

**New York
Small Group Employer Enrollment Application
For Groups of 1-100* (Medical/Vision)
For Groups of 1-50 (Dental)**



An Anthem Company

Consult the Evidence of Coverage for details regarding subscriber eligibility terms and coverage terms.

Please complete in black ink only.

| Section A: Company Information | | | |
|--|---------|--------------------------------|---------------------------------------|
| Company name | | Employer tax ID no. (required) | |
| Doing business as | | | SIC code – Required |
| Company street address | | | |
| City | | | State ZIP code |
| Billing address – If different from above | | | |
| City | | | State ZIP code |
| Company contact name | | Title | |
| Primary phone no. | Fax no. | | |
| Email address | | | |
| Additional company contact name | | Title | |
| Primary phone no. | Fax no. | | |
| Email address | | | |
| Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal revenue Code Section 414? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give the legal names, federal tax ID no. and number of employees employed by each. | | | |
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| | | | |
| Open Enrollment | | | |
| Our standard open enrollment period is 30 days before the Group's renewal date and 30 days after, which is held no more often than once in any 12 consecutive months. | | | |
| Section B: Application Type | | | |
| <input type="checkbox"/> New enrollment | | | Requested effective date (MM/DD/YYYY) |

* A small group must have at least one active full-time equivalent employee that meets the definition of employee in 42 U.S.C. 300gg-91(d)(5) but no more than 100 employees. A small group can consist of one non-spouse employee plus the business owner; a group of 100 would consist of the business owner plus 99 employees.

Section C: Type of Coverage

1. Medical Coverage

All medical plans include pediatric dental coverage (up to age 19).

If you want to contribute to your employee's medical premium, indicate the percentage you wish to contribute each month for each category. Employer contributions are voluntary and no minimum is required.

Non-HMO plans must meet participation requirement.

Contribution Option: Contribution Option may be from 0% to 100% and may differ by category:

_____ % Employee only _____ % Employee & Spouse/Domestic Partner _____ % Employee & Child(ren) _____ % Family

For HSA plans:

- Group will establish Health Savings Account (HSA) with Empire facilitating with a banking services provider.
- Group will establish Health Savings Account (HSA) and does not want Empire to facilitate the creation of the account.

For employers offering a Health Savings Account (HSA) compatible HMO, PPO or EPO plan: We, the employer, understand that the High Deductible plan is designed for Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Exclusive Provider Organization (EPO) usage, and that using non-participating providers will result in significantly higher out-of-pocket costs. Please refer to your Evidence of Coverage for additional benefit details. We understand that having this coverage does not establish an HSA. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. Consultation with a tax advisor is recommended.

Medical contract codes – Indicate the contract code(s) for the medical plan(s) selected. The codes can be found on the proposal/quote output.

| Contract code | Contract code | Contract code |
|---------------|---------------|---------------|
| 1. | 2. | 3. |

2. Dental Coverage

Empire Family Dental and Empire Family Dental Enhanced plans include pediatric dental essential health benefits. All other plans including Empire Dental Prime and Complete with product families including Value, Classic, Enhanced, and Voluntary do not include pediatric dental essential health benefits. Please list below the contract code for the dental plan(s) you select.

Dental contract codes – Indicate the contract code(s) for the dental plan(s) chosen. The codes can be found on your Empire proposal/quote output.

Contract code 1: _____ Contract code 2: _____ No dental coverage

Choose your dental contribution for each month:
 _____ % per employee _____ % per dependent (optional)

Select premium level: (Subject to underwriting approval)
 Base premium Bundled premium

Is this plan intended to replace any existing group dental coverage? Yes No
 If yes, please complete the information below for each group dental insurance plan you now have.

| Insurer | Type of plan (DHMO, PPO) | Effective date | Proposed termination date |
|---------|--------------------------|----------------|---------------------------|
| | | | |
| | | | |

Dental Participation Requirements

Voluntary participation

2-50 Eligible Employees: A minimum of two employees must enroll (there is no participation-percentage requirement for our voluntary dental plans). Dual Option is not available for voluntary plans.

