



A Broker Information

CHECK IF NEW ADDRESS

BROKER CODE
(IF KNOWN)

AGENT NAME _____

AGENCY _____

ADDRESS _____

CITY _____, **CA** ZIP _____

PHONE (____) _____ FAX (____) _____

DELIVERY OF PROPOSAL:

- WILL PICK UP
- MAIL COMPLETE PROPOSAL
- HAVE REPRESENTATIVE CALL
- EMAIL COMPLETE PROPOSAL TO: _____

**FAX COMPLETED FORM
TO (714) 542-4244**

721 S. Parker, Suite 200
Orange, CA 92868
(800) 542-4218 ■ (714) 542-4200

B Group Information

COMPANY NAME _____

STREET ADDRESS _____

(NO P.O. BOX)

CITY _____, **CA** ZIP _____

1. NATURE OF BUSINESS _____

SIC CODE

2. LEGAL STRUCTURE OF THE BUSINESS:

- CORPORATION PARTNERSHIP S CORPORATION
- SOLE PROPRIETOR OTHER _____

3. CURRENT MEDICAL CARRIER _____

CURRENT MONTHLY PREMIUM _____

PLAN TYPE: HMO PPO MULTI/OPTION

4. DOES GROUP CURRENTLY HAVE A DENTAL PLAN ? YES NO

NAME OF DENTAL CARRIER _____

5. REQUESTED EFFECTIVE DATE _____

6. # OF ELIGIBLE EMPLOYEES* _____

7. # OF PART-TIME EMPLOYEES _____

**AT LEAST 70% OF ELIGIBLE EMPLOYEES MUST ENROLL.
SEE PAGE 6 OF EMPLOYER BROCHURE FOR DETAILS.**

8. OUT-OF-STATE EMPLOYEES? YES NO

(IF YES, PLEASE COMPLETE OUT-OF-STATE CENSUS ON BACK)

9. % OF COSTS TO BE PAID BY EMPLOYER:

_____ % EMPLOYEE COSTS

_____ % DEPENDENT COSTS

**EMPLOYER MUST CONTRIBUTE A MINIMUM OF 50% OF THE
LOWEST COST EMPLOYEE PREMIUM AVAILABLE**

C Life Insurance Enrollment Information

Choose one of two methods below

Coverage limits available for both methods	ELIGIBLE EMPLOYEES	GUARANTEED ISSUE	
		MINIMUM	MAXIMUM
	2-10	\$10,000	\$25,000
	11-25	\$10,000	\$50,000
	26-50	\$10,000	\$75,000

METHOD 1:

EMPLOYER MAY SELECT A FLAT AMOUNT OF INSURANCE STARTING AT \$10,000 AND INCREASING BY INCREMENTS OF \$5,000 TO THE MAXIMUM AMOUNT ALLOWED FOR THE NUMBER OF ELIGIBLE EMPLOYEES (SEE CHART). INDICATE NUMBER OF ELIGIBLE EMPLOYEES AND FLAT AMOUNT BELOW:

OF ELIGIBLE EMPLOYEES: FLAT AMOUNT:

To obtain life coverage, ALL full time employees enrolling in or waiving medical must be covered

METHOD 2:

EMPLOYER MAY SELECT UP TO 4 CLASSIFICATIONS OF INSURANCE COVERAGE IN \$5,000 INCREMENTS, WITH THE HIGHEST AMOUNT NO MORE THAN 2.5 TIMES THE LOWEST AMOUNT SELECTED:

LOWEST AMOUNT: **\$5,000 INCREMENTS ONLY** X 2.5 = HIGHEST AMOUNT: **\$500 INCREMENTS O.K.**

PLEASE ENTER UP TO 4 LIFE COVERAGE AMOUNTS THAT INCLUDE AND/OR FALL WITHIN THE MINIMUM AND MAXIMUM AMOUNTS ABOVE & EMPLOYEE CLASSIFICATION (i.e. EXECUTIVE, MANAGEMENT, HOURLY, ETC.) FOR EACH:

LIFE AMOUNT	EMPLOYEE CLASSIFICATION LEVEL TO BE OFFERED THIS AMOUNT
\$ <input type="text"/>	<input type="text"/>
\$ <input type="text"/>	<input type="text"/>
\$ <input type="text"/>	<input type="text"/>
\$ <input type="text"/>	<input type="text"/>

D Census Information

REQUIRED!

	EMPLOYEE NAME		SEX (M/F)	DATE OF BIRTH (MO/DAY/YEAR)	DEPENDENTS		IF ON COBRA	HOME ZIP CODE	LIFE AMOUNT (\$)
	LAST	FIRST			✓ IF SPOUSE	# OF CHILDREN			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
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25									

E Out-of-State Census Information

REQUIRED!

	EMPLOYEE NAME		SEX (M/F)	DATE OF BIRTH (MO/DAY/YEAR)	DEPENDENTS		IF ON COBRA	WORK ZIP CODE	LIFE AMOUNT (\$)
	LAST	FIRST			✓ IF SPOUSE	# OF CHILDREN			
1									
2									
3									
4									
5									

Questions? Call your CaliforniaChoice Representative at (800) 542-4218