EmblemHealth®

HIP APPLICATION FOR LARGE GROUPS

(101+ Full-time Equivalent Employees)

For use with EmblemHealth insurance programs that are underwritten by Health Insurance Plan of New York (HIP)

PRINT IN INK

SECTION I: GROUP INFORMATION				
Company Name				Date
If applicable, DBA Company Name				
Address				
City		State	ZIP	County
Telephone No. ( )	Fax No. ( )			
Company Officer's Name	Email Address			
Title				
Group Contact	Title	Telephone No. ( )		
Email Address				
Address ☐ Same as above				
City		State	ZIP	County
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. ( )	Email Address			
Contact Person (if different than above)				
Telephone No. ( )	Email Address			

SECTION III: GROUP ADMINISTRATION

A. Number of full-time equivalent employees* employed by the employer: _____

B. Average full-time equivalent employees over the past 12 months: _____

C. Number of eligible employees (employees must work at least 20 hours per week for applicant): _____

D. Number of employees applying: _____

E. Number of COBRA participants: _____

* 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.

Employee Eligibility:

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 below:

_____

_____

_____

Retired Employees: ☐ Yes ☐ No

A retired employee is defined as an employee who is: (check any that apply)

☐ Retired on pension by the employer

☐ 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

☐ 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.

Other group health or HMO coverage: Indicate below all 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	Effective Date of Policy	Termination Date of Policy

SECTION IV: PRODUCT SELECTION

Desired Effective Date: _____

Product 1

Product Name: _____

Product 2

Product Name: _____

The following mandated "make available" riders have been offered as part of this product selection:

- Dependent coverage
- Domestic Partner coverage
- Dependent coverage through age 29
- Skilled nursing unlimited days

SECTION V: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

☐ Employee: _____ % or $ _____

☐ Family: _____ % or $ _____

☐ Other: _____

NEW HIRE ELIGIBILITY POLICY

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

PLUS:

☐ 30 Days ☐ 60 Days ☐ 90 Days

☐ Other (please specify): _____

TERMINATION POLICY

☐ Date Terminated ☐ End of Month ☐ Other _____

SECTION V-A: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

☐ Employee: _____ % or $ _____

☐ Family: _____ % or $ _____

☐ Other: _____

NEW HIRE ELIGIBILITY POLICY

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

PLUS:

☐ 30 Days ☐ 60 Days ☐ 90 Days

☐ Other (please specify): _____

TERMINATION POLICY

☐ Date Terminated ☐ End of Month ☐ Other _____

SECTION VI: GROUP SIZE

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) full-time equivalent employees on a typical business day during the preceding calendar year.

SECTION VII: BROKER INFORMATION

Primary Selling Agent Name:	**Commission %:**
License Number:	SA Code:
Address:	
Telephone No.: ( )	Fax No.: ( )
Email Address:	

Secondary/Split Selling Agent Name:	**Commission %:**
License Number:	SA Code:
Address:	
Telephone No.: ( )	Fax No.: ( )
Email Address:	

General Agent Name:	**Fee or Commission %:**
License Number:	SA Code:
Address:	
Telephone No.: ( )	Fax No.: ( )
Email Address:	

SECTION VIII: AGREEMENT AND SIGNATURE

The group agrees to do the following:

- Make payroll deductions, if employee contributions are required, and remit to Health Insurance 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 Health Insurance Plan of New York of the termination or addition of any Member(s) covered or to be covered.
- Promptly provide Health Insurance Plan of New York 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 Health Insurance Plan of New York.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by Health Insurance 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 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 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 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 (5,000) dollars and the stated value of the claim for each such violation.

Signed at: _____

On the _____ day of _____, 20_____

By: _____ Title: _____
(print name)

By: _____
(signature)

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