COMPREHEALTH FOR SMALL GROUPS

(2 - 50 Employees)

EmblemHealth

EmblemHealth insurance programs are underwritten by Group Health Incorporated (GHI) and HIP Insurance Company of New York (HIPIC).

PRINT IN INK

SECTION I: GROUP INFORMATION

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. ( ) _____ Fax No. ( ) _____

Company Officer's Name _____ E-Mail Address _____

Title _____

Group Contact _____ Title _____ Telephone No. ( ) _____

E-Mail Address _____

Address ☐ Same as above _____

_____

Additional Office Locations _____

_____

Taxpayer ID Number _____

SECTION II: BILLING

Premium invoices should be sent to:

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. ( ) _____ E-Mail Address _____

Contact Person *(if different than above)* _____

Telephone No. ( ) _____ E-Mail Address _____

SECTION III: GROUP ADMINISTRATION

1. Please check all applicable class(es) for the EmblemHealth coverage for which you are applying (note that classes must be based upon conditions pertaining to employment):

☐ Management ☐ Non-Management ☐ Union ☐ Part-Time ☐ Other

If you checked "Other" above, please identify the other class(es): _____

NOTE: Employees must work at least 20 hours per week for applicant in order to be eligible for EmblemHealth coverage. Retirees are not eligible for coverage under EmblemHealth small group programs.

At EmblemHealth's request, employer's quarterly report of wages paid to each employees (NYS-45) must be supplied to EmbemHealth within 15 days after it is filed with New York State.

2. If your Group is an association, chamber of commerce or fund comprised of one or more employees or labor unions, please identify the total number of member groups by the following group size(s):

   _____ Total number of member groups with 50 or fewer eligible employees.

   _____ Total number of member groups with 51 or more eligible employees.

3. Please specify the current number of COBRA participants: _____

4. Indicate the number of enrollees eligible for EmblemHealth by coverage type:

   _____ Individual _____ Employee/Spouse _____ Employee/Child(ren) _____ Family

5. Pre-Existing Condition Limitation:

   For members 19 years of age and over, there will be a waiting period of up to 12 months for benefits for any condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period ending on a member's enrollment date. This waiting period will be reduced to the extent that a member is entitled by law to a credit for prior continuous creditable coverage. The Certificate of Insurance or Certificate of Coverage will contain more information about the pre-existing condition waiting period and the types of coverage that qualify as prior continuous creditable coverage. The CompreHealth program applies a 12-month pre-existing condition limitation. Other EmblemHealth small group products apply an 11-month pre-existing condition limitation.

6. What is the nature of your business or organization? _____

   Which of the following describes your company or organization?

   ☐ Employer/Employee Group ☐ Business Association ☐ Fraternal/Religious Organization

   ☐ Sole Proprietor ☐ Partnership ☐ Non-Profit Organization

   ☐ Other Group. Please describe _____

   Which of the following describes your type of Association?

   ☐ Trade Association ☐ Labor Union or Employer Trust

   ☐ Professional Association ☐ Chamber of Commerce

   ☐ Credit or Bank Association ☐ Special Association (Approved by Department of Insurance)

7. Is your company or organization a subsidiary, division or affiliate of another company?

   ☐ Yes ☐ No

SECTION IV: OTHER COVERAGE

OTHER GROUP HEALTH OR HMO COVERAGE

Please complete the information below for your other group health coverage which is still in force or which was terminated within the past 12 months.

Name and Address of Insurer	Type of Coverage	Effective Date of Policy	Termination Date of Policy

Was your group health coverage terminated for non-payment of premiums in the last 12 months?

☐ Yes ☐ No

SECTION V: PRODUCT SELECTION

EMBLEMHEALTH PRODUCTS

Desired Effective Date: _____

☐ **EPO (underwritten by GHI)**

- Are all eligible employees covered under this program? ☐ Yes ☐ No
- If no, are at least 50% of the eligible employees selecting this program or another group health program? ☐ Yes ☐ No
- Will this program replace another group health coverage program? ☐ Yes ☐ No

☐ **PPO (underwritten by GHI)**

- Are all eligible employees selecting this program? ☐ Yes ☐ No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? ☐ Yes ☐ No
- Will this program replace another group health coverage program? ☐ Yes ☐ No

☐ **InBalance EPO (underwritten by GHI)**

- Are all eligible employees selecting this program? ☐ Yes ☐ No
- If no, are at least 50% of the eligible employees selecting this program or another group health program? ☐ Yes ☐ No
- Will this program replace another group health coverage program? ☐ Yes ☐ No

☐ **InBalance PPO (underwritten by GHI)**

- Are all eligible employees selecting this program? ☐ Yes ☐ No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? ☐ Yes ☐ No
- Will this program replace another group health coverage program? ☐ Yes ☐ No

☐ **ConsumerDirect EPO (underwritten by GHI)**

- Are all eligible employees selecting this program? ☐ Yes ☐ No
- If no, are at least 50% of the eligible employees selecting this program or another group health program? ☐ Yes ☐ No
- Will this program replace another group health coverage program? ☐ Yes ☐ No

☐ **ConsumerDirect PPO (underwritten by GHI)**

- Are all eligible employees selecting this program? ☐ Yes ☐ No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? ☐ Yes ☐ No
- Will this program replace another group health coverage program? ☐ Yes ☐ No

☐ **CompreHealth (underwritten by Health Insurance Plan of Greater New York)**

- Are all eligible employees selecting this program? ☐ Yes ☐ No
- If no, are at least 2 or 50% of the eligible employees selecting this program or another EmblemHealth program? ☐ Yes ☐ No
- Will this program replace another group health coverage program? ☐ Yes ☐ No

☐ **EmblemHealth Dental (underwritten by GHI)** ☐ Voluntary ☐ Contributory

SECTION VI: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth program premiums for your employees and their dependents.

