



**Blue Shield of California**  
An Independent Member of the Blue Shield Association

**Master Group Application  
For 2–50 Employees**



® Registered mark of the Blue Shield Association, an Association of Independent Blue Shield Plans  
® Registered mark of CPIC Life Insurance Company

## Get on the fast track

This handy checklist will make it easier for you to assemble all the information and forms we need to process your application package. Check all the boxes and it's ready to go!

- Master group application
- Employees' enrollment applications
- Health Statements are required for guaranteed issue groups of 2 – 24 eligible enrolling employees.
- Employer Questionnaires are required for guaranteed issue groups of 25 or more eligible enrolling employees. These must be dated within 45 days of the requested effective date.
- "Sole Proprietor, Partner, or Corporate Officer Statement" (form C-15293) for all enrolling owners/officers.
- Wage information for each enrolling employee will be required for eligibility verification as follows:
  - DE-6 for the previous quarter (notate updated employee status, i.e., part-time, full-time or terminated).
  - All four DE-6s from the previous year if group eligibility is based on, or includes, part-time employees.
  - Payroll records (for employees hired after the DE-6 filing)
  - Proof of owner/employer's eligibility if the owner/employer is not listed on the DE-6 (same as noted under "Owner Only Groups" below)
- Refusal of Coverage Forms for all eligible employees and any eligible dependents who refuse coverage.
- A copy of the previous carrier's current billing statement (if applicable)
- Disability form (if applicable)
- A **business check** in the amount of the first month's dues as a deposit. Blue Shield will refund the full deposit to the group if the group application is declined.
- For groups that choose Blue Shield Dental HMO or Dental PPO only, enclose a separate business check for the deposit for the dental portion of the dues, payable to Blue Shield.
- For groups that choose the stand-alone CPIC Life insurance products, send a separate business check for the deposit made payable to CPIC Life. Send it directly to CPIC Life with a copy of the CPIC Life Group Master Application New Group and Plan Design Summaries, and employee enrollment forms.
- Owner Only Groups will be required to submit documentation stating that they are active businesses, employing permanent, full-time employees, including but not limited to the following documentation:
  - Sole Proprietorship: 1040 Schedule C for the preceding calendar year
  - Partnership: K-1 for the preceding year for each partner

Corporation: Articles of Incorporation (state seal affixed) including officers; K-1 or signed refusal for each officer eligible for coverage

checklist

# MASTER GROUP APPLICATION

## (for 2-50 employees)

GROUP BILLING UNIT

DO NOT WRITE IN SHADED AREA

ACCESS+ HMO	Shield Spectrum PPO	Added Advantage POS	Shield Spectrum PPO Savings Plan	ACTIVE CHOICE	ACCESS BAJA HMO	DENTAL HMO	DENTAL PPO	OTHER
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**PLEASE TYPE OR PRINT CLEARLY. USE BLACK INK.**

