



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 agree to receive all Plan documents, including announcements, surveys, and/or invoices via e-mail.

CA Coverage Health Insurance Carrier(s):	Name of Current Workers' Comp Carrier:
Other Health Insurance Plans Offered:	Premium Billing Reference: <input type="checkbox"/> Bill One Location <input type="checkbox"/> Bill Multiple Locations
Effective Date Requested:	Rate Structure: <input type="checkbox"/> 3-Tier <input type="checkbox"/> 4-Tier
Are You Changing Cross-Border Providers? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PLAN SELECTION

MediExcel Health Plan Offering: <input type="checkbox"/> VP-5 HMO Plan <input type="checkbox"/> VP-10 HMO Plan <input type="checkbox"/> VP-20 HMO Plan <input type="checkbox"/> MEP HMO Plan <input type="checkbox"/> QEP HMO Plan	Choose a Dental Plan option: <input type="checkbox"/> D100 <input type="checkbox"/> D200 *CAN BE OFFERED AS VOLUNTARY <input type="checkbox"/> No Dental Plan	Confirm Vision Plan option: <input type="checkbox"/> V100 *CAN BE OFFERED AS VOLUNTARY *ACTIVE MEDIEXCEL MEDICAL COVERAGE REQUIRED <input type="checkbox"/> 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: ____
----------------------------	---	--	---	----------------------------------

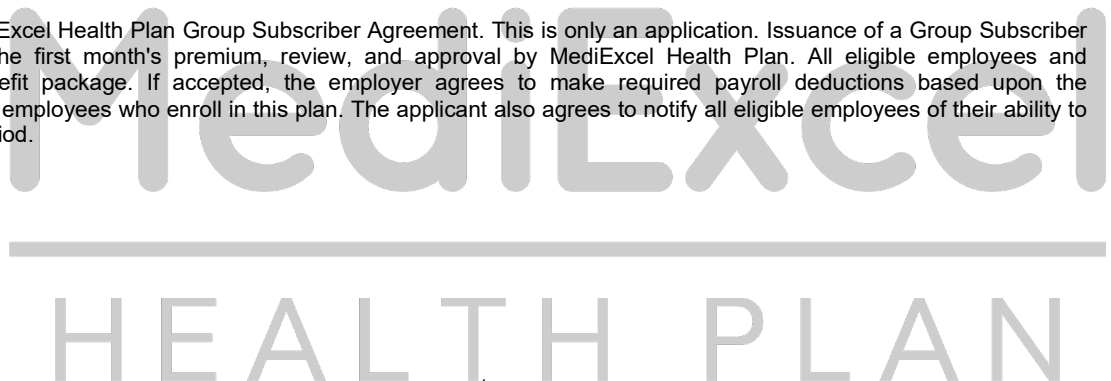
REQUIRED COBRA INFORMATION

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: Full-time EE's: <input type="checkbox"/> 30 hours+ per week Do you want to cover part-time employees that work a min. of 20-29 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer Contribution Levels: Employee _____ % or \$ _____ Dependent _____ % or \$ _____
Waiting Period for New Hires and Rehires New Hire (<i>check one</i>): 1 st of the month following <input type="checkbox"/> 60 days <input type="checkbox"/> 30 days <input type="checkbox"/> 0 days Re-Hires (<i>check one</i>): 1 st of the month following <input type="checkbox"/> 60 days <input type="checkbox"/> 30 days <input type="checkbox"/> 0 days	
EMPLOYER HEALTH QUESTIONNAIRE (<i>Complete ONLY if 10 EE's or less are enrolling</i>) 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.	
<div style="display: flex; justify-content: space-between;"> <div> 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? </div> <div style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> 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? </div> <div style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> </div> <p style="margin-top: 10px;">FOR EACH QUESTION ANSWERED "YES," PLEASE EXPLAIN TO THE BEST OF YOUR ABILITY:</p> <p>QUESTION # ____: _____</p> <p>QUESTION # ____: _____</p>	

Application is hereby made for a MediExcel Health Plan Group Subscriber Agreement. This is only an application. Issuance of a Group Subscriber Agreement is subject to receipt of the first month's premium, 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 <input type="checkbox"/> No <input type="checkbox"/> General Agency Name: Tax ID: _____
---	---