Master Group Application (For groups of 101 and above)

blue california

## Blue Shield of California and
## Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

| Section 1 – Company information | | | |
|---|---|---|---|
| 1 | Full legal business name of group | Requested effective date of coverage (month/day/year): | |
| | Doing business as (DBA), if applicable: | County location of physical address | |
| 2 | Billing street address (if providing P.O. Box, also complete #3 below) | | |
| | City | State | ZIP code |
| 3 | Physical address (if different from above) | | |
| | City | State | ZIP code |
| 4 | Legal entity type: ☐ S-Corporation ☐ C-Corporation ☐ Partnership ☐ Sole proprietorship ☐ LLC ☐ Nonprofit ☐ Other (specify) _____ | | |
| | **Federal Employer Tax Identification (TID) number** _____ | | |
| | Is the group subject to ERISA? ☐ Yes ☐ No | | |
| 5 | Is the group intending to offer Blue Shield alongside another carrier's plan? ☐ Yes ☐ No | | |
| | Other carrier initial effective date of coverage (month/day/year): | | |
| | Does the group have any subsidiary or affiliated companies? ☐ Yes ☐ No | | |
| | If yes, please provide the following: | Tax ID number | Include in coverage? |
| | Legal name 1 | | ☐ Yes ☐ No |
| | Legal name 2 | | ☐ Yes ☐ No |
| | Legal name 3 | | ☐ Yes ☐ No |
| | Are all employees covered by workers' compensation to the extent required by law? ☐ Yes Carrier name: _____ ☐ No If no, please explain: _____ | | |

| 6 | **Group contact for:** | | |
|---|---|---|---|
| | Overall group contact (primary - Daily general contact) | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Online administrator contact (This is applicable if you are providing your eligibility to Blue Shield via the Blue Shield proprietary online tool) | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Billing contact | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Evidence of Coverage/ Certificate of Insurance (EOC/COI) contact | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Legal contact (accountable for binding legal commitments on behalf of employer group) | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Account Based Health Plan (ABHP) contact | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | COBRA administrator contact | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Enrollment Discrepancy Report contact (if utilizing EDI for electronic enrollment) | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Survey contact | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |
| | Additional contact (Please Specify) | A. Group contact name | B. Job title |
| | | C. Phone number | D. Email address (required) |

## Section 2 – Eligibility

**7** Will you be utilizing an EDI electronic file for your ongoing enrollment? ☐ Yes ☐ No
If yes, will your COBRA members be included on that file? ☐ Yes ☐ No

**Employment-based affiliation and waiting periods** – An employer may impose a bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed a combined total of 90 days.

Please note: An employee's "date of hire" is the first day employment begins. However, if the employer imposes an orientation or waiting period, the "effective date of coverage" is the first day after completion of any orientation/waiting period.

**7a. Employer waiting period** – The group may select one or more of the following options.

Coverage for eligible employees will become effective following completion of the waiting period on the day specified.

**If** there are multiple waiting period options based on employment classification, please indicate at the option selected:

☐ **No waiting period (effective date of hire)** Reset

- ☐ All employees
- ☐ Other (please describe) _____

☐ **Effective first of the month FOLLOWING DATE OF HIRE**

a. ☐ If hired on the 1st of the month, coverage **effective 1st of following month**. Reset
Example: employee hired 12/1/2022 = effective 1/1/2023

- ☐ All employees
- ☐ Other (please describe) _____

b. ☐ If hired on the 1st of the month, coverage **effective on date of hire**. Reset
Example: employee hired 12/1/2022 = effective 12/1/2022

- ☐ All employees
- ☐ Other (please describe) _____

☐ **Effective first of the month FOLLOWING 30 DAYS FROM DATE OF HIRE** Reset

- ☐ All employees
- ☐ Other (please describe) _____

☐ **Effective first of the month FOLLOWING 60 DAYS FROM DATE OF HIRE** Reset

Example: employee hired 12/15/2022 add 60 days = effective 3/1/2023

- ☐ All employees
- ☐ Other (please describe) _____

☐ **Effective on the 91st DAY FOLLOWING DATE OF HIRE**

**7b.** Will the waiting period be waived:

☐ Yes ☐ No For current, actively at-work employees enrolling during the initial transition to Blue Shield.