<b>1</b>	FULL LEGAL BUSINESS NAME	EFFECTIVE DATE
<b>2</b>	BILLING ADDRESS (NUMBER, STREET, CITY, STATE, ZIP) IF P.O. BOX, COMPLETE NO. 3 BELOW	
<b>3</b>	PHYSICAL ADDRESS OF BUSINESS (IF DIFFERENT FROM ABOVE)	COUNTY
<b>4</b>	GROUP CEO NAME	GROUP CONTACT PERSON NAME/TITLE
		PHONE NUMBER ( )
		FAX NUMBER ( )
<b>5</b>	LEGAL ENTITY <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> OTHER (SPECIFY)	EMPLOYER TAX ID NUMBER EMPLOYER TAX ID # _____
<b>6</b>	TYPE OF BUSINESS (PROVIDE AS MUCH DETAIL AS POSSIBLE), LIST THE MAJOR INDUSTRIES AND PRODUCTS/SERVICES OF YOUR BUSINESS. IF KNOWN, LIST THE STANDARD INDUSTRY CLASSIFICATION CODE(S) (SIC CODE) IN WHICH THE BUSINESS IS CLASSIFIED.	
<b>7</b>	LIST SUBSIDIARY, OR AFFILIATED COMPANIES. GIVE NAME(S), ADDRESS(ES). IDENTIFY WHICH SUBSIDIARIES SHOULD BE INCLUDED IN THE COVERAGE.	IF NO SUBSIDIARY/AFFILIATED COMPANIES APPLY, CHECK "N/A" <input type="checkbox"/> N/A
<b>8</b>	PRIOR GROUP HEALTH CARRIER(S)	DO YOU OFFER OTHER CARRIER'S HEALTH PLANS TO YOUR EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO
		IF YES, ENTER DATES OF OPEN ENROLLMENT PERIOD FROM: _____ TO: _____
	EMPLOYEES TO BE EFFECTIVE ON	
	IF OTHER HEALTH CARRIER IS OFFERED (IN ADDITION TO BLUE SHIELD) LIST CARRIER NAME AND # OF EMPLOYEES COVERED BY THIS CARRIER NAME: _____ # EMPLOYEES _____	
	ARE YOU PLANNING ON OFFERING ANY TYPE OF SELF-FUNDED WRAP-AROUND PLAN, IN ADDITION TO YOUR BLUE SHIELD OF CALIFORNIA GROUP PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIOR DENTAL CARRIER(S)
		DO YOU OFFER OTHER CARRIER'S DENTAL PLANS TO YOUR EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO
		IF YES, ENTER DATES OF OPEN ENROLLMENT PERIOD FROM: _____ TO: _____
	EMPLOYEES TO BE EFFECTIVE ON	
	IF OTHER DENTAL CARRIER IS OFFERED (IN ADDITION TO BLUE SHIELD) LIST CARRIER NAME AND # OF EMPLOYEES COVERED BY THIS CARRIER NAME: _____ # EMPLOYEES _____	
<b>9</b>	FUTURE EMPLOYEE WAITING PERIOD: _____ MONTHS (MINIMUM 0, MAXIMUM 6 MONTHS). DOES THIS WAITING PERIOD APPLY TO CURRENT EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO UNLESS OTHERWISE NOTED, EMPLOYEES HIRED ON THE 1 <sup>ST</sup> OF THE MONTH WILL BE EFFECTIVE ON THE 1 <sup>ST</sup> OF THE MONTH FOLLOWING THE COMPLETION OF THE WAITING PERIOD. EMPLOYEES EFFECTIVE DATE IS THE FIRST BILL DATE FOLLOWING THE WAITING PERIOD.	
<b>10</b>	<b>TOTAL # OF ALL EMPLOYEES</b>	<b>TOTAL # OF ELIGIBLE EMPLOYEES</b>
	<b>TOTAL # OF ENROLLED EMPLOYEES</b>	<b>ACCESS+ HMO</b>
		<b>Shield Spectrum PPO</b>
		<b>Added Advantage POS</b>
		<b>Shield Spectrum PPO Savings Plan</b>
		<b>ACTIVE CHOICE</b>
		<b>ACCESS BAJA HMO</b>
		<b>DENTAL HMO</b>
		<b>DENTAL PPO</b>
	NUMBER OF FULL TIME EMPLOYEES IN WAITING PERIOD: _____ NUMBER OF EMPLOYEES WHO ARE DECLINING COVERAGE _____ <b>EMPLOYER IS RESPONSIBLE FOR COLLECTING REFUSAL OF COVERAGE.</b>	
	FOR EMPLOYERS OF FEWER THAN 20 EMPLOYEES: DO YOU CURRENTLY HAVE AN EMPLOYEE WHO IS 65 YEARS OR OLDER AND IS ELIGIBLE FOR MEDICARE PRIMARY RATES? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, PLEASE PROVIDE A COPY OF QUALIFYING MEDICARE CARD(S).</b>	
