ChoiceBuilder®
721 South Parker, Suite 140, Orange, CA 92868
Phone: (866) 412-9279 • Fax (866) 412-9280
www.choicebuilder.com

Employer Application

- Application must be completed in full, signed and dated for processing.
- E-mail address underwriting@choicebuilder.com
- **PLEASE DO NOT ALTER THIS FORM AS THIS WILL DELAY PROCESSING.**

REQUESTED EFFECTIVE DATE (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

STEP 1 - COMPLETE EMPLOYER INFORMATION

Company Name

Owner/President Name

DBA Name

Exact Nature of Business

SIC Code

Company Structure
☐ Corporation ☐ Sole Proprietorship ☐ LLC
☐ S Corporation ☐ Partnership ☐ Other

Date Business Started (MM/DD/YYYY)

CA Federal Tax ID #

Contact Name ☐ *Add Broker of Record as an Authorized Group Contact*

Contact Phone # (XXX) XXX-XXXX

Contact Fax # (XXX) XXX-XXXX

Contact Job Title

Contact E-mail Address

Street Address (no P.O. Box)

Suite/Unit #

City

State

ZIP Code

County

Residence ☐ Yes ☐ No

Mailing Address *(if different from above)*

Suite/Unit #

City

State

ZIP Code

County

Residence ☐ Yes ☐ No

STEP 2 - COMPLETE ENROLLMENT & ELIGIBILITY INFORMATION

Have you employed 20 or more employees during at least 50% of the preceding calendar year? (COBRA) ☐ Yes ☐ No

Waiting period for future employees is first day of the month following ☐ Date of Hire ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days
(Other options are not available, please do not write in)

Select who the waiting period applies to ☐ future employees *(hired after effective date)* ☐ current and future employees *(hired on or prior to effective date)*

How many pay periods per year? (will be shown on Employee Enrollment Worksheets) ☐ 12 ☐ 26 ☐ 52 ☐ 24 ☐ 48

Number of employees in the waiting period

Select the number of hours an employee must work per week to be eligible for benefits ☐ 20+ hours per week ☐ 30+ hours per week

Total number of employees on payroll regardless of hours worked *(Including owners, partners, part-time, seasonal, etc.)*

Total number of active eligible employees on payroll *(Including owners, partners, etc.)*

Note: Upon request, the employer applicant agrees to provide documentation verifying the above numbers. *(i.e. wage report, payroll records, etc.)*

SECTION 125 - PREMIUM ONLY PLAN *(complete this section if you want this benefit)* offered by WageWorks, a HealthEquity company

Note: A one-time $100 enrollment fee must be submitted with the premium deposit.

Name of Company President, Principal, or Partners

Name of Corporate Secretary *(if applicable)*

Plan Number *(usually 501)*

State of Incorporation *(if applicable)*

Premium payments may be elected for ☐ Medical ☐ Dental ☐ Vision ☐ Other

Last day of first plan year (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

(Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date.)

Participation Limitations: P.O.P. rules require that all participants in the plan be employees. Please be advised that 2% or greater shareholders in an S-Corporation, sole proprietors in a Sole Proprietorship, and partners in a Partnership are not considered employees as defined by Tax Code, and therefore, are ineligible to participate. **Important:** Read the information provided in your ChoiceBuilder® Quote pertaining to the Section 125 Premium Only Plan and tax consequences.

STEP 3 - SETUP YOUR DENTAL PLAN

Dental *(must be offered as core coverage, complete A-C)*

A. Select One Option Next

☐ Employer Sponsored *(complete employer contribution section below)*

☐ Voluntary *(no employer contribution)*

B. Select One PPO Carrier Next

(to be offered with DeltaCare® USA DHMO)

☐ Ameritas ☐ Delta Dental

☐ Anthem Blue Cross ☐ MetLife

C. Do you want to add orthodontic coverage for the PPO Carrier

☐ Yes ☐ No

Employer Contribution *(complete for Employer Sponsored option only) (select one option)*

☐ **Option 1 - Percentage of Cost**

Enter the percentage to contribute for each employee

_____ % for Employee *(minimum contribution is 50%)*

_____ % for Dependents *(no minimum)*

Based on:

☐ Highest - Cost Plan ☐ Lowest - Cost Plan

☐ Highest - Cost DHMO Plan ☐ Lowest - Cost DHMO Plan

☐ Highest - Cost PPO Plan ☐ Lowest - Cost PPO Plan

☐ Plan Selected by Employee ☐ Specific Plan _____

☐ **Option 2 - Fixed Dollar Amount**

Enter the dollar amount to contribute for each employee
(must be at least 50% of the lowest cost plan for each employee)