☐ Employee: _____ % or $ _____ ☐ Family: _____ % or $ _____

☐ Other: _____

NEW HIRE ELIGIBLITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth program.

☐ Date of hire ☐ First of the month following date of hire

PLUS:

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other: _____

Waived for rehire? ☐ Yes ☐ No If rehired within _____ days of rehire.

If more than one class of employees will be covered, please complete **Section (VI-A)** on next page.

SECTION VI-A: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth Program premiums for your employees and their dependents.

☐ Employee: _____ % or $ _____ ☐ Family: _____ % or $ _____

☐ Other: _____

NEW HIRE ELIGIBLITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth Program.

☐ Date of hire ☐ First of the month following date of hire

PLUS:

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other: _____

Waived for rehire? ☐ Yes ☐ No If rehired within _____ days of rehire.

For additional classes, please continue on a separate piece of paper.

SECTION VII

For employer groups comprised of one or more employees, please check your current employer status below to ensure proper coordination of benefits for your Medicare Eligible Active Employees *(you must check one of the boxes below)*:

A. ☐ Employed fewer than twenty (20) full time or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).

☐ Employed twenty (20) or more full or part-time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year)

NOTE: All employers that are treated as a single employer under Internal Revenue Code Section 52 must be treated as a single employer for purpose of the Medicare secondary payer rules. According to Internal Revenue Code Section 52, all employees of all corporations that are members of the same controlled group of corporations must be treated as employed by a single employer. This means that if a parent company owns at least fifty percent (50%) of a subsidiary, then the number of employees of the parent and the subsidiary must be combined for purposes of determining the 20-employee threshold. Similarly, brother-sister corporations may be combined in some cases if the parent corporation owns at least fifty percent (50%) of the brother-sister corporations.

B. ☐ Please check here if your group is a large group health plan. A large group health plan is a plan of, or contributed to by, an employer or employee organization to provide health benefits that cover the employees of at least one (1) employer that normally employed at least one hundred (100) employees on a typical business day during the preceding calendar year.

SECTION VIII

The group agrees to do the following:

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York, or Group Health Incorporated 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, and/or Group Health Incorporated, of the termination or addition of any member(s) covered or to be covered.
- Promptly provide HIP Health Plan of New York, or Group Health Incorporated with any information necessary to properly administer the coverage.
- Ensure compliance with ERISA/TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to your group's coverage, as applicable.

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 and/or Group Health Incorporated.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and/or Group Health Incorporated, 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 eligibility of the actual enrollees. Any material misrepresentation within this group application or the enrollee transaction and application form, whether intentional or unintentional, may cause termination of 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 an enrollment form or a waiver of coverage form 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. The premium deposit submitted with this application will be refunded if coverage does not become effective.

Subject to State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions if applicable 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 for insurance 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: _____

By: _____ Title: _____

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: **EmblemHealth**
New Business/Sales
55 Water Street
New York, NY 10041

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING

SECTION IX

To be completed by EmblemHealth General Agent or Selling Agent:

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. ( ) _____ Fax No. ( ) _____

Group Contact _____ E-Mail Address _____

Desired Effective Date _____

Effective date changed since original application? ☐ Yes ☐ No

Master Agency _____ MA No. _____ Override _____

EmblemHealth Group No. _____ EmblemHealth Marketing Rep _____

For EmblemHealth internal use only

General Agency ☐ To Be Credentialed

GA No. Override

Contact

Address

Telephone No. ( ) E-Mail Address

Fax No. ( )

Split Commision _____%

Selling Agent ☐ To Be Credentialed

SA No. Commission

Name/Agency Name

Address

Telephone No. ( ) E-Mail Address

Fax No. ( )

Split Commision _____%

Selling Agent ☐ To Be Credentialed

SA No. Commission

Name/Agency Name

Address

Telephone No. ( ) E-Mail Address

Fax No. ( )

Split Commision _____%

Selling Agent ☐ To Be Credentialed

SA No. Commission

Name/Agency Name

Address

Telephone No. ( ) E-Mail Address

Fax No. ( )

Split Commision _____%

Confirmation that the following items are attached:

Deposit Check	☐ Yes	☐ No	Amount: $ _____
Proof of Employment	☐ Yes	☐ No	
Last Paid Premium Invoice from Current Carrier	☐ Yes	☐ No	
COBRA Letters of Election	☐ Yes	☐ No	
Proof of Medicare Eligibility, Part A and B	☐ Yes	☐ No	

GA Authorized Signature _____ Date _____