EmblemHealth®

2023 EMBLEMHEALTH 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			
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

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: _____

   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: _____

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

4. Annual average eligible employees. (Add the employee counts for each month. Divide by 12 and round up to the nearest whole number.)
   2021 _____ 2022 _____

EmblemHealth small group HMO 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 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.

SECTION IV: EMBLEMHEALTH PRODUCT SELECTION Desired Effective Date: _____

Prime Network (All Plans are Non-Gated):

- ☐ HMO - Platinum Premier-P
- ☐ HMO - Gold Premier-P
- ☐ HMO - Silver Plus H.S.A.
- ☐ HMO - Silver Premier-P
- ☐ HMO - Bronze Plus H.S.A.
- ☐ HMO - Bronze Premier-P

Stand-Alone Dental

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

SECTION V: 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 VI: 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.

SECTION VII: 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 $56,000 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 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 VIII

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 IX

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, 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 X: 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 FNA Insurance Services	GA No. G046	

Selling Agent #1 ☐ To Be Credentialed	Broker Code or License
Name/Agency Name	
Address	
Telephone No. ( )	Email Address
	Split Commission _____%

Selling Agent #2 ☐ To Be Credentialed	Broker Code or License
Name/Agency Name	
Address	
Telephone No. ( )	Email Address
	Split Commission _____%

Confirmation that the following items are attached, if applicable:

EFT	☐ Yes	☐ No	Amount: $ _____
Proof of Employment (Federal tax forms; NYS-45, 1120, 1065, 1040, 1099, etc.)	☐ Yes	☐ No	
Last Paid Premium Invoice from Current Carrier	☐ Yes	☐ No	
COBRA Letters of Election	☐ Yes	☐ 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**

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

EmblemHealth®

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

Were you ever a member of EmblemHealth?
☐ NO ☐ YES
If YES, member ID _____

Marital Status:
☐ Single ☐ Married
☐ Domestic Partner (DP)

Birth Date:
Mo. Day Yr.

Home Tel. #: _____
Work Tel. #: _____
Cell Tel. # (see back of form*): _____

Email Address: _____

Applicant's hours worked per week:
☐ At least 20 hours ☐ Less than 20 hours ☐ COBRA
☐ Retiree (see back of form**)

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

Note: If electing Young Adult Coverage, please submit a completed Young Adult Election Form.

Primary Care Physician Name: (Not required for EPO/PPO members) _____ ID Number: _____
OB/GYN Selection Name: (Optional) _____ ID Number: _____

Are you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name: _____
Insurance Co. Telephone #: _____ Type of Coverage: _____
Policy #: _____ Effective Date: _____

Check One:
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ 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 Mo.	Day	Yr.	✓ if Disabled[1]	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
DEPENDENT				☐ Spouse ☐ DP ☐ Child						
Current Health Insurance Information:	Carrier Name: _____	Coverage Begin Date: _____	Coverage End Date: _____							
DEPENDENT				☐ Child						
Current Health Insurance Information:	Carrier Name: _____	Coverage Begin Date: _____	Coverage End Date: _____							
DEPENDENT				☐ Child						
Current Health Insurance Information:	Carrier Name: _____	Coverage Begin Date: _____	Coverage End Date: _____							

[1]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_____	☐ Health Insurance Plan of Greater New York (HIP) ☐ EmblemHealth Plan, Inc. ☐ 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**.

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
☐ 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.
☐ Add Spouse	Marriage	**If last name is different** ☐ Marriage Certificate ☐ 1040 Form
☐ Add Dependent	Birth or Adoption	**If last name is different** ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court-Approved Guardianship Papers
☐ Add Young Adult	Young Adult Coverage	Young Adult Election Form
☐ Add Dependent	Dependent Adult Child Incapable of Self-Sustaining Employment	Disability Status Request Form
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage
☐ 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.

100-23-TransForm (4/20)