$ _____ for Employee

$ _____ for Dependents *(no minimum)*

OR

$ _____ for Employee with remainder to Dependents

Provide Counts *(complete for Employer Sponsored option only) (write "0" if none)*

Total number of **ELIGIBLE** employees **APPLYING** for coverage _____

Total number of **COBRA** beneficiaries **APPLYING** for coverage _____

Total number of **ELIGIBLE** employees **WAIVING** coverage due to

Other **GROUP** coverage _____

Other **INDIVIDUAL** coverage _____

OTHER reasons _____

Note: A waiver must be completed for all eligible employees and dependents not applying for coverage. Employees cannot waive coverage if the employer's contribution is 100%, unless the waiver is due to other group coverage.

Provide Prior Coverage Information *(must complete to determine eligibility)*

Does your group currently have Group Dental Coverage? ☐ Yes ☐ No

If Yes, does the coverage include Orthodontic Coverage? ☐ Yes ☐ No

Is group enrolled or enrolling with CaliforniaChoice® ? ☐ Yes ☐ No

Carrier Name _____

Policy # _____

Termination Date (MM/DD/YYYY) _____

Requirements for Orthodontic Coverage and Takeover Credit

	Ameritas		Anthem Blue Cross		Delta Dental		MetLife	
Employer Sponsored	Ortho Min. Employees	5+ (Eligible)	Ortho Min. Employees	10+ (Eligible)	Ortho Min. Employees	10+ (Enrolled)	Ortho Min. Employees	10+ (Eligible) with 5+ (Enrolled)
	Ortho Waiting Period	12 Months	Ortho Waiting Period	None	Ortho Waiting Period	None	Ortho Waiting Period	None
	Major Waiting Period	None	Major Waiting Period	None	Major Waiting Period	None	Major Waiting Period	None
	Takeover Credit	Available*	Takeover Credit	Available*	Takeover Credit	None	Takeover Credit	Automatic*
Voluntary	Ortho Min. Employees	5+ (Eligible)	Ortho Min. Employees	N/A	Ortho Min. Employees	25+ (Eligible)	Ortho Min. Employees	10+ (Eligible) with 5+ (Enrolled)
	Ortho Waiting Period	12 Months	Ortho Waiting Period	N/A	Ortho Waiting Period	None	Ortho Waiting Period	None
	Major Waiting Period	None	Major Waiting Period	12 Months	Major Waiting Period	None	Major Waiting Period	None
	Takeover Credit	None	Takeover Credit	N/A	Takeover Credit	None	Takeover Credit	Automatic*

*Takeover credit is available to groups at initial enrollment only. Ameritas: the group must have at least 10 eligible employees and provide proof of having 12 consecutive months of prior coverage, with orthodontic coverage for orthodontic takeover credit. (12 months will be waived if 12 months proof is provided, no partial credit). Anthem Blue Cross: see plan specific EOC for takeover credit information. MetLife: Orthodontic Takeover Credit is automatic for groups with prior coverage, and there are no waiting periods for groups without prior coverage.

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STEP 4 - SELECT ADDITIONAL BENEFITS TO OFFER YOUR EMPLOYEES

☐ Vision *(optional, complete A and B)*

A. Select One Option

☐ Employer Sponsored *(complete employer contribution section below)*

☐ Voluntary *(no employer contribution)*

Next

B. Select One Vision Carrier

☐ Eyemed provided by Ameritas

☐ VSP

Employer Contribution *(complete for Employer Sponsored option only) (select one option)*

☐ **Option 1 - Percentage of Cost**

Enter the percentage to contribute for each employee

_____ % for Employee *(minimum contribution is 50%)*

_____ % for Dependents *(no minimum)*

Based on

☐ Highest - Cost Plan ☐ Lowest - Cost Plan

☐ Plan Selected by Employee ☐ Specific Plan _____

☐ **Option 2 - Fixed Dollar Amount**

Enter the dollar amount to contribute for each employee
(must be at least 50% of the lowest cost plan for each employee)

$ _____ for Employee

$ _____ for Dependents *(no minimum)*

OR

$ _____ for Employee with remainder to Dependents

Provide Counts *(complete for Employer Sponsored option only) (write "0" if none)*

Total number of **ELIGIBLE** employees **APPLYING** for coverage _____

Total number of **COBRA** beneficiaries **APPLYING** for coverage _____

Next

Total number of **ELIGIBLE** employees **WAIVING** coverage due to

Other **GROUP** coverage _____

Other **INDIVIDUAL** coverage _____

OTHER reasons _____

Note: A waiver must be completed for all eligible employees and dependents not applying for coverage.
Employees cannot waive coverage if the employer's contribution is 100%, unless the waiver is due to other group coverage.

