



MASTER APPLICATION FOR SMALL 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: 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: <input type="checkbox"/> Bill One Location <input type="checkbox"/> Bill Multiple Locations
Requested Effective Date:	Are you changing cross-border providers? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLAN SELECTION

MediExcel Health Plan Offering: <input type="checkbox"/> P5 Platinum HMO Plan <input type="checkbox"/> P10 Platinum HMO Plan <input type="checkbox"/> Platinum 90 HMO 0/20 INF Plan <input type="checkbox"/> Gold 80 HMO 250/35 INF Plan *Min. 3 EEs required for P5, P10 Platinum HMO Plans	Choose a Dental Plan option: <input type="checkbox"/> D100 <input type="checkbox"/> D200 Choose tier level: <input type="checkbox"/> 3-Tier <input type="checkbox"/> 4-Tier *CAN BE OFFERED AS VOLUNTARY <input type="checkbox"/> No Dental Plan	Confirm Vision Plan option: <input type="checkbox"/> V100 Choose tier level: <input type="checkbox"/> 3-Tier <input type="checkbox"/> 4-Tier *CAN BE OFFERED AS VOLUNTARY ACTIVE MEDIEXCEL MEDICAL COVERAGE REQUIRED <input type="checkbox"/> No Vision Plan
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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: _____
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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: _____

