blue california

Employer questionnaire for 51 to 299 eligible employees

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Participation and eligibility requirements apply

Reset form

Group name: Proposed effective date:

Address:

Type of business (SIC):

Has the group been previously covered by Blue Shield, or have other coverage with Blue Shield? ☐ Yes ☐ No
If yes, explain:

Carrier history for the past 5 years: (groups with more than 3 carriers in 5 years are ineligible)

Carrier name	Type of coverage	Period insured

Employee eligibility		**Employer contribution**
Eligible employees are active full-time employees who work at least 20 hours per week (retirees or 1099's are not eligible)		
How many employees do you employ?		For employees: _____%
How many employees are eligible for health benefits?		For dependents: _____%
How many eligible employees are enrolling?		
How many eligible employees are covered under a spouse's/domestic partner's plan?		(Minimum of 50% overall)
How many eligible employees are covered under Kaiser?		

Please answer the following questions to the best of your knowledge for the persons to be insured (employees, dependents, partners). Provide details for any YES responses on a separate sheet of paper.

1. In the past 12 months, has any person suffered a condition that resulted in expenses of $25,000 or more? ☐ Yes ☐ No

2. Are you aware of any person that is disabled, or being treated for heart disease, stroke, cancer, kidney disorder, AIDS or AIDS-related complex, chronic respiratory disease, or is currently hospitalized or has been told extensive medical treatment, surgery, or hospitalization is required? Please note: No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by health insurance companies or healthcare service plans as a condition of obtaining health coverage. ☐ Yes ☐ No

3. Are there any COBRA continuees? If yes, how many? _____ ☐ Yes ☐ No

4. Will an HRA or an HSA plan be offered? If yes, what will the employer contribution level be for? ☐ Yes ☐ No
   HRA employee $ _____ HSA employee $ _____
   Family $ _____ Family $ _____

This document expires 60 days from the date of execution. The information provided by the employer group in this questionnaire is correct and true to the best of the employer group's knowledge and belief, and Blue Shield relies upon this information in issuing a quote. If errors or omissions are subsequently found, Blue Shield of California, and/or Blue Shield of California Life & Heath Insurance Company as applicable, reserves the right to revise rates quoted or rescind the quote.
For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of company officer | Date

Print name | Title

Signature of broker/consultant | Date

Print name | Title