



## SMALL BUSINESS GROUP APPLICATION 1-50 ELIGIBLE EMPLOYEES

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**Colorado insurance law requires all carriers in the small group market to issue any health benefit plan it markets in Colorado to small employers of 2-50 employees, including a basic or standard health benefit plan, upon the request of a small employer to the entire small group, regardless of the health status of any of the individuals in the group. Business groups of one cannot be rejected under a basic or standard health benefit plan during an open enrollment period as specified by law.**

Employers with ten or more eligible employees are entitled to a choice of composite rates or four-tier age-banded rates.

Age-banded four-tier rates reflect a rate for each employee and their dependents based on the age of the employee. The rate for an older employee is higher than the rate for a younger employee because the expected health care costs of an older person are higher than those of a younger person.

In the first month of coverage, age-banded rates and composite rates will produce the same total premium for the group. With age-banded rates, as new employees are added, the total premium will change to reflect the age of the employee at the time of their enrollment for that policy year. With composite rates, the same rate per employee is charged, and the total will change only with the number of employees and the dependent coverage tier.

When composite rates are chosen, if the actual enrollment in the first month is different from that considered in our rate proposal, the composite rates will be recalculated prior to the first billing.

As an employer, you have the right to renew your coverage on your plan anniversary date provided that your premiums are paid current. Renewal information and rates will be sent to you 30 days prior to your renewal date.

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By purchasing the Basic Health Benefit Plan, you are waiving coverage for mammography screening, mental illness, prostate screening, hospitalization and anesthesia for dental procedures for children, alcoholism and hospice care.

The premium for all other plans includes the cost of the following benefits mandated pursuant to Section 10-16-104, Colorado Revised Statutes: newborn coverage; complications of pregnancy; maternity; therapies for congenital defects and birth abnormalities; mammography; mental illness; biologically-based mental illness; alcoholism (if included); hospice care (if included); prostate cancer screening; child health services; hospitalization and anesthesia for dental procedures for children; diabetes; and prosthetic devices.



Medical Plans		Dental Plans <sup>1</sup>
<b>PacifiCare SignatureValue<sup>SM</sup> (HMO)</b> <input type="checkbox"/> 15-30/300a <input type="checkbox"/> 25-40/400d <input type="checkbox"/> 15-35/200d <input type="checkbox"/> 30-50/500a <input type="checkbox"/> Standard <input type="checkbox"/> Basic	<b>PacifiCare SignatureOptions<sup>SM</sup> (PPO)<sup>2, 4</sup></b> <input type="checkbox"/> 20/80-60/500 <sup>4</sup> <input type="checkbox"/> 20/80-60/1,000 <sup>4</sup> <input type="checkbox"/> 25/80-60/1,500 <sup>4</sup> <input type="checkbox"/> 30/80-50/2,000 <sup>4</sup> <input type="checkbox"/> 30/70-50/2,000 LFS <sup>4</sup> <input type="checkbox"/> Standard PPO <sup>4</sup> <input type="checkbox"/> Basic PPO <sup>4</sup> <input type="checkbox"/> Bona Fide Association 20/80-50/500 <sup>3, 4</sup> <input type="checkbox"/> Bona Fide Association 20/70-50/1000 <sup>3, 4</sup>	<input type="checkbox"/> 100 <input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 500 <input type="checkbox"/> 550 <input type="checkbox"/> 600 <input type="checkbox"/> 800 Voluntary: <input type="checkbox"/> Y <input type="checkbox"/> N <b>Vision Rider<sup>1</sup></b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Chiropractic Rider<sup>1</sup></b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Age Banded Rates</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Composite Rates</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PacifiCare SignaturePOS<sup>SM</sup></b> <input type="checkbox"/> 15-30/300a	<b>PacifiCare SignatureFreedom<sup>SM</sup> (SDHP)</b> <input type="checkbox"/> Plan 7 <sup>4</sup> 80-60/1,500 10/30/50 (Rx) <input type="checkbox"/> Plan 8 <sup>4</sup> 70-50/2,000 LFS 10/30/60 (Rx) <input type="checkbox"/> Bona Fide Association 70-50/1500 10/30/60 (Rx) <sup>3, 4</sup>	

<sup>1</sup> Dental, Vision and Chiropractic riders are not available on the PPO plans. Chiropractic rider is not available on either the HMO Basic or PPO Basic plan.

<sup>2</sup> Enrollment of out-of-state-employees on any of the PPO plans may represent no more than 10% of the Group's enrolled Eligible Employees. Employees residing within PacifiCare Health Systems states (AZ, CA, CO, NV, OK, OR, TX, WA) do not count toward the 10%.

<sup>3</sup> Only available to members of a Bona Fide Association. Please check with your broker to determine whether you are eligible to enroll in these plans.

