



# 2022 EMBLEMHEALTH SMALL GROUP APPLICATION

Print In Ink

SECTION I: GROUP INFORMATION			
Company Name			Date
Address			
City	State	ZIP	County
Telephone No. ( )		Fax No. ( )	
Company Officer's Name		Title	Email Address
Group Contact Name		Title	
Telephone No. ( )		Email Address	
Address <input type="checkbox"/> Same as above			
Additional Office Locations			
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
<p>1. Indicate the average number of employees employed by the employer on business days during the preceding calendar year: _____            Indicate the number of 1099 Employees currently employed by the employer on business days during the preceding calendar year: _____</p> <p><b>NOTE:</b> 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.</p> <p>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.</p> <p>2. Please specify the current number of COBRA participants: _____</p> <p>3. Is your company or organization a subsidiary, division or affiliate of another company? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Annual average eligible employees. (Add the employee counts for each month. Divide by 12 and round up to the nearest whole number.)            2020 _____ 2021 _____</p>

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

I understand that the phone numbers I provided on this application may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit 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: OTHER COVERAGE****Other group health coverage**

Please complete the information below for your other group health coverage which is still in force or which was terminated within the past 12 months.

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

**SECTION V: EMBLEMHEALTH PRODUCT SELECTION** Desired Effective Date: \_\_\_\_\_

<b>Prime Network (All Plans are Non-Gated):</b>	<b>Bridge Network (All Plans are Non-Gated):</b>	<b>Select Care Network (All Plans are Non-Gated):</b>	<b>Millennium Network (All HMO Plans are Gated):</b>	<b>Stand-Alone Dental</b>
<input type="checkbox"/> HMO - Platinum Premier-P	<input type="checkbox"/> PPO - Platinum PPO-N	<input type="checkbox"/> HMO - Platinum Premier-S	<input type="checkbox"/> HMO - Platinum Premier-M	<input type="checkbox"/> EPO Access
<input type="checkbox"/> HMO - Platinum Value-P	<input type="checkbox"/> PPO - Gold PPO-N	<input type="checkbox"/> HMO - Platinum Value-S	<input type="checkbox"/> HMO - Platinum Value-M	<input type="checkbox"/> EPO Preferred
<input type="checkbox"/> HMO - Gold Premier-P	<input type="checkbox"/> EPO - Gold Virtual EPO-N	<input type="checkbox"/> HMO - Gold Premier-S	<input type="checkbox"/> EPO - Gold Virtual EPO-M	<input type="checkbox"/> PPO Preferred Premier
<input type="checkbox"/> HMO - Gold Value-P		<input type="checkbox"/> HMO - Gold Value-S	<input type="checkbox"/> HMO - Gold Premier-M	<input type="checkbox"/> PPO Preferred Plus
<input type="checkbox"/> HMO - Silver Plus H.S.A.		<input type="checkbox"/> HMO - Silver Premier-S	<input type="checkbox"/> HMO - Gold Value-M	
<input type="checkbox"/> HMO - Silver Premier-P		<input type="checkbox"/> HMO - Silver Value-S	<input type="checkbox"/> HMO - Silver Premier-M	
<input type="checkbox"/> HMO - Silver Value-P		<input type="checkbox"/> HMO - Bronze Premier-S	<input type="checkbox"/> HMO - Silver Value-M	
<input type="checkbox"/> HMO - Bronze Plus H.S.A.		<input type="checkbox"/> HMO - Bronze Value-S	<input type="checkbox"/> HMO - Bronze Premier-M	
<input type="checkbox"/> HMO - Bronze Premier-P			<input type="checkbox"/> HMO - Bronze Value-M	
<input type="checkbox"/> HMO - Bronze Value-P				

**SECTION VI: HEALTH SAVINGS ACCOUNT**

An HSA is a tax-free fund that can be used to pay for qualified medical and/or pharmacy expenses. EmblemHealth has partnered with Health Equity to offer a seamless HSA solution. Benefits include a full integration of enrollment and claim payment for our qualified high deductible Bronze Plus H.S.A. & Silver Plus H.S.A. plans.

Would you like more information about this HealthEquity HSA option and HealthEquity's fees for these services?  YES  NO

**SECTION VII: ENROLLMENT POLICIES CLASS****Employer Contributions**

Please specify the percent or amount that your group will contribute towards EmblemHealth program premiums for your employees and their dependents. 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.

**In order to meet eligibility for EPO and PPO products, a requirement of at least 60% of eligible employees must be enrolled.**

**SECTION VIII: SHOP CERTIFICATION**

You may qualify for tax credits if:

- You are a business with less than 25 full-time equivalent employees with an average annual salary of \$53,000 or less in 2020.
- 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 SHOP certification.

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

For more information visit [nystateofhealth.ny.gov/employer](http://nystateofhealth.ny.gov/employer) or call NY State of Health Customer Service at **855-355-5777**, or call your Broker.

**SECTION IX**

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-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).

**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.

**SECTION X**

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 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.