☐ Yes ☐ No For part-time employees upon attaining full-time status.

☐ Yes ☐ No If "Yes", the waiting period should be waived for employees rehired within:
☐ 1 month ☐ 90 days ☐ 3 months ☐ 6 months ☐ 12 months ☐ 13 weeks
☐ Anytime, effective date of rehire ☐ Anytime, effective first of month following date of rehire

Please note: If using EDI electronic file for ongoing enrollment and eligibility, the member effective dates are calculated by the dates on the EDI files and the applicable waiting period(s).

| 8 | **Employee count** |
|---|---|
| | Blue Shield asks the group to read these definitions of "employee" and provide the information requested using the definitions provided below. We rely upon the information provided by the group in determining group and employee eligibility for coverage.<br>**1. All employees** – Any individual employed by the group including full-time and part-time employees (29 USC 1002 (6)).<br>**2.Full-time employee (FTE) and FTE Equivalent** – FTE and FTE Equivalent is defined in Section 4980H(c)(2) of the Internal Revenue Code.<br>An FTE is an employee who has on average at least 30 hours of service per week, or at least 130 hours of service total, during a calendar month.<br>The number of FTE Equivalents is determined by combining the number of hours of service of all non-FTEs for the month, but no more than 120 hours of service per employee, then dividing the total number by 120.<br>**3.Eligible employee** – This definition is used to determine which employees are eligible to enroll, and remain enrolled, in coverage. An eligible employee is an individual who:<br>• Is an individual engaged on a full-time basis in the conduct of the business of the employer, whose normal work week is at least 30 hours, and whose duties in such employment are performed at the employer's regular places of business; or<br>• Is a sole proprietor or partner of a partnership engaged on a full-time basis, at least 30 hours per week, in the employer's business and who is included as an employee under a healthcare plan contract of the employer.<br>• An eligible employee does not include individuals working on a part-time, temporary, or substitute basis. |
| | **8a.** Total # of employees: |
| | **8b.** Total # of eligible full-time employees: |
| | **8c.** Total # of eligible employees enrolling in Blue Shield coverage (complete to the best of your knowledge): |
| | **8d.** Total # of eligible employees declining Blue Shield coverage (complete to the best of your knowledge): |
| | **8e.** Total # of FTE and FTE Equivalents: |
| | **8f.** Do you plan to offer Blue Shield coverage to out-of-state employees? ☐ Yes ☐ No<br>If yes, how many out-of-state employees do you have? _____ |
| | **Employer is responsible for collecting and retaining Refusal of Coverage forms, as well as providing the forms to Blue Shield upon request. If no Blue Shield medical plan is offered (e.g., dental, vision, or life insurance only), Refusal of Coverage forms are not required.** |

| | | | |
|---|---|---|---|
| **9** | **9a.** Are all full-time eligible employees being offered health coverage? | ☐ Yes | ☐ No |
| | **9b.** If the response to 9a is no, please explain: | | |
| | **9c.** Are all full-time eligible employees being offered health coverage actively working at least 30 hours per week? | ☐ Yes | ☐ No |
| | **9d.** If the response to 9c is no, please explain: | | |
| | **9e.** Are retirees eligible for benefits? Note: Retiree coverage option requires prior underwriting approval. | ☐ Yes | ☐ No |
| | **9f.** If the response to 9e is yes, please check any that apply:<br>☐ Early retirees under age 65 ☐ Retirees age 65 and over<br>Will the group contribute to retiree coverage? | ☐ Yes | ☐ No |
| | **9g.** Do you require your retiree coverage to be billed separately from your active employee population? | ☐ Yes | ☐ No |

