MASTER APPLICATION FOR LARGE 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 Contact: 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:	Rate Structure: ☐ 3-Tier ☐ 4-Tier	Are you changing cross-border providers? ☐ Yes ☐ No

PLAN SELECTION

MediExcel Health Plan Offering:
- ☐ VP-5 HMO Plan
- ☐ VP-10 HMO Plan
- ☐ VP-20 HMO Plan
- ☐ MEP HMO Plan
- ☐ QEP HMO Plan

Choose a Dental Plan option:
- ☐ D100
- ☐ D200

***CAN BE OFFERED AS VOLUNTARY**
- ☐ No Dental Plan

Confirm Vision Plan option:
- ☐ V100

***CAN BE OFFERED AS VOLUNTARY**
***ACTIVE 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

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

EMPLOYER HEALTH QUESTIONNAIRE (*Complete **ONLY** if 10 EE's or less are enrolling*)

Please answer the following questions to the best of your knowledge for your employees and/or dependents enrolling in MediExcel Health Plan, including any COBRA participants.

1) Is there any enrolling employee who will be covered under this plan who has received an excess of $20,000 in medical care expenses in the last 2 years? ☐ Yes ☐ No

2) Is there any enrolling employee to be covered under this plan who is unable to work or attend school due to an injury or illness? ☐ Yes ☐ No

FOR EACH QUESTION ANSWERED "YES," PLEASE EXPLAIN TO THE BEST OF YOUR ABILITY:

QUESTION #____: _____

QUESTION #____: _____

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.

_____	_____/_____	_____
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:** _____