Master Group Application

Group Sales: Tel: 1-888-371-3060 | Fax: 1-415-955-8819

Balance by CCHP

CCHP will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract.

1. Employer Group Information

Full Legal Business Name:	How Long in Business:	Type of Business (Be Specific):	Effective Date: (MM/DD/YY) / /
Primary Group Administrator Contact:	Title:	Phone:	Email:
Secondary Group Administrator Contact	Title:	Phone:	Email:
Federal Employer ID #:	State Employer ID #:	Fax:	Send administrative kit to: ☐ Employer ☐ Agent/Broker
Business Physical Address, City, State, ZIP (No P.O. Box):			
Billing Contact:	Title:	Phone:	Email:
Billing Address, City, State, ZIP (if different from above):			

Type of Entity: ☐ Corporation ☐ Sole Proprietorship ☐ S-Corporation ☐ Partnership ☐ Other (explain) _____

2. Employer Group Plan Coverage Selection

Medical Plans ☐ Ruby[10] HMO Platinum ☐ Ruby[20] HMO Platinum ☐ Ruby[40] HMO Platinum ☐ Opal[25] HMO Gold ☐ Opal[50] HMO Silver
☐ Platinum[90] HMO ☐ Gold[80] HMO ☐ Silver[70] HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO

Optional Riders (Applies to all Balance Enrollees) ☐ Adult Vision (VSP) ☐ Adult Dental (Delta) ☐ Other _____

Note(s) (CCHP Use Only):

3. Employer Premium Contribution

Employee (min. 50%): $ / % | Dependent: $ / %

4. Employees Will Be Eligible for Benefits Upon

1st of the month following: ☐ Date of Hire ☐ 30 days ☐ 60 days
Other _____

5. Number of Employees (Employer is responsible for collecting refusal of coverage forms)

Total # of employees:	Total # of eligible employees (30+hrs/week):	
Total # of eligible employees enrolled in Balance:	Total # of employees who wavie coverage:	Annual average # of employees:

6. Current Carrier Information

Name of your current group medical insurance carrier(s):

Are you intending to replace your existing group coverage? ☐ No ☐ Yes, Termination Date / /

Current Workers' Compensation Carrier:	Next Renewal Date (MM/DD/YY): / /

7. COBRA / CAL-COBRA Information

Is your group currently subject to COBRA or CAL-COBRA? ☐ No ☐ Yes, please complete the following for each person

1	Name:	Date of Birth (MM/DD/YY): / /	SSN:	Tel:	Date Continuation Begin (MM/DD/YY): / /
	Qualifying event description:				Date (MM/DD/YY): / /
2	Name:	Date of Birth (MM/DD/YY): / /	SSN:	Tel:	Date Continuation Begin (MM/DD/YY): / /
	Qualifying event description:				Date (MM/DD/YY): / /

8. Form of Member *Evidence of Coverage and Notices*

Employer are responsible for the distribution of the Evidence of Coverage and Notices to your covered employees. Electronic versions will be distributed to you upon request. Employer is responsible for distributing the documents using one of the following methods; 1.) posting on the employer's intranet for employee access or, 2) emailing these documents directly to their employees. Printed versions will only be mailed to the employer directly upon request.

☐ I elect to receive printed, not electronic, Evidence of Coverage and Notices. I understand that I am responsible for distributing the documents to my covered employees.

9. Signature and Conditional Receipt

This is an application for coverage only. The group understands that no contract for coverage will exist until CCHP has completed its review and communicated to the applicant or the applicant's broker that the application has been accepted and a group health service/group policy will be issued. The group's representative certifies to the best of his or her knowledge and belief, all of the responses given are true, correct, and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of issuance of coverage, CCHP may pursue one of the following remedies: coverage may be cancelled or the applicable dues/premiums may be adjusted, or following notice, the Health Service Contract/Insurance policy may be rescinded.

We, the employer, warrant that all information in this application is true and complete, and that CCHP may rely on this application in deciding whether to provide coverage. If the application is not complete, CCHP reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by CCHP and only if we have paid our first month's contribution and this application is accepted, and that we should keep prior coverage in force until notified of acceptance by CCHP. If this application is accepted, it becomes a part of our contract with CCHP.

We understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between us and CCHP and any of this affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage and Notice.

Signature of Employer/Authorized Representative: X	Print Name:	Title:	Date (MM/DD/YY): / /

10. Agent/Broker Certification (To be completed by your agent or broker after completion of this application)

I, _____, assisted the applicant in submitting this application. All information in the health questionnaire was completed by applicant. I advised the applicant to answer all questions completely and truthfully and that no information requested should be withheld. I explained that withholding information may result in cancellation of coverage in the future. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Notice to agent: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand ($10,000) dollars, as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

Agent/Broker Signature X	Agent/Broker Name:	CA License Number:	Note(s) (CCHP Use Only):
Email:	Phone:	Fax:	Date (MM/DD/YY): / /

CCHP Use Only

Sales Representative / Sales Executive [ ]	Sales Manager [ ]	COO [ ]
Payment [CC / Bill / Check #]	Amount [ ]	Date [ ]
Rec'd by Enrollment [ ]	Packet Sent Date [ ]	