If yes, provide the contact information and address to which the monthly bill should be sent for retiree coverage.

| | | | |
|---|---|---|---|
| Billing address | | | |
| City | | State | ZIP code |
| Contact name | Email address | | |

| | | |
|---|---|---|
| **9h. Optional:** Benefit selections default to member level benefits (MLB1) allowing dependents to elect equal to or less than subscriber regardless of Medical elections. By checking the following box, I am removing this option and all enrolled dependents will be equal to subscriber and must enroll in Medical. | ☐ | |

## Section 3 – COBRA/Cal-COBRA continuation coverage information

**10** Your group is subject to federal COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year. The group is solely responsible for all aspects of the administration of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

**10a**. How many existing COBRA participants do you have?

**10b**. Employees or COBRA/Cal-COBRA participants are required to complete a Disability Addendum (form C11248) if they are disabled or hospitalized.

Name of COBRA administrator: _____

COBRA member billing should be sent to the: ☐ Group ☐ COBRA administrator

Please provide COBRA administrator address:

| | | |
|---|---|---|
| Billing address | | |
| City | State | ZIP code |

## Section 4a – Blue Shield of California health plan selection

**11**

### Trio HMO plans

| | |
|---|---|
| Select first plan | Select second plan |
| Select third plan | Select fourth plan |

### Access+ HMO® plans

| | |
|---|---|
| Select first plan | Select second plan |
| Select third plan | Select fourth plan |

### Local Access+ HMO® plans[1]

| | |
|---|---|
| Select first plan | Select second plan |

1 Local Access+ HMO products are only available in designated counties: Marin, Orange, San Francisco, San Luis Obispo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Yolo, and portions of Contra Costa, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Ventura counties.

### Added Advantage POS℠ plans

| | |
|---|---|
| Select first plan | Select second plan |

### Full PPO/EPO plans

| | |
|---|---|
| Select first plan | Select second plan |
| Select third plan | Select fourth plan |

### PPO Savings plans

| | |
|---|---|
| Select first plan | Select second plan |
| Select third plan | Select fourth plan |

### Virtual Blue℠ plans

| | |
|---|---|
| Select first plan | Select second plan |

### Tandem PPO/EPO plans

| | |
|---|---|
| Select first plan | Select second plan |
| Select third plan | Select fourth plan |

### Active Choice® Plus/Active Choice® Classic plans

| | |
|---|---|
| Select first plan | Select second plan |

### Blue Shield 65 Plus℠ plans

☐ Custom plan (attach custom Summary of Benefits)

**12**

**Required employer contribution for Blue Shield health plans**
Enter percentage of dues/premium paid by the group for employees and dependents. If the group contributes 100%, then all eligible employees must enroll.

**Indicate medical plan employer contribution amount here:**

| | |
|---|---|
| **For employees** _____**%**<br>For retirees (if applicable) _____% | **For dependents** _____**%**<br>For retirees' dependents (if applicable) _____% |

**13** **Blue Shield account-based health plans (ABHP)**

Indicate if you are offering any of the following account options (check all that apply) and provide the name of the administrator of each program. Also, indicate any amount to be funded by employer contribution.

| Account type | Account administrator | Employer contribution amount INDIVIDUAL coverage | Employer contribution amount FAMILY coverage |
|---|---|---|---|
| ☐ Health savings account (HSA) | ☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims)<br>• **Mandatory with medical enrollment:** ☐ Yes ☐ No<br>☐ Other administrator (non-integrated option) | $ | $ |
| ☐ Health reimbursement arrangement (HRA) | ☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims)<br>• **Mandatory with medical enrollment:** ☐ Yes ☐ No<br>☐ Other administrator (non-integrated option) | $ | $ |
| ☐ Health incentive account (HIA) | ☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims)<br>• **Mandatory with medical enrollment:** ☐ Yes ☐ No<br>☐ Other administrator (non-integrated option) | $ | $ |
| ☐ Limited purpose flexible spending account (LPFSA – Dental and Vision) with HSA only | ☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims)<br>• **Mandatory with medical enrollment:** ☐ Yes ☐ No<br>☐ Other administrator (non-integrated option) | $ | $ |
| ☐ Flexible spending account (FSA)<br>☐ Medical FSA<br>☐ Dependent care FSA | ☐ HealthEquity (integrated model – Blue Shield shares eligibility and claims)<br>• **Mandatory with medical enrollment:** ☐ Yes ☐ No<br>☐ Other administrator (non-integrated option) | $ | $ |

