

**THE GROUP AGREES TO DO THE FOLLOWING:**

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify HIP Health Plan of New York of the termination or addition of any Member(s) covered or to be covered by HIP.
- Promptly provide HIP Health Plan of New York with any information necessary to properly administer the coverage.
- Ensure compliance with TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to group's coverage.

**IT IS UNDERSTOOD THAT:**

- If an acceptable employee enrollment form is received prior to the eligibility date coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt.
- All group applications are subject to approval by HIP Health Plan of New York.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the census of the actual enrollees. Any material misrepresentation within this group application or the group's census, whether intentional or unintentional, will permit HIP Health Plan of New York to terminate this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents; and I will provide to HIP Health Plan of New York an enrollment form or a waiver of coverage form (applicable to groups with 2-50 eligible employees) signed by each eligible employee within thirty (30) days of his/her eligibility date.

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. HIP Health Plan will refund the premium deposit submitted with this application if coverage does not become effective.

Subject to applicable State and Federal laws pertaining to preexisting conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from the effective date of this Contract.

All statements in this application for coverage under a Contract from HIP Health Plan of New York shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at: \_\_\_\_\_ On the \_\_\_\_ Day of, \_\_\_\_\_, 20\_\_\_\_

By: \_\_\_\_\_ Title: \_\_\_\_\_  
(Printed name of authorized officer)

By: \_\_\_\_\_  
(Signature of authorized officer)

Please return this completed application and the following items:

- "Employer's Quarterly Report of Wages Paid to Each Employee (NYS — 45)"
- Copy of a 12 month old (or more recent, if necessary) billing statement
- First month's premium

To: **HIP Health Plan of New York**  
**New Business/Sales**  
**Attn: Broker Administrative Rep.**  
**55 Water Street**  
**New York, NY 10041**

**COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING**



# GROUP APPLICATION

## Section 1 – APPLICANT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Requested Effective Date:							
Company's Legal Name:						SIC Code:	
Company DBA, if applicable:							
Company's Address (No. and Street):				Billing Address, if different:			
City	State	Zip	County	City	State	Zip	County
Company Officer:				Title:		Telephone:	
Company Contact Person:				Title:		Telephone:	
E-mail Address:				Fax Number:			
How long has your company been at the current address?				Indicate your Company's State Employer Identification Number:			
What is the nature of the Business or Organization?							
Which of the following describes your Company or Organization?							
<input type="checkbox"/> Employer/Employee Group		<input type="checkbox"/> Business Association		<input type="checkbox"/> Fraternal/ Religious Organization			
<input type="checkbox"/> Sole Proprietor		<input type="checkbox"/> Partnership		<input type="checkbox"/> Non-Profit Organization			
<input type="checkbox"/> Other Group, please describe _____							
Which of the following describes your type of Association?							
<input type="checkbox"/> Trade Association		<input type="checkbox"/> Labor Union and Employer Trust		<input type="checkbox"/> Professional Association			
<input type="checkbox"/> Chamber of Commerce		<input type="checkbox"/> Credit or Bank Association					
<input type="checkbox"/> Special Association (Approved by Department of Insurance)							
Is your Company or Organization a Subsidiary, Division or an Affiliate of another Company?							
<input type="checkbox"/> Yes		<input type="checkbox"/> No		If Yes, please complete the following:			

Company Name	Address	Number of Total Employees

Select Product Coverage:

<input type="checkbox"/> PRIME HMO	<input type="checkbox"/> access I	<input type="checkbox"/> HIP PRIME Dental PPO	<input type="checkbox"/> PRIME EPO	<input type="checkbox"/> SMART START EPO
<input type="checkbox"/> PRIME POS	<input type="checkbox"/> access II	<input type="checkbox"/> HIP VIP Medicare	<input type="checkbox"/> PRIME PPO	
<input type="checkbox"/> SELECT EPO	<input type="checkbox"/> SELECT PPO	<input type="checkbox"/> HIP CLASSIC	<input type="checkbox"/> Other: _____	

# HIP GROUP APPLICATION

## Section 2a – EMPLOYEE INFORMATION

(For Small Groups 2-50 employees and Large Groups 51+ employees)

PLEASE TYPE OR PRINT LEGIBLY

**Eligible Employees:** Employees on your payroll whose regular work schedule is at least [20.0] hours per week.

A - Total Number of Employees \_\_\_\_\_

C - Number of Employees Enrolling for Coverage \_\_\_\_\_

B\* - Number of Employees Eligible for Coverage \_\_\_\_\_

D - Number of Employees Waiving Coverage (B-C) \_\_\_\_\_

**Reasons for Waiver(s):**

### WAITING PERIOD:

**PRESENT EMPLOYEES' ELIGIBILITY** — Will all current employees be covered as of the effective date of coverage?

Yes  No If no, explain: \_\_\_\_\_

**FUTURE EMPLOYEES' ELIGIBILITY** — New employees will be eligible for coverage:

Date of Hire

First day of the month following date of hire

\_\_\_\_ Month(s) following the date of hire  Other \_\_\_\_\_

**CONTRIBUTIONS: Will the Group contribute 100% of the cost of the coverage?**  Yes  No **If no, complete below:**

**Group Contribution**

	Dollar Amount	or	Percentage
<input type="checkbox"/> Employee only coverage	\$ _____		_____ %
<input type="checkbox"/> Employee and Spouse	\$ _____		_____ %
<input type="checkbox"/> Employee and Child(ren)	\$ _____		_____ %
<input type="checkbox"/> Family	\$ _____		_____ %

If group contributes 100% of the cost of coverage, all eligible employees must participate.

**PREMIUM BILLING/PAYMENT FREQUENCY:**  Monthly  Quarterly  Semi- Annually  Annually

## Section 2b – SOLE PROPRIETOR INFORMATION

A Sole Proprietor purchasing coverage through an association must be a member of the association for at least 60 days prior to the effective date of the insurance coverage.

To be eligible to purchase Sole Proprietor health insurance, please provide the following with the application and on an annual basis:

1. A copy of the New York tax form NYS-45ATT-MN, or other comparable documentation of active employees status such as a copy of a pay stub or estimated tax form;
2. For a business in operation for more than 1 year, the prior year's federal income tax Schedule C for an incorporated business subject to Subscriber S with a Sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or
3. For a business in operation for less than one year, a cancelled business check, a copy of a business bank statement, a certificate of doing business, or appropriate tax documentation; and
4. Such other documentation as may be reasonably required by the insurer and as approved by the Superintendent to verify eligibility of an individual to purchase health insurance pursuant to Chapter 557.

**PAYMENT FREQUENCY:**  Monthly  Quarterly  Semi- Annually  Annually

# HIP GROUP APPLICATION

## Section 3 - REPLACEMENT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Does this Group Contract replace other coverage?  Yes  No

If "Yes", please attach a copy of a billing statement from 12 months ago\* (or more recent, if necessary) and complete the following:

Effective Date	Termination Date	Prior Carrier	
HMO	_____	_____	_____
POS	_____	_____	_____
Indemnity	_____	_____	_____
PPO/EPO	_____	_____	_____
Dental	_____	_____	_____
Other	_____	_____	_____

\* Note: A billing statement from 12 months ago will reduce the probability that employees will need to provide evidence of prior coverage. Eligible employees with less than 12 months of continuous coverage may be required to submit a "Certificate of Creditable Coverage" with their enrollment form.

## Section 4 -- GENERAL AGENT/BROKER INFORMATION

General Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Broker Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### For Office Use Only

HIP Marketing Representative and Code:

Broker/Agent:

Group Number (To Be Completed by Underwriting):