EmblemHealth®

EMBLEMHEALTH FOR SMALL GROUPS

EmblemHealth insurance programs are underwritten by Group Health Incorporated (GHI), HIP Health Plan of Greater New York (HIP) 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 EmblemHealth 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 100 or fewer full time equivalent eligible employees.

_____ Total number of member groups with 101 or more full time equivalent eligible employees.

3. Indicate the number of full time equivalent employees employed by the employer: _____

Indicate your annual average employees. Your number of average annual employees is determined by averaging the total number of all employees employed on business days during the preceding calendar year. By regulation full-time, part-time, and seasonal employees must be included in this calculation. 2015_____ 2016_____

NOTE: Use the "full time equivalent" (FTE) employee counting method set forth in 26 U.S.C. 4980(H) to determine group size. This is the same calculation method used to determine employer liability under the "Shared Responsibility for Employers" provisions of the Affordable Care Act (ACA) and Internal Revenue Code. Note that employees of affiliated entities under common control (such as parent corporations and wholly owned subsidiary corporations) must be counted together for this purpose.

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

5. Indicate the number of enrollees eligible for EmblemHealth by coverage type:
_____ Individual _____ Employee/Spouse _____ Employee/Child(ren) _____ Family

6. What is the nature of your business or your 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 Financial Services)

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

SECTION V: PRODUCT SELECTION

EmblemHealth Products **Desired Effective Date:** _____

Plan Name Selection: _____

- 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

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. There is no minimum employer contribution required.

☐ Employee: _____ % or $ _____ ☐ Family: _____ % or $ _____ ☐ No Contribution

New Hire Eligibility Policy (Newly eligible employees must be given 30 days to enroll.)

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 (waiting period may not exceed 90 days)

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).

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. There is no minimum employer contribution required.

☐ Employee: _____ % or $ _____ ☐ Family: _____ % or $ _____ ☐ No Contribution

New Hire Eligibility Policy (Newly eligible employees must be given 30 days to enroll.)

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 (waiting period may not exceed 90 days)

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-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).

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 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 Group Health Incorporated of the termination or addition of any member(s) covered or to be covered.
- Promptly provide 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.
- Employer/group acknowledges receipt of a Summary of Benefits and Coverage (SBC) in paper or electronic form from Group Health Incorporated (or its agent) for the health plan(s) for which the Employer/group is applying. Employer agrees that it shall deliver a copy of such SBC(s) to each eligible participant and beneficiary as part of any written application materials that are distributed by employer/group to participants and beneficiaries for purposes of enrollment under the health plan(s). If employer/group does not distribute written application materials for enrollment, the employer/group agrees to deliver the SBC to each participant no later than the first date on which the participant is eligible to enroll in coverage for the participant and any beneficiaries. The SBC shall be delivered to each participant and beneficiary either in paper form or, to the extent permitted by 45 C.F.R. 147.200(a)(4)(ii). electronically.

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 Group Health Incorporated.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by 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.

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)*
- 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 Commission _____%

Selling Agent		☐ To Be Credentialed
SA No.	Commission	
Name/Agency Name		
Address		
Telephone No. ( )	E-Mail Address	Fax No. ( )
		Split Commission _____%

Selling Agent		☐ To Be Credentialed
SA No.	Commission	
Name/Agency Name		
Address		
Telephone No. ( )	E-Mail Address	Fax No. ( )
		Split Commission _____%

Selling Agent		☐ To Be Credentialed
SA No.	Commission	
Name/Agency Name		
Address		
Telephone No. ( )	E-Mail Address	Fax No. ( )
		Split Commission _____%

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

EmblemHealth®

ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call **1-877-411-3625** (TTY/TDD: **711**).

Español (Spanish)
ATENCIÓN: Si usted habla español, tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

中文 (Traditional Chinese)
注意：如果您講中文，我們免費提供相關的語言協助服務。請致電 **1-877-411-3625** (TTY/TDD: **711**)。

Русский (Russian)
ВНИМАНИЕ! Если Вы говорите на русском языке, Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона, TTY/TDD: **711**).

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

한국어 (Korean)
주의: 귀하가 한국어를 사용하는 경우, 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625** (TTY/TDD: **711**)로 전화하십시오.

Italiano (Italian)
ATTENZIONE: Sono disponibili servizi gratuiti di assistenza linguistica in italiano. Chiamare il numero **1-877-411-3625** (TTY/TDD: **711**).

(Yiddish אידיש

אכטונג: אויב איר רעדט אידיש, שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625**(TTY/TDD: **711**).

(Bengali) বাংলা
দৃষ্টি আকর্ষণ করছি আপনি যদি বাংলাভাষী হন আপনার জন্য বিনামূল্যে ভাষা সংক্রান্ত পরিষেবা র ব্যবস্থা থাকবে। **1-877-411-3625** নম্বরে (TTY/TDD: **711**) ফোন করুন।

Polski (Polish)
UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Proszę zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

(Arabic) العربية

يرجى الانتباه: إذا كنت تتكلم اللغة العربية، تتوفر لك خدمات المساعدة اللغوية مجاناً, اتصل بالرقم **1-877-411-3625** أو (TTY/TDD: **711**)

Y0026_126476 Accepted 8/29/16

Français (French)
ATTENTION : si vous parlez français, une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le **1-877-411-3625** (Sourds et malentendants : **711**).

(Urdu)اردو

توجہ دیں: اگر آپ اردو بولتے ہیں تو، آپ کے لیے زبان سے متعلق مدد کی خدمات، مفت دستیاب ہیں۔ **1-877-411-3625** (ٹی ٹی وائی/ ٹی ڈی ڈی **711**) پر کال کریں۔

Tagalog (Tagalog)
NANANAWAGAN NG PANSIN: Kung nagsasalita ka ng Tagalog, mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε **1-877-411-3625** (για άτομα με προβλήματα ακοής/TTY/TDD: **711**).

Shqip (Albanian)
VINI RE: Nëse flisni Shqip, shërbimi i asistencës për gjuhën do të jetë në dispozicionin tuaj, pa pagesë. Telefononi **1-877-411-3625** (Shërbimi i teletekstit TTY/TDD: **711**).

Notice of Nondiscrimination Policy

EmblemHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EmblemHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

EmblemHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **1-877-411-3625**.

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.