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LARGE GROUP APPLICATION/CHANGE FORM (51+ eligible employees)

Thank you for choosing Empire. Please fill out all items below and print clearly in black or blue ink in order for us to quickly and accurately process your group's application. Once you've completed this form, please sign in the space provided in Section 22.

1. REASON FOR APPLICATION/CHANGE - CHOOSE ONE ONLY

Form with checkboxes for 'New' and 'Change Existing Benefits', each with an 'Effective Date' field.

2. GROUP INFORMATION

Form for group information including fields for Group Name, Mailing Address, City, State, Zip, County, Contact Information, and Federal Employer Identification Number.

Form asking if the group is a subsidiary/division of another company, with fields for Name and Number of Employees if yes.

3. EMPLOYER ONLINE SERVICES (if applicable)

Form with a checkbox for 'I want to manage my group's health plan information online...'.

4. OTHER COVERAGE

Has health insurance been purchased for the group from any carrier, including Empire, during the last twelve (12) months? If more than one carrier in 12 months, please attach a separate page.

Form with a checkbox for 'Yes' or 'No' and a table for 'If yes' with columns for Insurance Carrier, Coverage Type, Coverage start date, and Coverage end date.

5. GROUP ELIGIBILITY

Waiver of Waiting Periods

Form with checkboxes for various waiver options: Member and dependents initial and subsequent enrollment, Member and dependents initial enrollment, Member and dependents initial enrollment and member subsequent enrollment, No waiver of waiting periods, and Other (Specify).

Eligibility Dates (complete both A & B)

Form with sections A and B for Eligibility Dates. Section A covers Initial Enrollment of Group, and Section B covers New Employees. Includes checkboxes for enrollment dates and a note that forms must be received no later than sixty (60) days following the member's eligibility date.

Regions of Residence

Form with text explaining that if choosing HMO, Direct HMO, Direct POS or DirectShare POS, all regions must be checked. Lists regions: New York, Mid Hudson, Albany, New Jersey Contiguous Counties, and Connecticut.

For Empire Office Use Only

Table for Empire Office Use Only with columns: Group #, Sub-Group #, Sales Representative Last Name, Sales Representative First Name, Rep. Code.

Group No. _____

Sub-Group No. _____

6. NUMBER OF MEMBERS

	EMPIRE INSURED MEMBERS	TEFRA ELIGIBLE (actively employed)	MEDICARE-ELIGIBLE RETIREES	COBRA ELIGIBLES	TOTAL NUMBER COVERED	OTHER (not insured by Empire)
SINGLE						
FAMILY						

7. FINANCIAL ARRANGEMENT

- ADMINISTRATIVE SERVICES ONLY REQUIRED OPERATING FUND (Hospital)
 Closed End (Prospective + Retrospective) Deferred Payment of Premium
 Extended Grace Period Minimum Premium Arrangement
 Other (specify) _____

8. GROUP'S CONTRIBUTION

_____ % Employee Only _____ % 2 Party _____ % Employee & Spouse _____ % Parent & Child(ren) _____ % Family
Contribution to HRA \$ _____ Individual \$ _____ Family **HRA Carryover** Unlimited 2X Annual Amt 3X Annual Amt
 Incentive credits offered (HRA Only) Yes No

9. RATE TIER

- 2 Tier 3 Tier 4 Tier

10. ID CARD MAILING

Initial: Group Member **Subsequent:** Group Member

11. PRODUCT

- HMO* DHMO* DPOS* DSPOS EPO PPO Empire Prism EPO Empire Prism PPO Other_____

* HMO benefits provided by Empire HealthChoice HMO, Inc.

