

Employer Group Application



Sales Department: Tel: 415-955-8800 Fax: 415-955-8819
 Member Services: Tel: 415-834-2118 Fax: 415-397-2129

CCHP will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract

1. Employer Group Information

Company Name:			Effective Date:		
Group #:		Federal Tax ID #:		Preferred Language:	
Company Contact:			Title:		Send administrative kit to: <input type="checkbox"/> Employer <input type="checkbox"/> Agent/Broker
Tel:		Fax:		Email:	
Address (NO P.O. Box):				City:	State: ZIP:
Billing Address (if different from above):				City:	State: ZIP:
Type of Entity:	<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> LLC	Type of Business (be specific):	How long in business
<input type="checkbox"/> Partnership	<input type="checkbox"/> Other (explain) _____				
Subsidiary or Affiliated Companies to be included:				# of Eligible Employees:	# Enrolled:
Address, City, State & ZIP:					Tel:

2. Coverage Selection

Medical Plan Options (All medical plans come with a \$250 calendar year brand name drug deductible) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E <input type="checkbox"/> Ruby 10 <input type="checkbox"/> Ruby 20 <input type="checkbox"/> Ruby 40 <input type="checkbox"/> Opal 25 <input type="checkbox"/> Opal 50 <input type="checkbox"/> Active Choice	Optional Benefits (RIDERS) <input type="checkbox"/> SmileSaver Dental Plan 2000 <input type="checkbox"/> VSP Vision Plan C (12/12/12) <input type="checkbox"/> Chiropractic Plan (ASH 20)	Large Groups Only: (for groups with 50+ employees) <input type="checkbox"/> RX no Deductible <input type="checkbox"/> Infertility Benefit
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3. Employer Contribution

4. Probationary Period for New Hires /Re hires

Employee (min. 50%): _____ %	Dependent: _____ %	Others: _____	<input type="checkbox"/> Date of Hire <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ months (six months max)
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5. Number of Employees

Total # of eligible employees (including owner/officers): _____	Total # of full time employee (30+hrs/wk): _____
Total # of employees enrolled: _____	Total # of part time employee (20+hrs/wk): _____

6. Current Carrier Information

Name of your current group medical insurance carrier :

Are you intending to replace your existing group coverage? Yes No

If Yes, Proposed Termination Date: _____

If No, Name of other Carrier: _____

Current Workers' Compensation Carrier:

Next Renewal Date:

7. COBRA / CAL COBRA Information

Is your group currently subject to COBRA or CAL-COBRA? Yes No

If yes, please complete the following for each person covered under COBRA or CAL-COBRA.

Name:	Date of Birth	SSN :	Tel:	Date Continuation Begin:

8. Signature and Conditional Receipt

We, the employer, warrant that all information in this application is true and complete, and that CCHP may rely on this application in deciding whether to provide coverage. If the application is not complete, CCHP reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by CCHP and only if we have paid our first month's contribution and this application is accepted, and that we should keep prior coverage in force until notified of acceptance by CCHP. If this application is accepted, it becomes a part of our contract with CCHP.

We understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between us and CCHP and any of this affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

X

Signature of Employer /Authorized Representative

Print Name & Title

Date

9. Agent/Broker Certification

I hereby certify that I have advised the client not to terminate any existing coverage until receiving notification from CCHP that the coverage being applied for by this application is accepted. I have also fully discussed benefits, eligibility, pre-existing condition, open enrollment, COBRA / Cal-COBRA information to the employer. I agree that any dispute with CCHP shall be resolved by binding arbitration as disclosed directly above.

X

Agent/Broker Signature

Print Agent/Broker Name

Agent/Broker Code

Date