Large Group Employer Master Application

Effective Date (mm/dd/yyyy) _____

Email application to your Community Care Health representative or your broker.

COMMUNITY CARE HEALTH

1: APPLICANT

Group legal name _____ Nature of business _____ Federal Tax ID no. _____

Street address: _____ City: _____ State: _____ Zip: _____

Primary group contact name _____

Primary group contact phone no: _____ Primary group contact email address: _____

Form of organization : _____ If other, please specify: _____

Employees of the following subsidiaries or affiliates are to be included. Please attach a separate sheet for additional locations.

Company name: _____ Address : _____

Company name: _____ Address : _____

2: MEDICAL COVERAGE — Select all plans that will be offered

HMO		HMO HDHP	HMO/HSA COMP
☐ Vineyard Plan A	☐ Harvest Plan A	☐ Summit Plan A	☐ Glacier Plan A
☐ Vineyard Plan B	☐ Harvest Plan B	☐ Summit Plan B	☐ Glacier Plan B
☐ Vineyard Plan C	☐ Harvest Plan C	☐ Summit Plan C	☐ Glacier Plan C
☐ Vineyard Plan D	☐ Harvest Plan D	☐ Summit Plan D	☐ Glacier Plan D
☐ Vineyard Plan E	☐ Other _____	☐ Other _____	☐ Other _____
☐ Orchard Plan A			
☐ Orchard Plan B			
☐ Orchard Plan C			
☐ Orchard Plan D			

EPO		EPO HDHP	EPO/HSA COMP
☐ Vineyard Plan A	☐ Harvest Plan A	☐ Summit Plan A	☐ Glacier Plan A
☐ Vineyard Plan B	☐ Harvest Plan B	☐ Summit Plan B	☐ Glacier Plan B
☐ Vineyard Plan C	☐ Harvest Plan C	☐ Summit Plan C	☐ Glacier Plan C
☐ Vineyard Plan D	☐ Harvest Plan D	☐ Summit Plan D	☐ Glacier Plan D
☐ Vineyard Plan E	☐ Other _____	☐ Other _____	☐ Other _____
☐ Orchard Plan A			
☐ Orchard Plan B			
☐ Orchard Plan C			
☐ Orchard Plan D			

Hearing Aide Rider? ☐ Accept ☐ Decline

2B: DELTA DENTAL COVERAGE — Select all plans that will be covered

DENTAL					
☐ Program A:	$1,500 CYM 100/90/60	Ortho: $1,500 LTM	☐ Program F:	$2,000 CYM 100/90/60	
☐ Program B:	$1,500 CYM 100/90/60		☐ Program G:	$2,500 CYM 100/90/60	Ortho: $2,000 LTM
☐ Program C:	$1,500 CYM 100/80/50	Ortho: $1,500 LTM	☐ Program H:	$2,500 CYM 100/80/50	
☐ Program D:	$1,000 CYM 100/80/50		☐ Program I:	$3,000 CYM 100/90/50	Ortho $3,000 LTM
☐ Program E:	$2,000 CYM 100/90/60	Ortho: $1,500 LTM	☐ Program J:	$5,000 CYM 100/100/80	Ortho $2,500 LTM

2C: VSP VISION COVERAGE — Select all plans that will be covered

Plan Name	☐ DeltaVision Value	☐ DeltaVision Core	☐ DeltaVision Advantage	☐ DeltaVision Deluxe	☐ DeltaVision Easy Options
Frequency	12/12/24/12	12/12/24/12	12/12/12/12	12/12/12/12	12/12/12/12
Exam Copayment	$10	$10	$10	$10	$10
Materials Copayment	$25	$25	$25	$10	$25
Frame Allowance	$130	$150	$150	$200	$150/$230
Contact Lens Allowances	$130	$150	$150	$200	$150/$230
Packaged with Dental	Yes	Yes	Yes	Yes	Yes

3: ELIGIBILITY AND ENROLLMENT

Total number of people employed by the company: _____ (Include all employees regardless of whether those employees are benefit eligible.)
Please read the methodology below regarding FTEs[1],

In prior calendar year, how many employees were full time? _____ How many FTEs were calculated? _____
If count is 100+, you are attesting to being a Large Group.

Do you define employees as eligible (full time) if they work 30+ hrs/wk? ☐ Yes

☐ No, explain: _____

(A "No" response will require Underwriting review and approval.)

What is the number of eligible employees offered Community Care Health Insurance coverage?_____
(May differ from "total number of people employed" above.)

Are all employees under the same TIN/EIN? ☐ Yes

☐ No, please complete the "Common Ownership" form and include each company's information

4: WAITING PERIOD

All products sold or medical only

Waiting period for: _____ Eligibility/coverage begin date: _____

Specialty products only

Waiting period for: _____ Eligibility/coverage begin date: _____

Are all employees under the same TIN/EIN? ☐ Yes ☐ No
(i.e., all active full-time employees who have or have not met their probationary period can enroll.)

5: ELECTRONIC ACCESS OF GROUP INFORMATION BY AGENT/PRODUCER/BROKER

We, the employer, hereby authorize the agent/producer/broker/ whose name is attached to this application to use the Comprehensive Enrollment Wizard (CEW) of Community Care Health to access the group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/producer/broker is also hereby authorized to use the CEW of Community Care Health to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker changes.

☐ Check this box ONLY if the group elects to opt-out of authorizing the agent/producer/broker to access and change the group's information on behalf of the group

[1] A full-time equivalent (FTE) employee is a combination of employees, each of whom individually is not a full-time employee because they are not employed on average at least 30 hours of service per week with an employer, but who in combination, are counted as the equivalent of a full-time employee. The number of FTEs for each calendar month in the preceding calendar year is determined by calculating the aggregate number of hours of service for that calendar month for employees who were not full-time employees (but not more than 120 hours of service for any employee) and dividing that number by 120. The resulting number is the number of FTEs on a monthly basis. To qualify as a Large Group an employer must employ at least 101 full-time employees, including FTEs, on business days during the preceding calendar year (question 1 response must equal or exceed 101).

6: GENERAL AGREEMENT — READ CAREFULLY

Effective date requested _____ Actual date will be assigned by Community Care Health if application is accepted. _____

Upon acceptance of the application, the Group will inform all persons who are eligible for coverage that they may apply for Community Care Health coverage under the Agreement/Policy.

Application is hereby made to Community Care Health, or the appropriate affiliated company, for a Group Benefit Agreement/Group Policy providing health service benefits. If this application is accepted, an Agreement/Policy will be issued which will set forth the terms, benefits and conditions of the relationship between the Group and Community Care Health. This application will become part of that Agreement/Policy.

It is understood that no agent or representative except the President, a Vice President, or the Secretary has power on behalf of Community Care Health to bind Community Care Health to accept risk, issue an Agreement/ Policy, or commit to particular provisions of an Agreement/ Policy. No coverage will come into effect unless and until this application is accepted. If accepted, the terms of the relationship will be defined entirely within an Agreement/ Policy.

Broker of record and commissions		
Medical	_____%	_____
Dental	_____%	_____
Vision	_____%	_____
Life	_____%	_____

COMMUNITY CARE HEALTH ARBITRATION AGREEMENT*

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 between myself, my heirs, relatives, or other associated parties on the one hand and Community Care Health, any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Community Care Health, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to 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 Evidence of Coverage.

7: EMPLOYER SIGNATURE

I understand and agree to all of the above.

Authorized signature **X** _____ Date: _____

Printed name of officer, partner or proprietor _____ Title _____

Authorized Broker of Record signature **X** _____ Date _____

Printed name _____