| | Blue Shield of California optional benefits selection | |
|---|---|---|
| 14 | • Cannot be purchased without a medical plan.<br>• For Dual Choice packages, the same optional benefits must be purchased for all the plans selected.<br>• The rider product type must match the medical plan product type – only HMO to HMO, etc. | |
| | **Infertility rider – select plan type:** | **Select plan option:** |
| | Select plan type 1 | Select plan option 1 |
| | Select plan type 2 | Select plan option 2 |
| | Select plan type 3 | Select plan option 3 |
| | **Chiropractic and acupuncture riders – select plan type:** | **Hearing aid rider – select plan option:** |
| | Select plan type 1 | Select plan option 1 |
| | Select plan type 2 | Select plan option 2 |
| | Select plan type 3 | Select plan option 3 |
| | **Blue Shield of California outpatient prescription drug plan options (available for HMO/POS)** | |
| | Choose the Rx drug plan (Basic Rx) that applies:[1] | |
| | Select option 1 | Select option 2 |
| | Select option 3 | Select option 4 |
| | Choose the Rx drug plan (Enhanced Rx) that applies:[1] | |
| | Select option 1 | Select option 2 |
| | Select option 3 | Select option 4 |
| | Choose the Rx drug plan (Rx Spectrum) that applies:[1] | |
| | Select option 1 | Select option 2 |
| | Select option 3 | Select option 4 |
| | 1 Tier 4 Drugs, including Specialty Drugs, 20% up to a $250 maximum. | |
| | **Blue Shield of California outpatient prescription drug plan options (available for PPO, EPO, Active Choice® Classic, and Active Choice® Plus plans)** | |
| | Choose the Rx drug plan (Enhanced Rx or Premier Rx) that applies:[1] | |
| | Select option 1 | Select option 2 |
| | Select option 3 | Select option 4 |
| | Choose the Rx drug plan (Rx Spectrum) that applies:[1] | |
| | Select option 1 | Select option 2 |
| | Select option 3 | Select option 4 |
| | 1 Tier 4 Drugs, including Specialty Drugs, 30% up to $250 maximum. | |

**Section SB1 – Blue Shield of California dental plan options:**

**15** **The group may select from one of the following plan options:**

☐ **Single Dental Plan Option**

☐ **Dual Choice Dental Plan Options**

• 1 DPPO + 1 DHMO • 1 DPPO + 1 DINO • 2 DHMOs • 2 DPPOs

☐ **Triple Choice Dental Plan Options**

• 1 DPPO + 1 DHMO + 1 DINO

**Dental HMO**

| Select option 1 | Select option 2 |
|---|---|

**Dental PPO**

| Select option 1 | Select option 2 |
|---|---|

**Dental INO**

Select option

**16** **Required employer contribution for dental plans**

Enter percentage of dues/premium paid by the group for employees and dependents. For dental coverage, the employer must contribute at least 50% of the employee's premium (except voluntary). If 100% is paid, all eligible employees must enroll.

**Indicate dental plan employer contribution amount here:**

| | |
|---|---|
| **For employees** _____% | **For dependents** _____% |
| For retirees (if applicable) _____% | For retirees' dependents (if applicable) _____% |

**Section SB2 – Vision coverage***

**17**

| Select option 1 | Select option 2 |
|---|---|

**Vision Voluntary**†

| Select option 1 | Select option 2 |
|---|---|

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† A voluntary vision plan requires a minimum of 10 enrolling employees with Blue Shield Life medical coverage or 25% of eligible employees if without Blue Shield Life medical coverage. C17607-ML-SB

**18** **Required employer contribution for vision plans**

Enter percentage of premium paid by the group for employees and dependents. For vision coverage, the employer must contribute a minimum of 25% of the total employee's premium (except voluntary). If 100% is paid, all eligible employees must enroll.