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 five thousand dollars 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

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

**COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING**

**SECTION XI: To be completed by EmblemHealth General Agent or Selling Agent**

Group Name			Date
Address			
City	State	ZIP	County
Telephone No. ( )		Fax No. ( )	
Group Contact		Email Address	
Desired Effective Date	General Agency <b>FNA Insurance Services</b>	GA No. <b>G046</b>	
EmblemHealth Marketing Rep			

Selling Agent #1	<input type="checkbox"/> To Be Credentialed	Broker Code or License
Name/Agency Name		
Address		
Telephone No. ( )	Email Address	Fax No. ( )
		Split Commission _____%

Selling Agent #2	<input type="checkbox"/> To Be Credentialed	Broker Code or License
Name/Agency Name		
Address		
Telephone No. ( )	Email Address	Fax No. ( )
		Split Commission _____%

**Confirmation that the following items are attached, if applicable:**

Check or EFT	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount: \$ _____
Proof of Employment (Federal tax forms; NYS-45, 1120, 1065, 1040, 1099, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Last Paid Premium Invoice from Current Carrier	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
COBRA Letters of Election	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

If the date of application is past the 26th of the month deadline for new business submissions, please submit a late form, which can be found at [http://enet.emblemhealth.com/pdfs/NewBusiness\\_LateSubmission\\_SmallGroup.pdf](http://enet.emblemhealth.com/pdfs/NewBusiness_LateSubmission_SmallGroup.pdf)

**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.**

SA Authorized Signature	Date
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# Transaction Form for Group Accounts

**I. SUBSCRIBER INFORMATION**

Last Name		First Name		M.I.	Sex	Social Security Number	
Street Address		Apt.	City			State	ZIP Code
<b>Were you ever a member of EmblemHealth?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, member ID _____		<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)		<b>Birth Date:</b> Mo. Day Yr.		Home Tel. #: _____ Work Tel. #: _____ Cell Tel. # (see back of form*): _____ Email Address: _____	
Applicant's hours worked per week: <input type="checkbox"/> At least 20 hours <input type="checkbox"/> Less than 20 hours <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree (see back of form**)		<b>Type of Coverage:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse/DP <input type="checkbox"/> Employee & Child		<b>Note:</b> If electing Young Adult Coverage, please submit a completed Young Adult Election Form.			
<b>Primary Care Physician Name: (Not required for EPO/PPO members)</b> _____ ID Number: _____				<b>OB/GYN Selection Name: (Optional)</b> _____ ID Number: _____			
<b>Are you covered by any other health insurance or Medicare?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: _____				<b>Check One:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change		<b>Status:</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dep. <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	
				<b>Transfer:</b> <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group Change: From: _____ To: _____			

**II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY**

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date			✓ if Disabled <sup>1</sup>	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
					Mo.	Day	Yr.			
DEPENDENT				<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				<input type="checkbox"/> Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										
DEPENDENT				<input type="checkbox"/> Child						
Current Health Insurance Information: Carrier Name: _____ Coverage Begin Date: _____ Coverage End Date: _____										

<sup>1</sup>For dependent adult children incapable of self-sustaining employment, please see Section A on the back side of this form to check the appropriate "Add Dependent" box, and follow the instruction for required documentation.

**Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.**  
 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.  
**Applicant must sign here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP**

Name of Group:	Group Number:	Sub Group ID _____ Class ID _____ Plan ID _____			<input type="checkbox"/> Health Insurance Plan of Greater New York (HIP) <input type="checkbox"/> EmblemHealth Plan, Inc. <input type="checkbox"/> EmblemHealth Insurance Company Plan Name: _____
	If you selected a small group metal plan, please indicate which plan you are selecting: _____				
Requested Effective Date: Medical: _____ Dental: _____	Hire Date:	Waiting Period:	Date Submitted:	Approved By: (Group Plan Administrator)	

Instructions to Benefit Administrators or Group Representatives: For groups with 100 or fewer full-time equivalent eligible employees, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

## IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III, and if for a small group (100 or fewer full-time equivalent eligible employees) provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive enrollment period – members must be enrolled within 30 days (for small groups) or 90 days (for large groups) from the Qualifying Event.
3. As part of New York State's "Age 29" law, eligible young adults through age 29 may obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.
5. Return the completed Transaction Form along with any required documentation to: Membership, PO Box 2820, New York, NY 10116-2820.

Get more information at [www.emblemhealth.com](http://www.emblemhealth.com).

### HSA

An HSA is a tax-free fund that can be used to pay for qualified medical and/or pharmacy expenses. EmblemHealth has partnered with Health Equity to provide this service for our customers with a high deductible health plan. Benefits include a full integration of enrollment and claim payment for only qualified high deductible health plans. Would you like to open employee HSA accounts with Health Equity?  YES  NO

### HRA – Large Group Only

Health Reimbursement Arrangements (HRAs) are arrangements that allow an employer to reimburse for medical expenses paid by participating employees. HRAs reimburse only those items (copays, coinsurance, deductibles, prescription drugs, and services) agreed to by the employer which are not covered by the company's selected standard insurance plan. EmblemHealth has partnered with Health Equity to provide this service for our customers. Benefits include a full integration of enrollment and claim payment for only qualified high deductible health plans. Would you like to open an HRA account with Health Equity?  YES  NO

## SECTION A

(To be completed by Benefits Administrator)

ACTION Check (✓)One	Qualifying Event	Documentation Required
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work at least 30 hours per week, provide a recent Copy of NYS-45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W-4 Form.
<input type="checkbox"/> Add Spouse	Marriage	<b>If last name is different</b> <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> 1040 Form
<input type="checkbox"/> Add Dependent	Birth or Adoption	<b>If last name is different</b> <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Formal Adoption Papers <input type="checkbox"/> Court-Approved Guardianship Papers
<input type="checkbox"/> Add Young Adult	Young Adult Coverage	Young Adult Election Form
<input type="checkbox"/> Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
<input type="checkbox"/> Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence Form

**Note: No exceptions to our retroactive enrollment period will be allowed. Small group members must be enrolled within 30 days from the Qualifying Event/next billing date (or within 90 days for large group members).**

\* I understand that the phone number(s) I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

\*\*Retiree option is applicable for large groups only.

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