Empire Total BlueSM Choice HRA HSA* Empire Total BlueSM Select HRA HSA* *Requires completion of HSA addendum

12. CO-PAYMENTS (This Section does NOT apply to HRA/HSA)

PCP/Primary Home/Office/Outpatient \$ _____ Inpatient Facility \$ _____ Specialist Home/Office/Outpatient \$ _____

Emergency Room \$ _____ Ambulatory/Outpatient Surgery \$ _____ MRI/MRA, PET, CAT Scans, Nuclear Cardiology \$ _____

Empire Prism Plans Only

Durable Medical Equipment, Prosthetics & Orthotics 50% Coinsurance 20% Coinsurance \$0 Co-pay with \$2,000 Max

13. DEDUCTIBLE

In-Network Individual \$ _____ Family \$ _____ Out-of-Network Individual \$ _____ Family \$ _____

Combined INN & OON (Applies to Empire Total Blue Choice benefit only) Individual \$ _____ Family \$ _____

14. COINSURANCE

In-Network _____%	Out-of-Network _____%
Stop Loss Level Individual \$ _____	Stop Loss Level Individual \$ _____
Family \$ _____	Family \$ _____
Out-of-Pocket* Individual \$ _____	Out-of-Pocket* Individual \$ _____
Coinsurance Family \$ _____	Coinsurance Family \$ _____
<input type="checkbox"/> None *Does not include deductible	<input type="checkbox"/> None *Does not include deductible

15. DEDUCTIBLE CREDITS (This Section does NOT apply to HRA/HSA)

YES NO If yes, Empire requires proof from the prior carrier that the member and/or dependents met all or part of the deductible.

16. VISION COVERAGE Yes, complete the information below No

Blue View Vision – Exam Only Benefits

Exam Frequency Exam Co-Pay
 Every 12 Months \$0 \$10
 Every 24 Months \$5 \$15

Blue View Vision – Exam and Material Benefits

Frequency – Exam/Lenses/ Frames Copay – Exam/Lenses
 12/12/12 12/24/24 \$5/\$0 \$10/\$0
 12/12/24 24/24/24 \$10/\$10 \$10/\$20
 \$20/\$20

Includes a \$130 Frame or Contact Lenses Allowance

17. PRESCRIPTION DRUGS (Check all applicable)

Prescription Drug Program Generic \$ _____ Brand Name \$ _____ Non-Formulary \$ _____

Oral Contraceptives are mandatory unless group opts out as permitted by NY Insurance Law.

Deductible** \$0 \$50 \$100 \$150

\$250 \$500
 DPOS, DSPOS, HMO, Direct HMO & Prism Plans Only

Other _____ HRA (Fill in co-pays above) HSA (co-pays do not apply)

**not applicable to mail order program; not applicable to HRA/HSA

18. DENTAL BENEFITS SECTION (Check benefit and fill in)

MANAGED DENTAL PROGRAMS*

- Preventive Care
- Preventive Care Plus
- Comprehensive Care
 - Plan 1 Plan 2 Plan 3
 - Riders _____
- Office Visit Co-pays
 - \$0 \$5 \$10
- Orthodontics
 - Child only Child and Adult
 - Ortho Co-pay Max per member
 - \$2,000 \$2,500 \$3,000

* Existing groups may attach member listing with PCD selection.

- OPEN ACCESS VOLUNTARY**
 - Coinsurance Deductible
 - 100/50/50 \$25
 - 100/50/30 \$50
 - 100/50/0 \$50
 - Riders _____
- PREMIUM CARE PPO—51-100**
 - Option 1
 - Option 2
 - Riders _____
- OTHER** _____

PREMIUM CARE PPO—100+

	In-Network Coinsurance	Out-of-Network Coinsurance
Diagnostic/Preventive	_____ %	_____ %
Basic Restorative	_____ %	_____ %
Endodontics	_____ %	_____ %
Periodontics	_____ %	_____ %
Oral Surgery	_____ %	_____ %
Major Restorative	_____ %	_____ %
Prosthetic Repairs	_____ %	_____ %
Prosthetics	_____ %	_____ %
Orthodontics	_____ %	_____ %
<input type="checkbox"/> Child only <input type="checkbox"/> Adult & Child		
Out-of-Network Reimbursement	<input type="checkbox"/> 50% <input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	
Deductible	\$ _____	\$ _____
Annual Maximum	\$ _____	\$ _____
Ortho Lifetime Maximum	\$ _____	\$ _____
<input type="checkbox"/> Voluntary		
Waiting Periods		
Basic	_____ months	
Major	_____ months	
Ortho	_____ months	
<input type="checkbox"/> Full mouth X-rays — every 3 years		
<input type="checkbox"/> Sealants covered under D+P		
<input type="checkbox"/> Other _____		
Riders _____		