**Indicate vision plan employer contribution amount here:**

| | |
|---|---|
| **For employees** _____% | **For dependents** _____% |
| For retirees (if applicable) _____% | For retirees' dependents (if applicable) _____% |

**Section SB3 – Life/AD&D insurance***

**19** **Eligibility** – All full-time employees who are actively at work Reset

**Basic Group Term Life/AD&D insurance for Employees:**

☐ **Flat amount** $ _____

☐ **Multiple of salary** _____ times salary, maximum $ _____

Benefit amounts established by salary are rounded to the next highest $1,000.

☐ **Graded:** 1. Class description _____ amount $ _____

2. Class description _____ amount $ _____

3. Class description _____ amount $ _____

4. Class description _____ amount $ _____

☐ **Basic Dependent life insurance:** Select amount

The dependent coverage amount listed is per dependent (spouse/domestic partner and/or each child) for one flat rate. Employee enrollment in Basic Group Term Life is required; the dependent benefit may not exceed 50% of the employee's benefit amount. Benefits for children ages 14 days to 6 months are 10% of the Basic Dependent Life amount elected.

| | | |
|---|---|---|
| **20** | **Required employer contribution for Basic Group Term Life/AD&D insurance**<br>Enter percentage of premium paid by the group for employees and dependents. For employee coverage, the group must contribute a minimum of 25% of the total employee's premium. If the group pays 100% of the employee's premiums (considered non-contributory), then all full-time employees (who are actively at work) must be enrolled. | |
| | **Indicate Basic Group Term Life/AD&D insurance contribution amount here:** | |
| | **For employees** _____**%**<br>For retirees (if applicable) _____% | **For dependents** _____**%**<br>For retirees' dependents (if applicable) _____% |
| **21** | **Group Supplemental Life and Supplemental AD&D insurance*:**<br>Coverage is subject to participation levels and Evidence of Insurability. | |
| | **Employee Supplemental Life and Supplemental AD&D insurance** (check all that apply):<br>☐ Supplemental Life insurance ☐ Supplemental AD&D insurance<br>Eligible class(es) ☐ All Eligible Employees or ☐ Classes _____<br>☐ Increments of $ _____ or ☐ Multiple(s) of salary: _____ times salary<br>Maximum of $ _____ or _____ x salary, whichever is less<br>Guaranteed issue of $ _____ | |
| | **Spouse/domestic partner Supplemental Life and Supplemental AD&D insurance.**<br>Only available if employee also elects Supplemental Life insurance and cannot exceed 50% of the employee benefit amount (check all that apply):<br>☐ Supplemental Life insurance ☐ Supplemental AD&D insurance<br>Increments of $ _____ to a maximum of $ _____ Guaranteed issue of $ _____ | |
| | **Child(ren) Supplemental Life and Supplemental AD&D insurance.**<br>Only available if employee also purchases Supplemental Life and Supplemental AD&D insurance and cannot exceed 50% of employee benefit amount (check all that apply):<br>☐ Supplemental Life insurance ☐ Supplemental AD&D insurance<br>Increments of $ _____ to a maximum of $ _____ | |
| | *Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). C17607-ML-SB | |

