MASTER APPLICATION FOR SMALL GROUP EMPLOYERS

COMPLETE ALL FIELDS. IF A FIELD DOES NOT APPLY, ENTER "N/A."
DO NOT LEAVE ANY SECTION BLANK. INCOMPLETE APPLICATIONS MAY DELAY PROCESSING.

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 is 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
Effective Date Requested:	Are you changing cross-border providers? ☐ Yes ☐ No

PLAN SELECTION

MediExcel Health Plan Offering:

☐ P5 Platinum HMO Plan

☐ P10 Platinum HMO Plan

☐ Platinum 90 HMO 0/20 INF Plan

☐ Gold 80 HMO 250/35 INF Plan

***Min. 5 EEs required for P5, P10 Platinum HMO Plans**

Choose a Dental Plan option:
☐ D100 ☐ D200

Choose tier level:
☐ 3-Tier ☐ 4-Tier

***CAN BE OFFERED AS VOLUNTARY**

☐ No Dental Plan option

Confirm Vision Plan option:
☐ V100

Choose tier level:
☐ 3-Tier ☐ 4-Tier

***CAN BE OFFERED AS VOLUNTARY**
*** ACTIVE MEDIEXCEL MEDICAL COVERAGE REQUIRED**

☐ No Vision Plan option

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 $_____ Does the Employer have a Federal DOL Form 5500 #? ☐ Yes ☐ No If Yes, please provide the Form 5500 #: _____
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 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.

Underwriting Requirements: (*Effective 07/01/25*)

• Contingent Approval - Small Groups Enrolling Less Than 5 EEs and No DE9C:

- Group Must Submit DE9C in the Following Quarter for Complete Approval.

• New Documents Required When Enrolling 1-4 EEs:

- Government Issued IDs
- Marriage Certificate
- California Certificate of Domestic Partnership filed with the state, or a Notarized Declaration of Domestic Partnership from Mexico
- Birth Certificate for Dependent children matching at least one parent's surname

• Random Audit

- All Groups are subject to random recertification at renewal.

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:** _____