SHARP HEALTH PLAN
make life better.

MASTER APPLICATION (Large Group)

COMPANY INFORMATION

Exact Legal Name of Company:		"Doing Business As" (DBA):	
Street Address	City	State	Zip Code
Billing Address *(If different from above):*		Requested Effective Date:	

Key Contacts:

Routine:	Phone: ( )	Fax: ( )	E-mail address:
Billing:	Phone: ( )	Fax: ( )	E-mail address:
Executive:	Phone: ( )	Fax : ( )	E-mail address:

Type of Business *(please provide as much detail as possible):*

Tax ID:	SIC Code:	Years in Business:
Name of Current Workers' Comp Carrier:	Those not covered by Workers' Comp *(List names and why)*:	
Is your group subject to the Employee Retirement Income Security Act (ERISA)? ☐ Yes ☐ No* *If No, reason for exemption:	Does your group qualify as a Public Agency under CA Government Code § 6500? ☐ Yes ☐ No	
Current Health Insurance Carrier:	Other Health Insurance Plans Offered:	Rate Structure: ☐ Composite ☐ Age Banded *(exception only)*
Premium Billing Reference: ☐ Bill one location ☐ Bill multiple locations	COBRA Billing Reference: ☐ Bill employer ☐ Bill COBRA enrollee directly *(with fee)*	

NETWORK: ☐ **Choice** ☐ **Value** ☐ **Performance** ☐ **Premier**

PLAN SPECIFICATIONS

MEDICAL PLANS (Includes SMI/SED Mental Health and CD benefits) ☐ HMO ☐ PPO ☐ POS

Plan Choice(s):

_____

_____

_____

_____

PHARMACY PLAN CHOICE

_____

_____

_____

☐ **NON-SERIOUS MH** (Supplemental)

VISION
(Supplemental)
☐ A0 ($0)
☐ A2 ($20/$20)
☐ A8 ($30)
☐ Other _____
☐ ***No Vision***

ASSISTED REPRODUCTIVE TECH. ("ART")
(Supplemental – available to groups with 20+ eligible employees only)

☐ Plan A
☐ Plan B
☐ Plan C
☐ ***No ART***

ACUPUNCTURE
(Supplemental)
☐ AC17 ($10/20v)
☐ AC15 ($10/15v)
☐ AC13 ($10/12v)
☐ AC23 ($15/20v)
☐ AC21 ($15/15v)
☐ AC19($15/12v)
☐ ***No Acupuncture***

CHIROPRACTIC AND ACUPUNCTURE
(Supplemental)
☐ AC2 ($5/40v)
☐ AC3 ($10/40v)
☐ AC4 ($10/20v)
☐ AC27 ($10/15v)
☐ AC25 ($10/12v)
☐ AC33 ($15/20v)
☐ AC31 ($15/15v)
☐ AC29 ($15/12v)
☐ ***No Chiropractic and Acupuncture***

CHIROPRACTIC
(Supplemental)
☐ AC34 ($5/40v)
☐ B ($10/30v)
☐ D ($10/20v)
☐ ***No Chiropractic***

DENTAL PLAN CHOICES:
(Supplemental)

☐ DHMO _____
☐ PPO _____
☐ ***No Supplemental Dental***

Dental Contribution Levels (minimum contribution is 75%):

Employee _____% Dependent _____%

PRIOR DENTAL COVERAGE:

The Employer has current dental coverage for Employees: ❑ Yes ❑ No

If Yes, please complete the following:

Carrier Name: _____

Policy Number: _____

Carrier Phone Number: _____

ELIGIBILITY

Total # of Employees:	Total # of Benefit Eligible Employees:	Total # Enrolling in Sharp 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: _____

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:_____

Number of hours required per week to be eligible for benefits:

Full time EE's ☐ 30 hours ☐ 40 hours

☐ Other _____

Do you want to cover part time employees that work 20-29 hours?

☐ Yes ☐ No ☐ Other _____

Dependent Coverage: Sharp Health Plan will default coverage to include spouse, domestic partner and children to age 26. If you wish to exclude coverage, please check below.

Please note: Offering dependent coverage does not require employer contribution.

☐ No dependent coverage

Employer Contributions Levels:

Employee _____% or $ Dependent _____% or $

Waiting Period for New Hires/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.

Please provide a waiting period for new and rehires ONLY if you are applying for a PPO medical plan OR Supplemental Dental:

New Hire _____ ☐ First of the month following OR ☐ From date of Hire
Rehire _____ ☐ First of the month following OR ☐ From date of Hire

Domestic Partner Coverage (please check one) – Domestic Partner is option A and B must also meet Sharp Health Plan's dependent eligibility requirements as contractually defined:

☐ A. State 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. Opposite sex partners allowed if one partners is at least 62 years of age and eligible for Social Security)

☐ B. Expanded Coverage: California State Registration not required (both partners may be the same or opposite sex)

Leave of Absence:

Numbers of month's 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 case.

RESPONSIBILITIES FOR DISTRIBUTION OF THE SUMMARY OF BENEFITS AND COVERAGE ("SBC") TO PARTICIPANTS, BENEFICIARIES OR ELIGIBLE EMPLOYEES:

Sharp Health Plan:

- Upon application: as part of any written application materials provided by Sharp 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

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. The applicant also agrees to notify all eligible employees of their ability to enroll in the plan after their waiting period.

LARGE GROUP SIZE ATTESTATION: I attest that this employer group's size is large as defined by Health and Safety Code Section 1357.500(k). This employer group shall stay large 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 size changes to small, as defined by Health and Safety Code Section 1357.500(k).

I certify that all the information contained in this application is correct 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 the Employer Statement of Understanding above.

Premier Access Employer Statement of Understanding

VERIFICATION OF ELIGIBILITY: Verification of eligibility does not guarantee payment of claims. Retroactive eligibility changes supersede verifications of eligibility.

COVERAGE TERMINATION: Dental coverage will be terminated as of the last date for which premium has been paid.

MANDATORY BINDING ARBITRATION: As more fully set out in the Policy and Certificate, we agree that binding arbitration is the final process for the resolution of any dispute arising out of or relating to the Policy with Premier Access. If a face-to-face hearing is involved in the arbitration, the hearing shall be conducted in Sacramento, CA. By enrolling in this plan, Employer and Covered Persons waive their constitutional right to a trial before a jury or judge. Any dispute alleging the malpractice, negligence and/or wrongful act of a provider, shall not include Premier and shall include only the provider subject to the allegation.

Print Name and Title _____ Date _____

Authorized Employer Signature *(must be an officer)* _____

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

Broker/Agent Print Name _____ Date _____

Broker/Agent Signature _____

*All references to "Premier" herein refer to Premier Access Insurance Company