☐ Chiropractic *(optional)* offered by Landmark Healthplan *(complete A and B)*

A. Select One Option

☐ Employer Sponsored *(must be 100% employer paid)*

☐ Voluntary *(no employer contribution)*

Next

B. Select One Benefit Type

☐ Chiropractic Only

☐ Chiropractic & Acupuncture

☐ Life *(optional, complete A and B)*

Note: This benefit must be employer sponsored, 100% employer paid, and 100% of eligible employees must enroll.

A. Select One Life Carrier

☐ **Assurity**

Guaranteed Issue Amounts are available as indicated in table below:

- Amounts must be in increments of $5,000 (calculated from the minimum amount)
- Scheduled Amount:
  - o The highest amount may be no more than 2.5 X the lowest amount
  - o Employees must fall under specified classifications to qualify for specified amounts

Eligible Employees	Minimum Amount	Maximum Amount	# of Employee Classifications
2-10	$10,000	$25,000	up to 4
11-25	$10,000	$50,000	up to 4
26-199	$10,000	$75,000	up to 4
200-500	$10,000	$150,000	up to 4

☐ **MetLife**

Guaranteed Issue Amounts are available as indicated in table below:

- Scheduled Amount:
  - o Minimum 3 Employees per classification
  - o No more than 2.5 X difference between classifications
  - o Employees must fall under specified classifications to qualify for specified amounts

Eligible Employees	Coverage Amounts Available	# of Employee Classifications
2-4	$10,000; $25,000	N/A
5-9	$10,000; $25,000; $35,000; $50,000	N/A
10-24	$10,000; $25,000; $35,000; $50,000; $75,000	up to 2
25-49	$10,000; $25,000; $35,000; $50,000; $75,000; $100,000	up to 2
50-199	$10,000; $25,000; $35,000; $50,000; $75,000; $100,000; $150,0000	up to 3
200-500	$10,000; $25,000; $35,000; $50,000; $75,000; $100,000; $150,0000	up to 3

B. Select One Option for Employee Life Amount

☐ **Option 1 - Flat Amount**

Select a Flat amount for all employees

Amount

$ _____

☐ **Option 2 - Scheduled Amount** *(select # of classifications that corresponds with the # of eligible Employees and Carrier selected in A above)*

Life Amount	Employee Classification *(i.e. management, executive, etc.)*	Life Amount	Employee Classification *(i.e. management, executive, etc.)*
$ _____	_____	$ _____	_____
$ _____	_____	$ _____	_____

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ADDITIONAL TERMS & CONDITIONS TO THE CHOICEBUILDER® WELFARE BENEFIT INSURANCE TRUST MASTER APPLICATION

1. Participation. The employer or employee organization (as described in sections 3(4) or 3(5) of ERISA, respectively) named in the Master Application (**"Participating Employer"**) hereby adopts as a participating employer the ChoiceBuilder Welfare Benefit Insurance Trust (the **"Trust"**), as set forth in the instrument(s) creating such Trust (the **"Trust Agreement"**). Such action shall be effective on the date shown below with respect to the sub-trust first named below that the Participating Employer is eligible to adopt in accordance with the terms of the Trust.

(a) Master Trust
(b) Industry Sub-Trust
(c) Single Employer Sub-Trust

2. Ratification of Trust Agreement. Participating Employer hereby ratifies, accepts and agrees to be bound by all of the provisions of the Trust Agreement as amended from time to time, a copy of which has been made available to it.

3. Acceptance of Trustee and Administrator. Participating Employer hereby accepts the trustee and administrator named in the Trust Agreement as the trustee and administrator of the Trust (the **"Trustee and Administrator"**) with all of the rights, powers and responsibilities set forth in the Trust Agreement and agrees to be bound by and ratifies the actions heretofore or hereafter taken by the Trustee and Administrator in accordance with the terms of the Trust Agreement.

