

MASTER APPLICATION

COMPANY INFORMATION				
Exact Legal Name of Company:			"Doing Business As" (DBA):	
Street Address		City	State	Zip Code
Billing Address <i>(If different from above)</i> :			Requested Start Date:	
Key Contacts: Routine:	Phone: ()	Fax: ()		
Billing:	Phone: ()	Fax: ()		
Executive:	Phone: ()	Fax: ()		
e-mail address:				
Type of Business <i>(please provide as much detail as possible)</i> :				Yrs. In Business:
Name of Current Workers' Comp Carrier:		Those <u>not</u> covered by Workers' Comp <i>(List names and why)</i> :		
Prior Health Insurance Carrier:	Other Health Insurance Plans Offered:	Rate Structure <i>(Small groups only)</i> : Age-banded Composite <i>(Must have 10+ enrolled)</i>		
Premium Billing Preference: Bill one location Bill multiple locations <i>(with fee)</i>		COBRA Billing Preference <i>(if applicable)</i> : Bill employer Bill COBRA enrollee directly <i>(with fee)</i>		

PLAN SPECIFICATIONS				
MEDICAL PLANS: Large Group				
E-1 (\$15 office copay /\$25 Specialist Physician copay /100% Hospitalization)				
E-2 (\$25 office copay /\$35 Specialist Physician copay /\$500 Hospitalization copay per admission)				
E-3 (\$40 office copay /\$40 Specialist Physician copay /\$1,500 Hospitalization copay per admission)				

ELIGIBILITY				
Total # of Employees:	Total # of Benefits Eligible Employees:	Total # Enrolled in Sharp Health Plan:	Total # Enrolled in other Employer Sponsored Plans:	Total # Declining Coverage:
Is your group currently subject to <u>Cal-COBRA</u> ? Yes No <i>(Employed 2-19 employees on 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)</i>			Number of hours required per week to be eligible for benefits: Full time EE's 30 hours 40 hours Other _____	
Is your group currently subject to <u>Federal COBRA</u> ? Yes No <i>(Employed 20 or more total employees during at least 50% of the working days in the previous calendar year)</i>			Part time EE's working 20-29 hours Yes	
Number of existing COBRA or Cal-COBRA participants: _____		Employer Contributions Levels: Employee _____% Domestic Partner _____% Dependents _____% Spousal Surcharge _____		
Coverage for Full-time college students? Yes → to age 23 to age 25 No	Domestic Partner Coverage: State Expanded		Waiting Period for New Hires and Rehires : 1st of the month following _____ days <i>(for new hires)</i> 1st of the month following _____ days <i>(for rehires)</i>	

BROKER / GENERAL AGENCY INFORMATION			
Broker Name / Agency Name: General Agency Name <i>(if applicable)</i> :		Tax ID:	
Address:		License:	Exp.
City/State/Zip:		Phone:	Fax:
		E-mail:	

Application is hereby made for a Sharp Health Plan HMO Contract. This is an application only. Issuance of a Group Agreement is subject to receipt of first month's premium and to review and approval by Sharp Health Plan. All eligible employees and dependents will be offered this benefit package. If accepted, the employer agrees to make required payroll deductions for 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.