SHARP HEALTH PLAN

Small Group (1-100 Employees*)

Enrollment Application

Purpose

The purpose of this form is to help you apply for health insurance on behalf of a small employer group. Filling out this form means your company wants its employees to get access to health insurance through Sharp Health Plan.

Instructions

This application must be completed in its entirety. Please visit **sharphealthplan.com/for-brokers** to download the Small Group HMO Submission Checklist for a list of the required documents that must be submitted with this completed application. Please mail the first month's premium check to Sharp Health Plan.

Submit

By mail or in person:**
Sharp Health Plan
Attention: Small Group Sales
8520 Tech Way, Suite 200
San Diego, CA 92123

By email:
shp.commercialsales@sharp.com

If you need assistance, we're here to help.
You may contact our small business group account executive, Cheryl Cote, by email at shp.commercialsales@sharp.com or by phone at 1-858-499-8235. We are available to assist you Monday through Friday, 8 a.m. to 5 p.m.

Company Information

Legal company name:		Doing business as (DBA):	
Type of company: ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ Limited Liability Company (LLC) ☐ Other:			
Type of business:			
Years in business:	Requested effective date:	Tax ID:	SIC code:
Physical street address (P.O. Box is not allowed):			
City:		State:	ZIP code:
Billing address (if different from above):			
City:		State:	ZIP code:
Is your group subject to the Employee Retirement Income Security Act (ERISA)? ☐ Yes ☐ No If no, list reason for exemption: _____		Does your group qualify as a public agency under California Government Code Section 6500? ☐ Yes ☐ No	
Name of current workers' compensation carrier:		Those not covered by workers' compensation (list names and reasons):	
Current health insurance carrier:		Other health insurance plans offered:	
Key Contacts			
Routine:	Phone number: ( )	Fax: ( )	Email address:
Billing:	Phone number: ( )	Fax: ( )	Email address:
Executive:	Phone number: ( )	Fax: ( )	Email address:

* For groups with less than 101 full-time equivalent employees.
** Pending safety guidelines.

Plan Specifications

Class carve-out? ☐ Yes ☐ No If yes, please provide details on carve-out: _____
If offering benefits on a class basis or as part of a multi-choice offering, please indicate class or plan description below.

Network: ☐ Choice ☐ Value ☐ Performance ☐ Premier

Medical plan (includes all essential health benefits mandated by the Affordable Care Act, including pediatric dental and vision benefits for members under the age of 19): _____
Plan choice(s): _____

Assisted reproductive technology (ART) (supplemental; available to groups with 20 or more eligible employees only): ☐ ARTC1 ☐ No ART

Chiropractic (supplemental): ☐ CH5_40 ☐ CHB ☐ CHD ☐ No chiropractic

Acupuncture (supplemental): ☐ AC10_20 ☐ AC10_15 ☐ AC10_12 ☐ AC15_20 ☐ AC15_15 ☐ AC15_12 ☐ No acupuncture

Chiropractic and acupuncture (supplemental):
☐ ACCH5_40 ☐ ACCH10_40 ☐ ACCH10_20 ☐ ACCH10_15 ☐ ACCH10_12 ☐ ACCH15_20
☐ ACCH15_15 ☐ ACCH15_12 ☐ No chiropractic & acupuncture

Vision (supplemental):
☐ VSOE ☐ No vision

Owner or Corporate Officer Information (please list all)

1. _____ Actively engaged in business and eligible for benefits? ☐ Yes ☐ No
2. _____ Actively engaged in business and eligible for benefits? ☐ Yes ☐ No
3. _____ Actively engaged in business and eligible for benefits? ☐ Yes ☐ No
4. _____ Actively engaged in business and eligible for benefits? ☐ Yes ☐ No

Eligibility

Total number of employees:	Total number of benefit-eligible employees (as defined in the California Health and Safety Code Sections 1357(b) and 1357.500(c)):
Total number enrolling in Sharp Health Plan:	Total number enrolling in other employer-sponsored plans:

Total number declining coverage:

Are all eligible employees subject to withholding, as on a W-2 form? ☐ Yes ☐ No If no, list reason for exemption:

What type of continuation of coverage is your company subject to?
☐ Federal COBRA ☐ Cal-COBRA Number of existing COBRA or Cal-COBRA participants: _____

Premium billing reference:	COBRA billing reference (if applicable):
☐ Bill one location ☐ Bill multiple locations (with fee)	☐ Bill employer ☐ Bill COBRA enrollee directly (with fee)

Number of hours required per week for full-time employees to be eligible for benefits:
☐ 20-29 hours ☐ 30 hours ☐ 40 hours ☐ Other _____
Health benefits must be offered to 100% of eligible employees (average of 30 hours per week) in order to be subject to guaranteed issue. Sharp Health Plan has the right to reject an application if health benefits are not offered to 100% of eligible employees. Employers with 50 or more full-time or full-time equivalent employees that do not offer coverage to 100% of their eligible employees (30+ hours) may be subject to the penalties by the IRC Section 4980H(c)(2).

