SHARP HEALTH PLAN

Large Group (101+ Employees*)

Employer Application

Purpose

The purpose of this form is to help you apply for health insurance on behalf of a large 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 mail the first month's premium check to the address listed in the "Submit" section.

Submit

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

By email:
judith.schaller@sharp.com

If you need assistance, we're here to help.
You may contact our large business group account executive, Judy Schaller, by email at judith.schaller@sharp.com or by phone at 1-858-499-8228. We are available to assist you Monday through Friday, 8 a.m. to 5 p.m.

Company Information

Company name:	Doing business as (DBA):	Requested effective date:

Tax ID:	SIC code:	Years in business:

Address:

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:
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)

Key Contacts

Routine:	Phone number: ( )	Fax: ( )	Email address:
Billing:	Phone number: ( )	Fax: ( )	Email address:
Executive:	Phone number: ( )	Fax: ( )	Email address:

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

Plan Specifications

Medical plans: ☐ HMO ☐ POS ☐ PPO

HMO network: ☐ Choice ☐ Value ☐ Performance ☐ Premier

Medical benefit plan(s):	**Pharmacy plan(s):**

HMO Supplemental Riders

Vision:	**Hearing aids:**	**Chiropractic and/or acupuncture:**	
☐ None	☐ None	☐ None	☐ CHD
☐ A0	☐ HAAB	☐ CHB	☐ ACCH10_40
☐ A2	☐ HA3	☐ ACCH5_40	☐ ACCH15_20
☐ A8	☐ Other _____	☐ ACCH10_20	☐ ACCH15_40
☐ Other _____		☐ ACCH10_3	☐ Other _____

Note:

Eligibility

Total number of employees:	Total number of benefit-eligible employees:
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? If no, list reason for exemption:	☐ Yes ☐ No
Is your group currently subject to federal COBRA (employing 20 or more employees during at least 50% of the working days in the previous calendar year)? Number of existing COBRA or Cal-COBRA participants: _____	☐ Yes ☐ No

What is the number of hours required per week for employees to be eligible for benefits?:
☐ 20-29 hours ☐ 30 hours ☐ 40 hours ☐ Other _____

Dependent coverage: Sharp Health Plan will default coverage to include state-registered domestic partners and children up 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 you may be subject to the Employer Shared Responsibility penalty. For more information, refer to Section 4980H(c)(2) of the Internal Revenue Code.

* 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 and 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. The employer shall determine the waiting period for new hires, rehires and other eligible employees, which shall not exceed 90 calendar days from the date the employee or dependent is otherwise eligible to enroll under the terms of the group health plan.

Please provide a waiting period for new hires and rehires.
New hire: _____ ☐ First of the month following OR ☐ From date of hire
Rehire: _____ ☐ First of the month following OR ☐ From date of hire

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 contract. This is an application only. Issuance of a Group Agreement is subject to receipt of the first month's premium and review and approval by Sharp Health Plan. All eligible employees and dependents (if dependent coverage is offered by the 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.*

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.

I attest that this employer is not a small employer as defined in Health and Safety Code Section 1357.500 (i.e., employs more than 100 employees). Subsequent to the issuance of a health care service plan contract and for the purpose of determining eligibility, the size of the employer shall be determined annually at the time of the plan contract anniversary. The employer group will notify Sharp Health Plan within 30 days if the group size changes to small as defined in Health and Safety Code Section 1367.500(k).

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 the Employer Statement of Understanding above.

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 the employer.

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. A copy of the Nondiscrimination Notice can also be accessed at **sharphealthplan.com/members/notices-and-disclosures**.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters.
- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternative formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities.
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters and language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency. If you need these services, contact Customer Care at 1-800-359-2002 (TTY 711).

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 and Section 1557 Nondiscrimination Coordinator at:

- Address: Sharp Health Plan Compliance Department, Attn: Director of Compliance and Regulatory Affairs Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572
- Email: shpcompliance@sharp.com

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / 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 (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 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، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید
1-800-359-2002 (TTY:711) با .باشد می فراهم.

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。

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

ਪੰਜਾਬੀ **(Punjabi):**
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁ ਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁ ਹਾਡੇ ਲਈ ਮੁ ਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY/TDD: 711) ‘ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួ ល 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 है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-800-359-2002 (TTY:711) पर कॉल करें।कॉल करें।

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