Value, Classic and Enhanced participation

2-4 Eligible Employees: 100% of eligible employees not covered by another dental plan minimum of two must enroll.
 5-50 Eligible Employees: A minimum of 50% of employees not covered by another dental plan are required to enroll. A minimum of two must enroll. For orthodontia, a minimum of 10 employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of five employees must enroll in each of the two plans and the two plans offered must have a 20% premium differential.

3. Vision Coverage – Select one plan option.

- No vision coverage
- Employer-Sponsored Plans (available for groups with 2-100 employees, minimum of two subscribers must enroll).
- Voluntary Plans (available for groups with 5-100 employees, minimum of five subscribers must enroll).

Vision contract codes – Indicate the contract code for the vision plan selected. The codes can be found on your Empire proposal/quote output.

Contract code: _____

Choose your vision contribution for each month.

Employer-sponsored plans require employers to contribute between 50% and 100%.

For Voluntary plans employers may contribute between 0% and 49%.

We will contribute: _____% per employee _____% per dependent (optional).

Section D: Eligibility¹

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|--|--|
| <p>1. Total number of full-time equivalent employees over the previous year (including employed owners/officers, part-time employees, excluding COBRA): _____</p> <p>2. Number of ELIGIBLE full-time employees as defined in 42 U.S.C. 300gg-91(d)(5). To help with this calculation, see Empire worksheet “Determining Group Size”: _____</p> <p>3. Number of INELIGIBLE employees: _____ (For additional information, please contact your Broker or Empire representative.)</p> <p>4. Total number of employees ENROLLING: _____</p> <p>5. Probationary period/waiting period for new employees:</p> <p><input type="checkbox"/> None <input type="checkbox"/> First of month after hire date <input type="checkbox"/> 1 month <input type="checkbox"/> 30 days <input type="checkbox"/> 2 months <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days*</p> <p>6. Probationary period/waiting period for rehired employees:</p> <p><input type="checkbox"/> None <input type="checkbox"/> First of month after hire date <input type="checkbox"/> 1 month <input type="checkbox"/> 30 days <input type="checkbox"/> 2 months <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days*</p> <p>7. New eligible enrollees² will become effective on:</p> <p><input type="checkbox"/> First of month following completion of waiting period/probationary period</p> <p><input type="checkbox"/> Day following completion of waiting period/probationary period (*required for 90 day waiting period)</p> | <p>8. Do you wish to offer Dependent child coverage from age 26 through age 29 for eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you wish to offer coverage for domestic partners? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>The following information is needed to determine TEFRA³ status. Employers may need to consult a tax expert to determine TEFRA status.</p> <p>10. Is your group TEFRA eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will (or did) your group have at least 20 full-time and part-time employees for at least 20 weeks:</p> <p>In the current calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list number of employees: _____</p> <p>In the last calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list number of employees: _____ (Include owners and partners. Count all locations.) _____</p> <p>11. Is your group subject to Federal COBRA or NY State Continuation of Coverage (fewer than 20 employees)? (check one box) See this site for additional COBRA information: www.dol.gov/ebsa/cobra</p> <p><input type="checkbox"/> Federal COBRA <input type="checkbox"/> NY State Continuation of Coverage</p> |
|--|--|

1 Empire requires certain forms of proof to establish eligibility. See the small group guide for more details regarding eligibility categories and required forms of proof. For non-HMO products, 60% of total eligible employees must enroll, except during an annual waiver period pursuant to 45 C.F.R. 147.104. Empire reserves the right to request additional documentation to verify group size/eligibility for participation. Temporary employees; consultants; independent contractors; directors and officers who are not an owner, partner or employee; and union members covered by a union sponsored health plan are not eligible unless they meet the definition of “employee” in NY Ins Law Sect. 4235(d) as amended to have the meaning of “employee” set forth in 42 USC 300gg-91(d)(5).

2 New eligible employees include new employees and rehired employees. Newly eligible employees have 45 days from time of eligibility to enroll in coverage.