<sup>4</sup> Underwritten by PacifiCare Life Assurance Company.

**Business Group of One (BG1):** The Basic, Standard and 30-50/500a Health Benefit plans are available on a guaranteed issue basis for 31 days following a qualifying event. 30/70-50/2,000 LFS, Standard PPO and Basic PPO are also available guaranteed issue for BG1. Please check if one of these events apply:

- Exhausted COBRA or State Continuation coverage     Involuntary loss of other Creditable Coverage  
 Meet the definition of a Business Group of One for the first time.     31 days of birthday: \_\_\_\_\_

**Documentation will be required to show the qualifying event.**

**Employer Statement of Understanding:** Please read and initial the following statements.

- \_\_\_\_\_ **Eligibility:** The group understands that eligibility (e.g. waiting period, minimum hours, etc.) must be established at the time of initial application and may be changed only at contract renewal. The group's eligibility guidelines must be adhered to for all employees.
- \_\_\_\_\_ **Enrollment of New Employees:** The group understands that employees must be enrolled according to the group's established eligibility guidelines. Enrollment applications must be submitted **within 30 days of an employee becoming eligible.**
- \_\_\_\_\_ **Termination of Employees:** The group understands that terminated employees will be covered through the end of the month in which their employment ends **or PacifiCare receives notice of termination.** A change form must be submitted to terminate an employee. **The group is responsible for all premiums due until we receive an official notification of termination.**
- \_\_\_\_\_ **Continuation of Coverage:** The group understands that terminated employees and/or dependents must be offered Continuation of Coverage according to federal or state guidelines, whichever applies to the group.
- \_\_\_\_\_ **Addition/Deletion of Benefits:** The group understands that benefit riders (i.e. vision, dental, chiropractic) may be added or deleted only at the time of initial application or at contract renewal.
- \_\_\_\_\_ **Group Changes:** The group understands that PacifiCare must be notified of changes to the group (e.g. name, address, phone number, contact person, ownership status, etc.) when the change occurs.
- \_\_\_\_\_ **Payment of Premiums:** The group understands that monthly Premiums are due to PacifiCare by the last day of the preceding month, for coverage to continue in the current month.

I hereby certify that all statements on this document are complete and true to the best of my knowledge and belief. I understand that PacifiCare will rely on these statements and this information as the basis for approving this Application. I have read and understand the information herein. Further, the authorized person agrees to PacifiCare's payment terms and conditions. Undersigned represents that he/she is an authorized person of the small employer group applying for the coverage indicated above and is authorized to enter into a PacifiCare Health Plan Medical and Hospital Group Subscriber Agreement and/or PacifiCare Life Assurance Co. Group Policy on the small employer group's behalf. It is understood for the purposes of compliance with ERISA, the undersigned employer is to be named fiduciary of the employee benefit plan covered under this policy.

**EMPLOYER AGREES AND UNDERSTANDS THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENCELY OR INCOMPETENTLY RENDERED), EXCEPT FOR DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF COLORADO, INC., OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT 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. RIGHTS AFFORDED UNDER THE INTERNAL APPEALS PROCESS AND INDEPENDENT EXTERNAL REVIEW ARE NOT AFFECTED BY THIS PROVISION. DISPUTES NOT FULLY RESOLVED THROUGH THE INDEPENDENT EXTERNAL REVIEW PROCESS ARE SUBJECT TO THIS PROVISION.**

Authorized Signature	Date
Print Name	Title

Check here if you do not have a broker of record. If you do, please complete the information below:

Broker Information			
Agent Name	Firm Name	Phone ( )	E-mail Address
Address	City	State	ZIP
Payee: <input type="checkbox"/> Agent    or <input type="checkbox"/> Firm		Fax ( )	
Payee's SS# or Tax ID #:	Payee's Colorado License #:	Expiration Date	
Broker Signature			

For Internal Use Only:			
G.A. #	A.P. #	MKTG. #	G.C. #

# CENSUS DATA SHEET

In order to comply with State Regulation 4-6-8, Section 5, B(3) and (4) we require the following information before final approval of a group or renewal of an existing group.

Group Name

**Section I**

Please list **all** employees and their number of Dependents. Check those employees who are regularly scheduled to work 24 or more hours per week in column 1. If your company's eligibility rules are different than 24 hours, check which employees meet your rules in column 2. Please print or type.

Employee Name	# of Dependents	1 24 hours/wk	2 Specific Eligibility Rules
1. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
5. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
6. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
7. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
8. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
9. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
10. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
11. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
12. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
13. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
14. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
15. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>

**Section II**

Please list all current employees on State Continuation or COBRA coverage. Include date of birth, continuation effective date and projected termination date.

Continuation Member	Date of Birth	Effective Date	Termination Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____