GROUP APPLICATION

EmblemHealth
GHI and HIP are EmblemHealth companies

Underwritten by Health Insurance Plan of Greater New York (HIP)
and HIP Insurance Company of New York (HIPIC)

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?

☐ 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 and Employer Trust ☐ Professional Association
☐ Chamber of Commerce ☐ Credit or Bank Association
☐ Special Association (Approved by Department of Insurance)

Is your Company or Organization a Subsidiary, Division or an Affiliate of another Company?

☐ Yes ☐ No If Yes, please complete the following:

Company Name	Address	Number of Total Employees

Select Product Coverage:

☐ PRIME HMO ☐ *access* I ☐ PRIME EPO
☐ PRIME POS ☐ *access* II ☐ PRIME PPO
☐ SELECT EPO ☐ SELECT PPO ☐ Other: _____

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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
☐ Employee only coverage	$ _____		_____%
☐ Employee and Spouse	$ _____		_____%
☐ Employee and Child(ren)	$ _____		_____%
☐ Family	$ _____		_____%

If the 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 one 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

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Section 3 – REPLACEMENT INFORMATION

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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):

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 preexisting 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