3 TEFRA stands for the Tax Equity and Fiscal Responsibility Act of 1982. Under TEFRA, when an employer has 20 or more full-time and/or part-time employees on its payroll for 20 weeks in the current or preceding calendar year, the group becomes the primary payer and Medicare becomes the secondary payer for the remainder of the calendar year and the following calendar year. This applies to claims of working-aged employees and their spouses age 65+ even if they go below the 20/20 threshold. The 20 weeks in a calendar year do not have to be consecutive to reach the 20/20 threshold. Employees of affiliated service groups and controlled groups of businesses should also be counted. Employers may need to consult a tax expert to determine TEFRA status.

Also, under OBRA (Omnibus Budget Reconciliation Act), when an employer has 100 or more full-time and/or part-time employees on its payroll for 26 weeks in a calendar year, the group becomes the primary payer and Medicare becomes the secondary payer for the remainder of the calendar year and the following calendar year for claims of actively working employees and their dependents under the age of 65 that are Medicare eligible because of a disability.

Section E: General Agreement**Please read this section carefully before signing the application.**

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

Or, we, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Empire may rely on this application in deciding whether to provide coverage. If the application is not complete, Empire reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Empire, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We further understand and agree that it is recommended that we keep prior coverage in force until notified of acceptance in writing by Empire and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Empire.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Empire received the written notification of cancellation or such later date as requested, and that no premiums will be refunded for any period between Empire's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums paid after the cancellation date, we understand that Empire will refund these premiums.

In addition, the Broker(s) named on the next page of this application is hereby authorized to process any enrollment transactions for my company's Empire coverage upon direction from the authorized group representative (including, but not limited to, Member enrollment, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations). This authorization shall be effective immediately and I agree that my company will be bound by the actions performed by the herein-named Broker pursuant to my signature. Additionally, I acknowledge that I must notify Empire in writing to void this broker authorization in the event of a change in my company's Broker of Record.

INSURANCE FRAUD STATEMENT: 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 five thousand dollars and the stated value of the claim for each such violation.

| | | | | |
|------------------|---------------------------------------|--------------|-------|-------------------|
| Sign here | Company officer signature X | Printed name | Title | Date (MM/DD/YYYY) |
|------------------|---------------------------------------|--------------|-------|-------------------|

Section F: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this group or any member's eligibility.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual employee(s) application. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Empire to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage and that coverage shall not be effective until Empire reviews and approves the application and the employer receives a written notice from Empire.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Empire shall be paid to an agent/broker/producer not appointed/approved by Empire.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Empire that the coverage being applied for by this application is accepted.

| Writing payable/sub-agent/producer/broker | | | % | Second writing payable/sub-agent/producer/broker | | | % |
|---|--|-------------------|----------|---|--|-------------------|----------|
| Agency name | | Agency ID no. | | Agency name | | Agency ID no. | |
| Agent/producer/broker name | | | | Agent/producer/broker name | | | |
| Agent/producer/broker ID no. | | | | Agent/producer/broker ID no. | | | |
| Payable/sub-agent/producer/broker ID no. if different | | | | Payable/sub-agent/producer/broker ID no. if different | | | |
| Street address | | | | Street address | | | |
| City | | State | ZIP code | City | | State | ZIP code |
| Phone no. | | Fax no. | | Phone no. | | Fax no. | |
| Email address | | | | Email address | | | |
| Signature | | Date (MM/DD/YYYY) | | Signature | | Date (MM/DD/YYYY) | |
| For General Agent/Producer/Broker use only | | | | | | | |
| General agent/producer/broker name | | | | Agent/producer/broker ID no. | | | |
| Street address | | | | City | | State | ZIP code |
| Sales Representative and Account Manager | | | | | | | |
| Sales representative name | | | | Sales representative ID no. | | | |
| Street address | | | | City | | State | ZIP code |
| Account manager name | | | | Account manager ID no. | | | |

Empire USE ONLY

Group no.

Tracking no.

Effective date



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