19. ADDITIONAL BENEFIT RIDERS AND DESCRIPTIONS (Must also include Drug, Dental and Vision Riders.)

RIDER CODE	DESCRIPTION OF BENEFIT

20. RATES:

PRODUCT	INDIVIDUAL	FAMILY	EMPLOYEE/ SPOUSE	PARENT/ CHILD	PARENT/ CHILDREN	COMPOSITE

HRA/HSA Admin Fee (PEPM) \$ _____

MEDICARE CARVEOUT RATES

HRA Admin Fee (PEPM) \$ _____

21. AGENT/BROKER DECLARATION AND INFORMATION

To the best of my knowledge, all the statements/responses in this application are true and complete. I have no knowledge about the Applicant, his/her employees, the dependents of such employees or an individual who is receiving continuation of coverage under federal or state laws which is not fully stated in this application.

1st BROKER

Last Name		First Name		MI	Social Security/Tax ID Number
Company Name					
E-mail Address					
Mailing Address					
City	State	Zip	Phone	Fax	

2nd BROKER

Last Name		First Name		MI	Social Security/Tax ID Number
Company Name					
E-mail Address					
Mailing Address					
City	State	Zip	Phone	Fax	

1st Broker Signature

Date

2nd Broker Signature

Date

The Personnel Record and the attached complete copy of my New York State Department of Taxation and Finance "Quarterly Combined Withholding and Wage Reporting return of Wages Paid to each Employee (NYS-4/NYS-45/NYS-45ATT)" as filed, signed by an officer or owner of the group, W-2 forms or any additional documentation validating enrollment of employees, owners or partners (i.e., K-1, notarized statements, payroll records) are a completed statement of the total number of our employees, including the reasons why any individuals are not being covered, for which appropriate documentation is submitted.

For eligible retirees, evidence of past employment and continuing financial arrangements is required.

If the enrollment forms submitted meet Empire's underwriting requirements, and are in compliance with New York State law, and we issue coverage, THE GROUP AGREES TO THE FOLLOWING:

Remit to Empire the charges payable in accordance with the terms of such contracts, and if employee contributions

are required, make necessary payroll deductions; group must also submit payment promptly, not to be received after the expiration of the grace period. (Failure to pay promptly will result in the termination of the group's coverage.) Empire must be allowed to audit and/or make copies of any records or information that relate to the administration of this coverage.

Ensure compliance with HIPAA (45 CFR Parts 160-164) as it relates to health plans. Ensure compliance with TEFRA / DEFRA / COBRA / OBRA legislation as it relates to any active employee or dependent of an active employee who elects the group's benefits as primary. Ensure prompt conversion to Medicare-related / Carveout coverage of Medicare-eligible actively employed group members and dependents not covered by TEFRA / DEFRA / OBRA legislation. Ensure prompt conversion to Medicare-related/ Carveout coverage for eligible Medicare retirees.

Promptly submit an employee's enrollment form for eligible members only and promptly remove members who are no longer eligible. Failure to report removals promptly could

result in the group being responsible for premiums or claims paid subsequent to the employee's removal date. The group must also ensure all employees enroll in accordance with their marital status.

If an acceptable enrollment form is received prior to or within 60 days after the eligibility date, coverage will begin on the date of eligibility; otherwise, coverage will begin on open enrollment or the next group renewal date.

Benefits purchased and established eligibility selected may be changed at renewal only. It is understood that this agreement may be terminated by the group giving 60 days prior written notice. In the event of termination by the group, the group will be required to pay premiums to a date not less than 60 days subsequent to the written notification by the group to Empire. Empire may terminate this agreement for any of the reasons set forth in the group contract. This group application is a part of the agreement between Empire and the group for health insurance benefits.

22. SIGNATURE OF AUTHORIZED REPRESENTATIVE I HAVE READ THIS ENTIRE APPLICATION AND THE CERTIFICATION AND FRAUD STATEMENT.

Authorized Group Signature

Date

Print Name and Title

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 material fact thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.