EmblemHealth®

New Business Checklists

EmblemHealth Underwriting Guidelines Checklist for Small Business

☐ The account indicated below qualifies for small business rates and benefits because the group's membership includes one (1) to one hundred (100) Full-Time Equivalent Employees.

Group Name:	
Completed by: Broker Signature:	Date:

CONTRIBUTION: Will group contribute toward the cost of coverage? ☐ Yes ☐ No

If "Yes," the group will contribute to the cost of:

- ☐ Employee-Only Percentage _____ ☐ or Dollar Amount _____
- ☐ Employee/Spouse Percentage _____ ☐ or Dollar Amount _____
- ☐ Employee/Child Percentage _____ ☐ or Dollar Amount _____
- ☐ Family Percentage _____ ☐ or Dollar Amount _____

ELIGIBLE MEMBERS: (Check ALL boxes that apply to this group.)

- ☐ Owner(s) of the group/corporate officers/partners
- ☐ Members of the Board of Directors
- ☐ Employees on the group's payroll whose regular work schedule is at least 20 hours per week
- ☐ Group employee's eligible family members (Note that children are eligible until the age of 26, unless an Age 29 Rider is purchased that allows for children to be eligible until the age of 30)
- ☐ Former employees and their family members (COBRA continuation of coverage)

CLASSES NOT ELIGIBLE FOR COVERAGE: (Check ALL boxes that apply to this group.)

- ☐ Part-time employees who work less than 20 hours per week
- ☐ Seasonal employees whose employment is six months or less each year
- ☐ Temporary employees (EmblemHealth does not cover temporary workers)
- ☐ Employees in the armed forces of any government other than for duty of 30 days or less
- ☐ Owner(s) applying solely without a common-law employee enrolling as well

TYPES OF ORGANIZATIONS: (Check ONE box that applies to this group.)
Proper documentation must be provided.

- ☐ Business establishment, partnership, or corporation (LLC, S Corp, C Corp)
- ☐ Not-for-profit organization
- ☐ State, county, or municipal government body
- ☐ Union or Union Management Welfare Fund (members and/or employees of a union and their dependents)
- ☐ Other (Co-op, Mission, Religious establishment, etc.):

DOCUMENTS THAT MUST BE SUBMITTED TO ENROLL:

- ☐ Completed Group Application
- ☐ Copy of the NYS-45; must indicate New York State Tax ID, and listed employees must be marked up as either Part-Time, Full-Time, Terminated, or Waiving
- ☐ Business check for the first month's premium
- ☐ Signed rate sheet along with plan(s) selected
- ☐ Completed Enrollment Form for each applying Full-Time Eligible Employee

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PRINT CLEAR FORM

REQUESTED EFFECTIVE DATE MUST BE:

☐ The 1st of the month for small business

ADDITIONAL REQUIRED DOCUMENTS FOR:

☐ **Any employee NOT listed on the NYS-45:** Submit a copy of the payroll check showing the company's name, along with the employee name, Social Security number, and a W-4

☐ **Employees waiving coverage:** Any Full-Time Equivalent Employees deciding to waive coverage must be marked as such on the submitted NYS-45

☐ **Owners/Partners of the business NOT reflected on the NYS-45:** Submit a copy of any other official document substantiating the name of the owners/partners and the company's name

☐ **New Business:** Submit an accountant's letter indicating the date the business started and the number of Full-Time Equivalent Employees, along with a business certificate

☐ **Members of the Board of Directors:** Submit a copy of the annual report indicating the names of the directors

☐ **COBRA continuees:**

- ☐ Copy of the company's last NYS-45 that includes the former employee.
- ☐ Copy of the individual's COBRA election form. In the absence of the election form, a letter from the former employee/family member resulting in continuation of coverage and the date of the qualifying event may be submitted

☐ **Family members with a different last name than the policy holder:** Submit a copy of the federal Form 1040, or birth certificate. If these forms are not available, then other documentation will be reviewed on a case-by-case basis.

FOR SECURITY REASONS, PLEASE MAKE ALL BUSINESS CHECKS PAYABLE TO EMBLEMHEALTH

Emblemhealth Sales Rep's Name:
Broker's Name:

PLEASE RETURN A COMPLETED COPY OF THIS FORM, IN ADDITION TO ALL OTHER REQUIRED DOCUMENTS AS INDICATED ABOVE, TO:

Small Group Sales Rep: _____

IMPORTANT DEADLINES:

Small Groups applying for a 1st of the month effective date must submit their new business application to EmblemHealth by the 26th of the month **prior** to the desired effective date.