EmblemHealth®

2027 Small Group Application

Print in ink. Applications must be submitted through our broker portal for proper processing.

SECTION I: GROUP INFORMATION

Company Name		Telephone No. ( )	Date
Address			
City	State	ZIP	County
Company Officer's Name	Title	Email Address	
Group Contact Name		Title	
Telephone No. ( )		Email Address	
Address ☐ Same as above			
City	State	ZIP	County
Additional Office Locations			
City	State	ZIP	County
Taxpayer ID Number	SIC Code		

SECTION II: BILLING — PREMIUM INVOICES SHOULD BE SENT TO:

Address			
City	State	ZIP	County
Telephone No. ( )	Email Address		
Contact Person (if different than above)			
Telephone No. ( )	Email Address		

SECTION III: GROUP ADMINISTRATION

1. Indicate the average number of employees employed by the employer on business days during the preceding calendar year: _____

   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. 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 employee (NYS-45) must be supplied to EmblemHealth within 15 days after it is filed with New York State, if available.

2. Please specify the current number of COBRA participants: _____. **Note:** EmblemHealth does not administer COBRA.

3. Is your company or organization a subsidiary, division, or affiliate of another company? ☐ Yes ☐ No

EmblemHealth small group HMO and POS medical plans are underwritten by Health Insurance Plan of Greater New York (HIP). EmblemHealth small group EPO and PPO dental plans are underwritten by EmblemHealth Plan, Inc.

I understand that the phone numbers I provide on this application may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health insurance plan, or related programs or services provided to me.

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

SECTION IV: EMBLEMHEALTH PRODUCT SELECTION DESIRED EFFECTIVE DATE: _____

Select Care Network (All plans are non-gated):

- ☐ POS - Platinum Premier
- ☐ POS - Gold Premier

Stand-Alone Dental

- ☐ EPO Access
- ☐ EPO Preferred
- ☐ PPO Preferred Premier
- ☐ PPO Preferred Plus

SECTION V: ENROLLMENT POLICIES CLASS

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute toward EmblemHealth program premiums for your employees and their eligible family members. There is no minimum employer contribution required.

☐ Employee: ____ % or $ ____ ☐ Family: ____ % or $ ____ ☐ No contribution

WAITING PERIOD

Please specify the waiting period for new employees.

☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days (waiting period may not exceed 90 days) ☐ Other _____

NOTE: EmblemHealth does not enforce a waiting period for new hires; the responsibility remains with the employer to advise when the new hire will be effectuated.

SECTION VI: SHOP CERTIFICATION

You may qualify for tax credits if:

- You are a business with fewer than 25 full-time equivalent employees with an average annual salary of $67,000 or less.
- Contribute at least 50% toward the cost of employee-only coverage.
- Offer coverage to all full-time equivalent employees.

Only the NY State of Health can certify whether your small businesses is eligible for the tax credit. All EmblemHealth small business plans are eligible for Small Business Health Options Program (SHOP) certification.

Is your small business SHOP-certified by NY State of Health? ☐ Yes ☐ No

For more information visit **nystateofhealth.ny.gov/employer** or call NY State of Health customer service at **855-355-5777**, or call your broker.

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.):

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

☐ Employed 20 or more full-time or part-time employees for 20 or more calendar weeks for each working day in each of 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 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 50% of the brother-sister corporations.

EmblemHealth reserves the right to audit groups at any time to verify group size for eligibility purposes.

SECTION VIII

The group agrees to do the following:

- Make payroll deductions if employee contributions are required, and remit to EmblemHealth 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 EmblemHealth of the termination or addition of any member(s) covered or to be covered.
- Promptly provide EmblemHealth 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 EmblemHealth (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 EmblemHealth.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by EmblemHealth, 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 intentional material misrepresentation within this group application or the enrollee transaction and application form, 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 eligible family members, and I will provide an enrollment form or a waiver of coverage form signed by each eligible employee within 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 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 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 submitted via an electronic funds transfer (EFT) payment.

To: EmblemHealth, New Business/Sales, 55 Water Street, 8th Floor, New York, NY 10041-8190. If you have any questions, please call **866-614-6040**.

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING.

SECTION IX: TO BE COMPLETED BY EMBLEMHEALTH GENERAL AGENT OR SELLING AGENT

Group Name	Telephone No. ( )	Date
Address		
City	State	ZIP	County
Group Contact	Email Address	
Desired Effective Date	General Agency	General Agency No.

Selling Agent	Broker Code or License Number
Name/Agency Name	
Address	
Telephone No. ( )	Email Address
	Split Commission ____%

General Agent	General Agent Code
Name/Agency Name	
Address	
Telephone No. ( )	Email Address
	Split Commission ____%

CONFIRMATION THAT THE FOLLOWING ITEMS ARE ATTACHED, IF APPLICABLE:

Electronic Funds Transfer (EFT)	☐ Yes	☐ No	Amount: $ _____
Proof of Employment (federal tax forms; NYS-45, 1120, 1065, 1040, etc.)	☐ Yes	☐ No	
COBRA Letters of Election	☐ Yes	☐ No	

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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Selling Agent Authorized Signature	Date

PRINT RESET

EmblemHealth®

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **877-411-3625** (TTY: **711**) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-411-3625** (TTY: **711**) o hable con su proveedor.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **877-411-3625**（文本电话：**711**）或咨询您的服务提供商。

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **877-411-3625** (TTY: **711**) или обратитесь к своему поставщику услуг.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **877-411-3625** (TTY: **711**) oswa pale avèk founisè w la.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **877-411-3625** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **877-411-3625** (tty: **711**) o parla con il tuo fornitore.

(**Yiddish**) **יידיש** נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פֿראַוויידינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן **877-411-3625** (TTY: **711**) אָדער רעדן מיט דיין טרעגער.

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

বাংলা (Bengali) মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। **877-411-3625** (TTY: **711**) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-411-3625** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **877-411-3625** (**711**) أو تحدث إلى مقدم الخدمة.

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **877-411-3625** (TTY: **711**) ou parlez à votre fournisseur.

اردو (Urdu)

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: **711**) **877-411-3625** پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **877-411-3625** (TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **877-411-3625** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

SHQIP (Albanian) VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **877-411-3625** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

NOTICE OF NONDISCRIMINATION POLICY

Discrimination is Against the Law

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. EmblemHealth does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

EmblemHealth:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Customer Service at **877-411-3625** (TTY: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to the EmblemHealth Grievance and Appeals Department, P.O. Box 2844, New York, NY 10116-2844; faxing them at **212-510-5320**; or calling Customer Service at **877-411-3625**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. 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 for Civil Rights electronically through the Office for 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**; **800-368-1019** (TTY: **800-537-7697**).

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

This notice is available on EmblemHealth's website at **emblemhealth.com/legal/nondiscrimination**.