="checkbox"/> Dental 140 <input type="checkbox"/> Dental 142 <input type="checkbox"/> Dental 144 <input type="checkbox"/> Dental 146	<input type="checkbox"/> Dental 140 <input type="checkbox"/> Dental 142 <input type="checkbox"/> Dental 144 <input type="checkbox"/> Dental 146	<input type="checkbox"/> Dental 410 <input type="checkbox"/> Dental 420 <input type="checkbox"/> Dental 440 <input type="checkbox"/> Dental 460 <input type="checkbox"/> Child-Only Orthodontic Rider Please choose: Calendar Year Max <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500* Endo, Perio, OS in Major ⁹ <input type="checkbox"/> Yes <input type="checkbox"/> No	Deductible <input type="checkbox"/> \$50 In / \$100 Out <input type="checkbox"/> Dental 410 <input type="checkbox"/> Dental 420 <input type="checkbox"/> Dental 440 <input type="checkbox"/> Dental 460	<input type="checkbox"/> Vision 480 <input type="checkbox"/> Vision 490 <input type="checkbox"/> Vision 499	<input type="checkbox"/> Dental 805 <input type="checkbox"/> Dental 815 <input type="checkbox"/> Child-Only Orthodontic Rider	<input type="checkbox"/> Dental 805 <input type="checkbox"/> Dental 815
					<p>PacifiCare SignatureSavings^{SM10} Discount Dental and Vision Program</p> <input type="checkbox"/> 510 <input type="checkbox"/> Group Bill <input type="checkbox"/> Individual Bill	

Supplemental Benefits		Other Coverage (required)
<p>Group Term Life: Benefit: _____ Offered by American Medical Security Life Insurance Company (AMS LIC)*</p>	<input type="checkbox"/> Chiropractic/Acupuncture Supplemental Chiropractic/ Acupuncture through an arrangement with American Specialty Health Plans (for PacifiCare SignatureValue, PacifiCare SignatureValue Advantage and PacifiCare SignaturePOS only)	<p>Domestic Partners Coverage All PacifiCare plans include Domestic Partner coverage as required by state law.</p>

6 Groups with 2-9 eligible employees may only select \$1,000 Calendar Year Maximum, \$50 In / \$100 Out Deductible.
 7 For Voluntary Groups, only Fee Schedule plans are available to group of 5+.
 8 Groups of 10-24 must have a \$1,500 Calendar Year Maximum to purchase \$1,500 Calendar Year Maximum coverage.
 9 Endo, Perio, OS in Basic is only available to groups 25 or more.
 10 PacifiCare SignatureSavings is a discount access program offered by PacifiCare Dental and Vision Administrators and is not a health maintenance organization or insurance product.
 *Group Term Life Insurance requires a completion of a separate application
 NOTES: 12-Month wait on Major Services can be waived with proof of prior coverage. Dual Choice not available on all plans. Groups without any current dental coverage may only select from the following options: PacifiCare SignatureValue and PacifiCare SignatureSavings 510.

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Signature Required for Terms and Conditions and Arbitration Disclosure

Terms and Conditions

I hereby certify that all statements on this document are complete and true to the best of my knowledge and belief, and I understand that PacifiCare will rely on these statements and this information as the basis for approving this Application. I have read and understand the information herein. Further, the authorized person agrees to PacifiCare's payment terms and conditions. Undersigned represents that he/she is an authorized person of the small employer group applying for the coverage indicated above and is authorized to enter into a PacifiCare Health Plan Medical and Hospital Group Subscriber Agreement and/or PacifiCare Life and Health Insurance Co. Group Policy on the small employer group's behalf. It is understood for the purposes of compliance with ERISA, the undersigned employer is to be named fiduciary of the employee benefit plan covered under this policy.

Arbitration Disclosure

EMPLOYER AGREES AND UNDERSTANDS THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, INC., OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Authorized Signature	Date
Print Name	Title

Check here if you do not have a broker of record. If you do, please complete the information below:

PacifiCare compensates Agents/Brokers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use an Agent/Broker. Please contact your Agent/Broker, if applicable, regarding the amount of compensation. In addition, you may request information regarding broker commissions attributable to your policy by contacting PacifiCare Membership Accounting.

Broker Information

(Signature above acknowledges broker assignment) If a split commission, please attach payee information including percentages for each payee.

Agent Name	Firm Name	Phone ()	E-mail Address
Address	City	State	ZIP ()
Payee: <input type="checkbox"/> Agent or <input type="checkbox"/> Firm			
Payee's SS# or Tax ID #:	Payee's California License #:	Expiration Date	
Broker Signature			

FOR INTERNAL USE ONLY:

G.A. #	A.P. #	MKTG. #	G.C. #
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PacifiCare products and services are offered by one or more of the following PacifiCare family of companies: Health plan products and services are offered by PacifiCare of California, PacifiCare Behavioral Health of California, Inc., and PacifiCare Dental (in California). Indemnity insurance products (including PPO products) are underwritten by PacifiCare Life and Health Insurance Company. Other products and services are offered by PacifiCare Health Plan Administrators, Inc., RxSolutions, Inc., and PacifiCare Behavioral Health, Inc. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.

