

Master Group Application

Group Sales: Tel: 1-888-371-3060 | Fax: 1-415-955-8819



Balance by 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			
Full Legal Business Name:	How Long in Business:	Type of Business (Be Specific):	Effective Date: (MM/DD/YY) / /
Primary Group Administrator Contact:	Title:	Phone:	Email:
Secondary Group Administrator Contact	Title:	Phone:	Email:
Federal Employer ID #:	State Employer ID #:	Fax:	Send administrative kit to: <input type="checkbox"/> Employer <input type="checkbox"/> Agent/Broker
Business Physical Address, City, State, ZIP (No P.O. Box):			
Billing Contact:	Title:	Phone:	Email:
Billing Address, City, State, ZIP (if different from above):			
Type of Entity: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> S-Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other (explain) _____			
2. Employer Group Plan Coverage Selection			
Medical Plans <input type="checkbox"/> Ruby ¹⁰ HMO Platinum <input type="checkbox"/> Ruby ²⁰ HMO Platinum <input type="checkbox"/> Ruby ⁴⁰ HMO Platinum <input type="checkbox"/> Opal ²⁵ HMO Gold <input type="checkbox"/> Opal ⁵⁰ HMO Silver <input type="checkbox"/> Platinum ⁹⁰ HMO <input type="checkbox"/> Gold ⁸⁰ HMO <input type="checkbox"/> Silver ⁷⁰ HMO <input type="checkbox"/> Bronze ⁶⁰ HMO <input type="checkbox"/> Bronze ⁶⁰ HDHP HMO			
Optional Riders (Applies to all Balance Enrollees) <input type="checkbox"/> Adult Vision (VSP) <input type="checkbox"/> Adult Dental (Delta) <input type="checkbox"/> Other _____			
Note(s) (Balance Use Only):			
3. Employer Premium Contribution		4. Employees Will Be Eligible for Benefits Upon	
Employee (min. 50%): \$ / %	Dependent: \$ / %	1 st of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Other _____	
5. Number of Employees (Employer is responsible for collecting refusal of coverage forms)			
Total # of employees:		Total # of eligible employees (30+hrs/week):	
Total # of eligible employees enrolled in Balance:	Total # of employees who waive coverage:	Annual average # of employees:	
6. Current Carrier Information			
Name of your current group medical insurance carrier(s):			
Are you intending to replace your existing group coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes, Termination Date (MM/DD/YY): / /			
Current Workers' Compensation Carrier:		Next Renewal Date (MM/DD/YY): / /	

7. COBRA / CAL-COBRA Information

Is your group currently subject to COBRA or CAL-COBRA? ☐ No ☐ Yes, please complete the following for each person

1	Name:	Date of Birth (MM/DD/YY): / /	SSN:	Tel:	Date Continuation Begin (MM/DD/YY): / /
	Qualifying event description:				Date (MM/DD/YY): / /
2	Name:	Date of Birth (MM/DD/YY): / /	SSN:	Tel:	Date Continuation Begin (MM/DD/YY): / /
	Qualifying event description:				Date (MM/DD/YY): / /

8. Form of Member Evidence of Coverage and Notices

Employer are responsible for the distribution of the Evidence of Coverage and Notices to your covered employees. Electronic versions will be distributed to you upon request. Employer is responsible for distributing the documents using one of the following methods; 1.) posting on the employer's intranet for employee access or, 2) emailing these documents directly to their employees. Printed versions will only be mailed to the employer directly upon request.

☐ I elect to receive printed, not electronic, Evidence of Coverage and Notices. I understand that I am responsible for distributing the documents to my covered employees.

9. Signature and Conditional Receipt

This is an application for coverage only. The group understands that no contract for coverage will exist Balance has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted and a group health service/group policy will be issued. The group's representative certifies to the best of his or her knowledge and belief, all of the responses given are true, correct, and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of issuance of coverage, Balance may pursue one of the following remedies: coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the Health Service Contract/Insurance policy may be rescinded.

We, the employer, warrant that all information in this application is true and complete, and that Balance may rely on this application in deciding whether to provide coverage. If the application is not complete, Balance 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 Balance 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 Balance. If this application is accepted, it becomes a part of our contract with Balance.

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 Balance 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 and Notice.

Signature of Employer/Authorized Representative: X	Print Name:	Title:	Date (MM/DD/YY): / /
---	-------------	--------	-------------------------

10. Agent/Broker Certification (To be completed by your agent or broker after completion of this application)

I, _____, assisted the applicant in submitting this application. All information in the health questionnaire was completed by applicant. I advised the applicant to answer all questions completely and truthfully and that no information requested should be withheld. I explained that withholding information may result in cancellation of coverage in the future. 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.

Notice to agent: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand (\$10,000) dollars, as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

Agent/Broker Signature X	Agent/Broker Name:	CA License Number:	Note(s) (Balance Use Only):
Email:	Phone:	Fax:	Date (MM/DD/YY): / /
Balance Use Only			
Sales Representative / Sales Executive []	Sales Manager []	COO []	
Payment [CC / Bill / Check #]	Amount []	Date []	
Rec'd Enrollment []	Packet Sent Date []		