**Section 5 – Employer distribution of member** *Evidence of Coverage/Certificate of Insurance* **(EOC/COI)**

| | |
|---|---|
| **22** | You are responsible for the distribution of the EOC/COI booklets to your covered employees.<br>Electronic versions will be distributed via the Blue Shield employer website. Blue Shield will notify the individual responsible for EOC/COI distribution, identified in Section 1, #6 above, by email when the EOC/COI is ready for distribution. Employer is responsible for distributing these documents using one of the following methods: (1) posting on the company intranet for employee access, (2) emailing these documents directly to their employees, or (3) providing employees with instructions from Blue Shield about how to electronically retrieve the documents from the Blue Shield website.<br>**Note:** You can log in to **blueshieldca.com/policies** and download a *Summary of Benefits & Coverage* (SBC) for each plan you are considering. Once you purchase a plan(s), you will be asked to complete an attestation confirming you have downloaded the SBC(s) for those plans and will issue them to enrollees and prospective enrollees as required by law. |

## Agreement

**23** The group hereby applies for the group products selected on this application, as those benefit plans are outlined in the benefit summary(ies), with the understanding and agreement that:

1. Group benefits will not become effective, unless:
   a. Blue Shield receives and approves the application; and
   b. The group meets Blue Shield's underwriting requirements, including minimum participation and contribution requirements. (Participation and contribution requirements are required only upon renewal.)
2. The group agrees to pay the required monthly premium/dues to Blue Shield in a timely manner.
3. The group agrees to:
   a. Enroll all employees as they become eligible if the Health Service Contract/Group Policy is issued on a non-contributory basis; or
   b. Give all eligible employees an opportunity to apply for such group benefits if the Health Service Contract/Group Policy is issued on a contributory basis.
4. No waiver or requested change in coverage will become effective unless agreed to and signed by an officer of Blue Shield.
5. For life insurance/AD&D products only: enrolling employees must be actively at work or meet the active employment provisions for coverage before coverage may become effective. Coverage for any person not meeting these provisions on the effective date of the Group Policy, or any increase in coverage for any person not meeting these provisions on the effective date of such increase in coverage, will be deferred until the person returns to work or active employment.
6. The group consents to and authorizes Blue Shield to send all business correspondence through electronic communications. Blue Shield will notify the group contact, identified in Section 1, #6 above, by email. Other forms of contact will only be made upon direct request. Employers requesting mail correspondence may incur an additional cost.

It is understood that the group agrees to receive electronic communications from Blue Shield.

## Authorization and signature

**24** The following authorization section must be signed by the primary group representative/contact. **This is an application for coverage. The group understands that no contract for coverage will exist until Blue Shield has completed its review and communicated to the applicant or the applicant's producer that the application has been accepted and a group health service contract has been issued. The group representative certifies, to the best of his or her knowledge and belief, all of the responses provided in this application 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, Blue Shield of California may pursue one of the following remedies within the first 24 months of coverage: group coverage may be canceled, or the applicable premium/dues may be adjusted, or following notice, the Health Service Contract/Group Policy may be rescinded.**

**I certify to the best of my knowledge and belief that all responses given above are true, correct, and complete.**

| Authorized group representative signature | Name and title (please print) | Date |
|---|---|---|
| | | |

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.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**Producer information (To be completed by producer or general agent. All information is required.)**

**25** Primary producer company name

| Primary producer contact name | Primary producer contact phone number |
|---|---|

Primary producer office address

| City | State | ZIP code |
|---|---|---|

Primary producer contact email

Primary producer Tax ID number

Primary producer contact Department of Insurance license number

Secondary producer company name

| Secondary producer contact name | Secondary producer contact phone number |
|---|---|

Secondary producer office address

| City | State | ZIP code |
|---|---|---|

Secondary producer contact email

Secondary producer Tax ID number

Secondary producer contact Department of Insurance license number

**Producer/General Agent Attestation**
Attestation of Agent/Broker assisting in the submission of this application: (1) to the best of my knowledge, the information on the application is complete and accurate; and (2) I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

| _____ Today's date (required) | _____ Primary producer signature (required) | _____ Print producer name |
|---|---|---|
| _____ Today's date (required) | _____ Secondary producer signature (when applicable) | _____ Print producer name |

General agency Tax ID number

General agency name

| Today's date (required) | General agent authorized signature (required) | Print general agent contact name |
|---|---|---|