Groups with 10-50 enrolling employees must complete the Medical Questionnaire on the next page.

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Small Business Medical Questionnaire

For Small Employer Groups with 10–50 enrolling Employees only

Employer groups with 2-9 enrolling employees must have each employee complete the Small Business Individual Health Statement with the enrollment form.

Small Business Employers must answer the questions below to the best of their knowledge. PacifiCare reserves the right to use the entire New Group Submission materials, including, but not limited to, Employer Group Application, Employer Medical Questionnaire, DE6, Enrollment/Declination Forms and any other requested documentation to determine the group's Risk Adjustment Factor and eligibility. Rates and eligibility are based on the actual number of enrolled and on Underwriting approval.

Company Name	Number of Enrolling Employees
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- To the best of your knowledge, are any of your employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) pregnant? Yes No If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.
- Do you have Federal COBRA participants? Yes No Do you have Cal-COBRA participants? Yes No
If "yes," please list number of Federal COBRA participants _____ and/or Cal-COBRA participants _____ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, have any employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) been treated in the last 5 years for cancer, heart disease/condition, stroke, Acquired Immune Deficiency Syndrome (AIDS), ARC, nervous or mental condition, or any other serious or chronic, continuing condition that required hospitalization or medical treatment? Yes No
If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, have any employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) been treated in the last 12 months for arthritis, hypertension, diabetes, epilepsy, ulcers, hepatitis or hypo/hyperthyroidism? Yes No
If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, have any employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) been advised by a medical professional to have surgery in the past 12 months or anticipate hospitalization for any other reason? Yes No
If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, are you aware of any employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) who suffered a condition which resulted in expenses of \$5,000 or more, or have been hospitalized during the past 24 months?
 Yes No If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, are you aware of any employees, Dependents or continuation Members (COBRA and/or Cal-COBRA) to be covered who have been unable to work due to injury or illness within the past 12 months? Yes No
If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, are you aware of any employees who are currently being treated by a medical professional for alcoholism or chemical dependency, or have been advised by a medical professional to seek treatment for these conditions?
 Yes No If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.
- To the best of your knowledge, are you aware of any employees who are currently hospitalized or have been told extensive medical treatment, surgery or hospitalization is required? Yes No If "yes," please list number of persons _____ and submit a completed Individual Health Statement for each person.

I verify, to the best of my knowledge, that the above answers are true and correct.

Small Business Employer's Name: (print) _____

Authorized Representative/Employer's Signature _____ Date _____

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Dental & Vision Administrators Employer Agreement

Small employer groups who are electing dental and/or vision coverage

- I understand the pre-existing conditions limitations of the insurance plan and understand that coverage is renewable at the option of the Underwriting Company.
- I understand the underwriting and participation requirements and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The Open Enrollment period shall be during group's 11th month of annual continuous coverage.
- For the PacifiCare SignatureIndependence Plan and the PacifiCare SignatureOptions Plan, I understand that there is a one-year waiting period for "Major" dental services. This waiting period will be waived for employees/Dependents listed on the prior carrier's billing at the time of transfer to a PacifiCare SignatureIndependence or PacifiCare SignatureOptions plan. New hires are subject to a one-year waiting period for all "Major" dental services. "Major" dental services include crowns, dentures and bridges OR crowns, dentures, bridges, oral surgery, periodontics and endodontics.
- The PacifiCare SignatureIndependence and PacifiCare SignatureOptions dental and vision plans are underwritten by PacifiCare Life and Health Insurance Company.
- The PacifiCare SignatureValue dental plans are offered by PacifiCare Dental.

For the PacifiCare SignatureIndependence plans only, please initial the following statement:

The undersigned employer hereby adopts and enrolls in the group insurance plan of the Vanguard Group Dental Trust and subscribes to the terms of the Trust agreement which established such Trust. It is understood that no coverage is in force until notice of approval has been furnished by the Trust Administrator and premium has been received by the Trust Administrator.

I further acknowledge and agree that no one other than the Trustees or a person designated in writing by the Trustees may accept this application on behalf of the Vanguard Group Dental Plan Trust, and that no agent or broker has the authority to change any provision of the master policy or of the Trust. _____ (Initials of authorized person)

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge. I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Signature of Authorized Person for Employer _____ Date Signed _____

Broker or General Agent Signature _____ Date Signed _____

**P.O. Box 6006
M/S CY24-515
Cypress, CA 90630
www.pacificare.com**

Customer Service:

- PacifiCare SignatureValueSM (HMO): 1-800-624-8822
or 1-800-442-8833 (TDHI)
- PacifiCare SignaturePOSSM (POS): 1-800-913-9133
or 1-800-442-8833 (TDHI)
- PacifiCare SignatureOptionsSM (PPO) or
PacifiCare SignatureIndependenceSM (Indemnity): 1-866-316-9776
or 1-866-816-2018 (PPO/Indemnity TDHI)
- PacifiCare SignatureFreedomSM (SDHP): 1-866-867-0700
or 1-866-867-0701 (TDHI)
- PacifiCare Dental and Vision Administrators: 1-800-228-3384