EmblemHealth®

2024 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: _____

   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

EmblemHealth small group HMO & POS 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: _____

Select Care Network (All Plans are Non-Gated):

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

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	GA No.	

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, 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