Small Groups (1-50)

Sponsored Medical Insurance Program

AMBA

Sponsored by the California Optometric Association

300011dg

★ **FOR MORE INFORMATION:** Return completed application to LH.Admin@getamba.com or mail to: AMBA, P.O. Box 14555, Des Moines, IA 50306.

Personal Information

Member Name _____ Contact Name _____

Association Name California Optometric Association

Practice Name _____

Address _____ City _____ State CA ZIP _____

Phone (_____) _____ Fax (_____) _____

Email Address _____ Effective Date Requested _____

Coverage Requested *(Choose coverage type and carriers you would like a quote from.)*

Plan Type:

☐ PPO ☐ HMO

☐ High-Deductible Health Plan (for HSAs)

Small Group: *(1–50 employees)*

☐ Aetna ☐ Anthem BC ☐ Blue Shield

☐ Kaiser ☐ UnitedHealthcare ☐ California Choice

☐ Other _____

Options:

☐ Dental Option ☐ Vision Option ☐ Life Option

Census Information *(Required for a quote)*

Fill out the name, birth date, home ZIP code, and gender for each member/employee to be insured. If you have additional employees, or they have additional dependents, please continue on a separate sheet.

1

Employee 1: First and Last Name	Gender (M/F)	Birth Date (MM/DD/YYYY)	Home ZIP Code
		/ /	

Spouse/Domestic Partner			**Dependent 1**		
First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)	First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /			/ /	

Dependent 2			**Dependent 3**		
First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)	First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /			/ /	

2

Employee 2: First and Last Name	Gender (M/F)	Birth Date (MM/DD/YYYY)	Home ZIP Code
		/ /	

Spouse/Domestic Partner			**Dependent 1**		
First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)	First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /			/ /	

Dependent 2			**Dependent 3**		
First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)	First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /			/ /	

SIGNATURE REQUIRED ON PAGE 2

3 **Employee 3:** First and Last Name | Gender (M/F) | Birth Date (MM/DD/YYYY) | Home ZIP Code

/ /

Spouse/Domestic Partner

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 1

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 2

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 3

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

4 **Employee 4:** First and Last Name | Gender (M/F) | Birth Date (MM/DD/YYYY) | Home ZIP Code

/ /

Spouse/Domestic Partner

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 1

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 2

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 3

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

5 **Employee 5:** First and Last Name | Gender (M/F) | Birth Date (MM/DD/YYYY) | Home ZIP Code

/ /

Spouse/Domestic Partner

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 1

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 2

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 3

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

6 **Employee 6:** First and Last Name | Gender (M/F) | Birth Date (MM/DD/YYYY) | Home ZIP Code

/ /

Spouse/Domestic Partner

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 1

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 2

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Dependent 3

First Name	Birth Date (MM/DD/YYYY)	Gender (M/F)
	/ /	

Compensation earned by AMBA, depending on the carrier you choose. Commission percentages are shown below.

Health Plan Name	Small Group Medical (1–50) Percent of Premium	Small Group Dental (1–50) Percent of Premium	Small Group Vision (1–50) Percent of Premium	Small Group Life (1–50) Percent of Premium
Aetna	5% to $1,000,000, 1% after $1,000,000.	Stand alone: 9% With medical: 10%	7.5%	15%
Anthem Blue Cross	5% to $1,000,000, 0.8% after $1,000,000.	10%	10%	10%
Blue Shield	5%	10%	10%	10%
Kaiser Permanente	5% to $1,000,000, 1% after $1,000,000.	PPO $2.59 (per member per month.) HMO $1.29 (per member per month.)	N/A	N/A
California Choice	5%	12%	12%	12%
UnitedHealthCare	5%	10%	10%	10%

AMBA, a leader in business transparency, is committed to complete disclosure of the compensation we receive from the insurance companies for the services we perform on your behalf and that of your sponsoring organization.

Expenses are incurred in the administration of all insurance plans (marketing and communications, billing and collecting premium, payment of claims benefits, responding to customer inquiries, and compensation in the form of commission for agents or companies who provide these services), and these are included as part of the premium rate structure.

The premium quoted includes compensation (shown above) received by AMBA for providing services that may include enrollments, ongoing servicing, billing and communications. Marketing expenses for this plan are paid by AMBA. These rates are subject to change and will be updated promptly upon such changes.

In this transaction, AMBA is paid a standard commission of the insurance premium (see chart above). Periodically insurance carriers will pay incentives based on the number of lives insured during a certain period of time. We may also earn contingent commission on this transaction. For more information on contingent commission amounts received by AMBA, please call 800-775-2020 and request information about the Bonus Commissions. Where permitted by law, AMBA may also earn and retain interest income on premiums held by AMBA on behalf of insurers during the period between receipt of such payments from clients and the time such payments are remitted to the applicable insurer. If you utilize premium financing, additional fees may also be earned that will be disclosed at the time premium financing is offered.

AMBA is prohibited by law in most states from altering the amount of compensation received from the insurer based in whole or in part on the sale of this insurance[1].

1 This disclosure is mandated by New York State Insurance Department Regulation No. 194 (11 NYCRR 30.3(b) (5)) (Regulation 194), which we interpret to apply to the various anti-rebating insurance laws throughout the country, such as New York Insurance Law § 2324, which prohibits insurance companies, agents and brokers from sharing or rebating commissions as an inducement to making an insurance contract. Irrespective of whether Regulation 194 applies to anti-rebating laws or whether rebating is prohibited by law in your state, AMBA will not alter its compensation for this program.

Signature *(required)*

I authorize AMBA to obtain a Medical insurance premium indication(s) on my behalf:

Signature **X** _____ Date **X** _____