4. Trustee's Action. Participating Employer acknowledges and agrees that its request to participate in the Trust pursuant to this Request for Participation shall not be effective until accepted by the Trustee in accordance with the terms of the Trust Agreement. Trustee hereby represents that, before this Request for Participation was entered into, all information described in Paragraph 9 hereof was provided to the fiduciary of the Participating Employer with the authority to enter the Participating Employer into the Trust (the **"Responsible Plan Fiduciary"**).

5. Benefits Subject to Provisions of Insurance Policies. Participating Employer agrees to be bound by the terms and conditions of the Trust Policies (as defined in the Trust Agreement) under which its employees become covered and agrees to pay all premiums required by the provisions of the Trust Policies for the coverages it purchases. Participating Employer understands that the insurance coverages it elects to purchase hereunder may terminate or lapse if such premiums are not paid when required by the provisions of the Trust Policies.

6. Assignment to Applicable Trust. Participating Employer agrees that the Trustee may assign or cause it to be assigned to any sub-trust under the Trust for which the Participating Employer is eligible at the time of this request. The Participating Employer acknowledges that it has indicated its proper Standard Industry Classification Code below to facilitate such assignment and that the Trustee may assign or cause it to be assigned to a different sub-trust under the Trust for which it becomes eligible in the future, should the Trustee deem this advisable.

7. Establishment of Plan; Designation of Claims Administrator. Participating Employer agrees that, by adopting this Trust, it is establishing an employee welfare benefit plan (the **"Plan"**) in accordance with the Employee Retirement Security Act of 1974, as amended (**"ERISA"**) to provide its eligible employees with the insurance benefits provided by the Policies. Participating Employer further agrees that it will communicate the terms of the Plan to all eligible employees, and will maintain such Plan in full force and effect so long as any employee remains eligible for such insurance benefits. Participating Employer hereby designates, in accordance with Section 503 of ERISA, the Carrier issuing a Policy as the named fiduciary under the Plan with complete and discretionary authority to review all denied claims for insurance benefits under such Policy and to construe disputed or doubtful Policy terms with respect to such insurance benefits and that such Carrier shall be deemed to properly exercise such authority unless it abuses its discretion by acting arbitrarily and capriciously.

8. Limitations on Participating Employer's Rights and Responsibilities under the Trust. Participating Employer's sole responsibility under the Trust is to adopt it as set forth in this Request for Participation. Upon acceptance of its adoption by the Trustee, Participating Employer shall have no further rights, duties or responsibilities under the Trust, except to the extent otherwise provided therein.

9. Disclosure of Fees and Conflicts of Interest. Notwithstanding anything herein to the contrary, this Request for Participation shall not become effective until the Trustee, to the best of its knowledge, provides or causes to be provided to the Responsible Plan Fiduciary the following disclosures or such other disclosures as may be required by ERISA:

(a) All services to be provided by the Trustee or any of its affiliates (collectively, the **"Service Providers"**) pursuant to the Trust Agreement, this Request for Participation and any other agreements or arrangements related to the provision of benefits by the Trust or Policies (collectively, the **"Service Agreements"**), the compensation or fees (including, gifts, awards, or trips received, or to be received, from any source on account of the Service Provider's position with the Plan) for such services, and the manner of receipt of such compensation. Such disclosure shall provide a description of the manner of receipt of compensation or fees and shall state whether the Service Providers will bill the Participating Employer, deduct fees directly from the Plan accounts, or reflect a charge against the Plan investment. Such disclosure will also describe how any prepaid fees will be calculated and refunded when Participating Employer withdraws from the Plan.

(b) Whether any Service Provider will provide any services to the Plan as a fiduciary either within the meaning of Section 3(21) of ERISA or under the Investment Advisers Act of 1940.

(c) Whether any Service Provider expects to participate in, or otherwise acquire a financial or other interest in, any transaction to be entered into by the Plan and, if so, a description of the transaction and the Service Provider's participation or interest therein.

(d) Whether any Service Provider has any material financial, referral, or other relationship or arrangement with a money manager, broker, other client of the Service Provider, other service provider to the Plan, or any other entity that creates or may create a conflict of interest for the Service Provider in performing services to the Plan and, if so, a description of such relationship or arrangement.

(e) Whether any Service Provider will be able to affect its own or another Service Provider's compensation or fees, from whatever source, without the prior approval of an independent fiduciary of the Plan, in connection with the provision of services to the Plan (for example, as a result of incentive, performance-based, float, or other contingent compensation) and, if so, a description of the nature of such compensation.