	ARE THERE ANY OUT-OF-STATE EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MANY OUT-OF-STATE EMPLOYEES DO YOU HAVE? _____	
	DO YOU WISH TO OFFER COVERAGE TO YOUR OUT-OF-STATE EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>11</b>	<b>ARE ALL FULL TIME ELIGIBLE EMPLOYEES BEING OFFERED HEALTH COVERAGE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE EXPLAIN:	
	<b>ARE ALL OF THE FULL TIME ELIGIBLE EMPLOYEES TO WHOM YOU WILL BE OFFERING HEALTH COVERAGE ACTIVELY WORKING AT LEAST 30 HOURS PER WEEK?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE EXPLAIN:	
	DO YOU WISH TO OFFER COVERAGE FOR YOUR PERMANENT EMPLOYEES WHO WORK FEWER THAN 30 BUT NOT FEWER THAN 20 HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>12</b>	DO YOU WISH TO OFFER COVERAGE FOR DOMESTIC PARTNERS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COVERAGE FOR: <input type="checkbox"/> SAME SEX <input type="checkbox"/> SAME SEX AND OPPOSITE SEX	
<b>13</b>	FOR EMPLOYER CONTRIBUTION, ENTER PERCENT OF DUES PAID BY EMPLOYER FOR EEs (EMPLOYEES) AND DEPs (DEPENDENTS). <b>IF 100%, ALL ELIGIBLE EMPLOYEES MUST ENROLL.</b>	
	ACCESS+ [FOR EEs _____ %] <b>ADDED ADVAN-</b> [FOR EEs _____ %] <b>SHIELD SPEC-</b> [FOR EEs _____ %] <b>SHIELD SPECTRUM</b> [FOR EEs _____ %] <b>DENTAL</b> [FOR EEs _____ %] <b>DENTAL</b> [FOR EEs _____ %]	<b>HMO</b> [FOR DEPs _____ %] <b>TAGE POS</b> [FOR DEPs _____ %] <b>TRUM PPO</b> [FOR DEPs _____ %] <b>PPO SAVINGS PLAN</b> [FOR DEPs _____ %] <b>HMO</b> [FOR DEPs _____ %] <b>PPO</b> [FOR DEPs _____ %]
<b>14</b>	ARE ALL EMPLOYEES COVERED BY WORKERS' COMPENSATION, AS REQUIRED BY LAW? <input type="checkbox"/> YES CARRIER NAME: _____ <input type="checkbox"/> NO PLEASE EXPLAIN: ARE ALL OFFICERS AND PARTNERS COVERED BY WORKERS' COMPENSATION, AS REQUIRED BY LAW? <input type="checkbox"/> YES CARRIER NAME: _____ <input type="checkbox"/> NO PLEASE EXPLAIN:	
<b>15</b>	ARE ANY COBRA PARTICIPANTS ENROLLING IN THE BLUE SHIELD PLAN DISABLED OR HOSPITALIZED, AND ARE ANY ACTIVE EMPLOYEES CURRENTLY NOT WORKING, DISABLED OR HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, COMPLETE DISABILITY ADDENDUM FORM NUMBER C-11248)	
<b>16</b>	A) IS YOUR GROUP CURRENTLY SUBJECT TO CAL-COBRA? (EMPLOYED 2-19 EMPLOYEES FOR AT LEAST 50% OF THE WORKING DAYS IN THE PREVIOUS CALENDAR YEAR) <input type="checkbox"/> YES <input type="checkbox"/> NO B) IS YOUR GROUP SUBJECT TO FEDERAL COBRA? (EMPLOYED 20 OR MORE EMPLOYEES DURING AT LEAST 50% OF THE WORKING DAYS IN THE PREVIOUS CALENDAR YEAR) <input type="checkbox"/> YES <input type="checkbox"/> NO C) IF YOUR GROUP IS SUBJECT TO FEDERAL COBRA, DO YOU WISH TO WAIVE COBRASERV? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE ATTACH A COPY OF THE COBRASERV WAIVER FORM. D) HOW MANY EXISTING COBRA OR CAL-COBRA PARTICIPANTS DO YOU HAVE? _____ HOW MANY IN ELIGIBILITY PERIOD? _____	