Dependent coverage: Sharp Health Plan will default coverage to include state-registered domestic partner and children to age 26.*
Please check the box if you wish to extend coverage to nonregistered domestic partners or exclude coverage to dependents.
☐ No dependent coverage ☐ Nonregistered domestic partners

If you have 50 or more full-time or full-time equivalent employees, you must offer dependent coverage or else may be subject to the Employer Shared Responsibility penalty. For more information, refer to IRC Section 4980H(c)(2).

* Every plan contract that provides that coverage of a dependent child of a subscriber shall terminate upon attainment of the limiting age for dependent children specified in the plan, shall also provide that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria: (A) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and (B) Chiefly dependent upon the subscriber for support and maintenance.

Employer contribution levels: Employee: _____% Dependent: _____%

Waiting period for new hires and rehires

Sharp Health Plan does not require a waiting period. Employer shall determine waiting period for new hires, rehires, and other eligible employees, which shall not exceed the waiting period permitted by applicable state or federal law.

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*

* If a longer period of time is required by state or federal law, Sharp Health Plan will accommodate an employer's request for continued coverage in such cases.

Sharp Health Plan Employer Statement of Understanding

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 review and approval by Sharp Health Plan. All eligible employees and dependents (if dependent coverage is offered by employer) 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. I understand that the employer group is responsible for notifying all eligible employees of their ability to enroll in the plan after their waiting period.*

Sharp Health Plan shall provide the employer group with copies of the Member Handbook, Provider Directory, supplemental benefits brochures (if applicable), other required plan materials, and copies of all amendments to such documents. I understand that the employer group is responsible for the prompt distribution of these required materials to enrolled employees.

Small group size attestation

I attest that this employer group's size is small as defined by California Health and Safety Code Section 1357.500(k). This employer group shall stay small until the plan contract date the employer no longer meets the definition. The employer group will notify Sharp Health Plan within 30 days if the group no longer meets the definition of a "small employer."

I understand that if I performed an act or practice constituting fraud or made an intentional misrepresentation of material fact in conjunction with this application, Sharp Health Plan may, following notice, cancel or rescind the plan contract.

I certify that all the information contained in this application is true, correct, and complete to the best of my knowledge, and all participation requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been thoroughly explained to eligible employees. I certify that I have read, understand, and concur with the provisions of this Employer Statement of Understanding.

Verification of eligibility

Verification of eligibility does not guarantee payment of claims. Retroactive eligibility changes supersede verifications of eligibility.

Mandatory binding arbitration

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute or controversy that may arise under this agreement between the employer group and Sharp Health Plan, or any Sharp Health Plan-contracted health care providers, administrators, or other associated parties, for alleged violation of any duty arising out of or related to this agreement, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), must be decided by binding arbitration under California law. All parties to this agreement, by entering into it, agree to binding arbitration and give up the right to have such disputes resolved by lawsuit or court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Agreement.

Authorized company signer (print name and title):	Signature:	Date: MM/DD/YYYY

* "Eligible employee" means any employee who has satisfied the employer group waiting period and works the number of required hours per week as set forth by employer and as required by California Health and Safety Code Section 1375.500(c).

Broker/Agency/General Agency Information

Broker/agency:	Tax ID:	License:	Exp: MM/DD/YYYY
Address:			
City:		State:	ZIP code:

Phone number:	Fax number:	Email address:
General agency name (if applicable):	Phone number:	Email address:
Address:		
City:		State: ZIP code:

Notice to agent, broker, or representative: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If you state any material fact you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c) or Insurance Code Section 10119.3.
Select one:

- ☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.
- ☐ I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice from me.

Broker or agent (print name):	Broker or agent (signature):	Date: MM/DD/YYYY

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats, or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY/TDD 711); Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance and Appeal Form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability, or sex with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY/TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TTY/TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English:
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish):
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese):
注意 ： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711).。

Tiếng Việt (Vietnamese):
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) **'ਤੇ ਕਾਲ ਕਰੋ।**

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)**។**

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).