(f) Whether any Service Provider has any policies or procedures that (i) address actual or potential conflicts of interest or (ii) are designed to prevent either compensation or fees or any other business ventures or relations that may be entered into between the Plan and a Service Provider, from adversely affecting a Service Provider's ability to provide services under the Service Agreements, and, if so, an explanation of these policies or procedures and how they address such conflicts of interest or prevent an adverse effect on the provision of services.

The Trustee shall disclose or cause to be disclosed to the Responsible Plan Fiduciary any material change to the information disclosed above not later than 30 days from the date on which the Service Provider acquires knowledge of the material change. The Trustee shall also disclose or cause to be disclosed all information related to the Service Agreements and any compensation or fees received there under that is requested by the Responsible Plan Fiduciary or administrator of the Plan in order to comply with the reporting and disclosure requirements of Title I of ERISA and the regulations, forms, and schedules issued there under.

(continued on next page)

STATEMENT OF COMPLIANCE

I hereby certify that all the information contained in the employer application is true and correct to the best of my knowledge. I have read and understand the following statements and confirm that my group complies with all the rules and regulations of the ChoiceBuilder® Program. I understand that no coverage will become effective until notified by the ChoiceBuilder Underwriting Department.

- Our Home Office is located in California
- ChoiceBuilder coverage will be offered to all eligible employees on a uniform basis

I understand that ChoiceBuilder coverage will be administered under the laws of California for all enrollees.
I understand that once ChoiceBuilder coverage is approved, group policy changes cannot be implemented until the next renewal period. These changes shall include, but are not limited to COBRA provisions, new hire waiting period, minimum hours worked per week, and premium contribution amounts.
I understand that once membership information is transmitted to the elected health plans, our group coverage effective date cannot be changed nor can our coverage be terminated until after the first month of coverage.
I understand that no alterations can be made to this section and that it must be signed exactly as stated.
I understand that the above statements are subject to audit at any time.
I understand that the above qualifications must be maintained in order for my group to continue coverage through ChoiceBuilder.
I agree to provide ChoiceBuilder with any and all information necessary to prove the above statements.
I understand that if I am unable to provide the requested information, all ChoiceBuilder benefits will terminate 15 days following notice of termination and employees will be held responsible for all services and charges incurred through ChoiceBuilder program providers.
I understand that any persons, business, or health plan that suffers a loss because of false declarations contained in this employer application may have cause to bring civil action against our company to recover their losses.
I understand that premium payments are to be received by ChoiceBuilder by the statement due date.
I agree and understand that if the contributory status or participation percentages change that ChoiceBuilder reserves the right to non-renew or adjust premiums accordingly.

I DECLARE UNDER THE PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

Owner/Partner Signature

Print Name

Today's Date (MM/DD/YYYY)

Signature of Broker of Record

Print Name

Today's Date (MM/DD/YYYY)

Company Name

BROKER/AGENT ACKNOWLEDGEMENT

General Agent/PPGA Name *(if applicable)*

Enrollment Quote Number *(must include version number)*

Broker Name *(please print)* Must be broker name - not agency

Phone # (XXX) XXX-XXXX

Fax # (XXX) XXX-XXXX

Commissions payable to

% Commission if split

Co-Broker Name *(please print)*

Phone # (XXX) XXX-XXXX

Fax # (XXX) XXX-XXXX

Commissions payable to

% Commission if split

I certify that the employer applying for coverage through the ChoiceBuilder program has met all applying participation requirements
Agent/Producer/Broker Attestation – To be completed by the agent/broker

1. To the best of my knowledge, the information on this application is complete and accurate.
2. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
3. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
4. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize ChoiceBuilder to attribute such additions or changes to me.
5. I have advised the employer, in easy-to-understand language, that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until ChoiceBuilder reviews and approves the application and the employer receives a written notice from ChoiceBuilder. The employer understood my explanation.
6. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from ChoiceBuilder shall be paid to an agent/producer/broker not appointed/approved by ChoiceBuilder.
7. I have advised the client not to terminate any existing coverage until receiving written notification from ChoiceBuilder that the coverage being applied for by this application is accepted.
8. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.
9. I understand that if any portion of this statement signed by me is willfully false, I may be subject to civil penalties as authorized under California Health and Safety Code Section 1389.8 and Insurance Code Section 10119.3: if I willfully state as true any material fact that I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000.

Broker Signature

Today's Date (MM/DD/YYYY)

Co-Broker Signature

Today's Date (MM/DD/YYYY)

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