EMBLEMHEALTH FOR LARGE GROUPS
(51 + Employees)

EmblemHealth

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 _____

_____

Nature of Business _____ SIC/NAIC Code _____

Taxpayer ID No. _____

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

A. Number of Eligible Employees (Employees must work at least 20 hours a week for applicant) _____

B. Number of Employees Applying _____

C. Number of COBRA Participants _____

EMPLOYEE ELIGIBILTY:

Active Employees: All active, permanent, full-time employees who work at least _____ hours per week (minimum 20 hours/week).

Are any classes excluded? ☐ Yes ☐ No

If yes, indicate classes excluded: _____

Retired Employees: ☐ Yes ☐ No

The definition of a retired employee is:

☐ an employee who is retired on pension by the employer.

☐ an employee who is retired from service by the employer and who immediately prior to the date of his/her retirement had completed at least _____ years of service with the employer.

☐ an employee who is retired on pension by the employer and who immediately prior to the date of his/her retirement had completed at least _____ years of service with the employer.

Pre-Existing Condition Limitation: ☐ Yes ☐ No

The CompreHealth EPO program does not contain a pre-existing condition limitation. The PPO, EPO, InBalance PPO, InBalance EPO, ConsumerDirect PPO, ConsumerDirect EPO programs give you the option to apply a pre-existing condition limitation to your group coverage for members 19 years of age and over. If you choose this limitation, there will be an eleven (11) month waiting period 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 will contain more information about the pre-existing condition limitation waiting period and the types of coverage that qualify as prior continuous coverage. Please indicate whether you would like to apply a pre-existing condition limitation to your group coverage by checking the appropriate box above. If you would like to apply the pre-existing condition limitation only to late entrants, please check the appropriate box below.

Pre-existing condition limitation applies to late entrants only: ☐ Yes ☐ No

Other group health or HMO coverage: Indicate below other group health coverage which is still in force or which terminated within the past three (3) years.

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

SECTION IV: PRODUCT SELECTION

EMBLEMHEALTH PRODUCTS Desired Effective Date _____

☐ **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

☐ **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 EPO (underwritten by HIP Insurance Company of 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** ☐ Voluntary ☐ Contributory

RATE STRUCTURE ☐ 2-Tier ☐ 3-Tier ☐ 4-Tier

Is this a replacement policy? ☐ Yes ☐ No

Is this an option? ☐ Yes ☐ No

SECTION V: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

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

☐ Other: _____

NEW HIRE ELIGIBLITY POLICY

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

PLUS:

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other (please specify): _____

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

TERMINATION POLICY

☐ Date Terminated ☐ End of Month ☐ Other _____

SECTION V-A: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

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

☐ Other: _____

NEW HIRE ELIGIBLITY POLICY

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

PLUS:

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other (please specify): _____

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

TERMINATION POLICY

☐ Date Terminated ☐ End of Month ☐ Other _____

SECTION VI

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 VII

The group agrees to do the following:

- Make payroll deductions, if employee contributions are required, and remit to HIP Insurance Company 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 Insurance Company 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 Insurance Company of New York, and/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 Insurance Company 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 Insurance Company 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 eleven (11) 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 (5,000) dollars and the stated value of the claim for each such violation.

Signed at: _____

On the _____ day of _____, 20_____

By: _____ Title: _____

By: _____

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

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