MASTER APPLICATION FOR SMALL GROUP EMPLOYERS

COMPANY INFORMATION

Exact Legal Name of Company:			"Doing Business As" (*DBA*):		
Street Address			City	State	Zip Code
Billing Address (*if different from above*):			City	State	Zip Code
Tax ID:	SIC Code:	Type of Business:		Years in Business:	

Key Contacts (*Please complete this section. *Email address required*):

☐ **HR Manager is also Billing Contact**

HR Manager: Phone: ( ) E-mail*:

Billing: Phone: ( ) E-mail*:

Company Officer/Owner: Phone: ( ) E-mail*:

MediExcel Health Plan is an environmentally conscious organization that takes great pride in reducing paper waste. By signing our Master Application, you acknowledge that all Plan documents, including announcements, surveys and/or invoices will be sent to you via e-mail.

CA Coverage Health Insurance Carrier(s):	Name of Current Workers' Comp Carrier:
Other Health Insurance Plans Offered:	Premium Billing Reference: ☐ Bill One Location ☐ Bill Multiple Locations
Requested Effective Date:	Are you changing cross-border providers? ☐ Yes ☐ No

PLAN SELECTION

MediExcel Health Plan Offering:	Choose a Dental Plan option:	Confirm Vision Plan option:
☐ P5 Platinum HMO Plan ☐ P10 Platinum HMO Plan ☐ Platinum 90 HMO 0/20 INF Plan ☐ Gold 80 HMO 250/35 INF Plan ***Min. 3 EEs required for P5, P10 Platinum HMO Plans**	☐ D100 ☐ D200 Choose tier level: ☐ 3-Tier ☐ 4-Tier ***CAN BE OFFERED AS VOLUNTARY** ☐ No Dental Plan	☐ V100 Choose tier level: ☐ 3-Tier ☐ 4-Tier ***CAN BE OFFERED AS VOLUNTARYACTIVE MEDIEXCEL MEDICAL COVERAGE REQUIRED** ☐ No Vision Plan

OWNER/CORPORATE INFORMATION

Company is a: ☐ Sole Proprietor ☐ Partnership or LLC ☐ Corporation ☐ Non-Profit

REQUIRED ENROLLMENT INFORMATION

Total # of Employees: ____	Total # of Benefit Eligible Employees:____	Total # Enrolling in MediExcel Health Plan: ____	Total # Enrolling in other Employer-Sponsored Plans:___	Total # Declining Coverage: _____

REQUIRED COBRA INFORMATION

Is your group currently subject to **Cal-COBRA**? ☐ Yes ☐ No
(Employed 2-19 employees during at least 50% of the working days in the previous calendar year or previous quarter if not in business in the previous calendar year, and are not subject to Federal COBRA)

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: _____

Name of your COBRA or Cal-COBRA Administrator: _____

Number of hours required per week to be eligible for benefits:	**Employer Contribution Levels:**
Full-time EE's: ☐ 30 hours+ per week Do you want to cover part-time employees that work a min. of 20-29 hours? ☐ Yes ☐ No	Employee_____% or $_____ Dependent_____% or $_____
Waiting Period for New Hires and Rehires **New Hire** (*check one*)**:** 1st of the month following ☐ 60 days ☐ 30 days ☐ 0 days **Re-Hires** (*check one*)**:** 1st of the month following ☐ 60 days ☐ 30 days ☐ 0 days	

Application is hereby made for a MediExcel Health Plan Group Subscriber Agreement. This is an application only. Issuance of a Group Subscriber Agreement is subject to receipt of the first month's premium and review and approval by MediExcel Health Plan. All eligible employees and dependents 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.

Administrative Fees: *(Fees waived for 4 Enrolled Employees or more)*

- **1-3 Enrolled Employees: $10.00 monthly administrative fee.**

***Dependents are not included towards count.**

_____	_____/_____	_____
X Signature of Company Officer or Owner	**Print Name and Title**	**Date**

MANDATORY BROKER / GENERAL AGENCY INFORMATION (PLEASE COMPLETE BOTH SECTIONS)	
Broker Agency: **Broker Name:** **Broker/Agent Signature:** _____ **Account Manager:** **Date:** _____ **Tax ID:** _____ **License #:** _____ **Telephone #:** _____	**General Agency (please check one): Yes** ☐ **No** ☐ **General Agency Name:** **Tax ID:** _____