

Large Group Application/Change Form (51+ Eligible Employees)



Thank you for choosing Empire. Please fill out **all** items in order for us to quickly and accurately process your application. Once you've completed this form, please sign in the space provided in Section 26.

1. REASON FOR APPLICATION/CHANGE (FILL IN ONE ONLY)

<input type="checkbox"/> New policy	Requested effective date (MMDDYY)	<input type="checkbox"/> Change existing benefits	Revision or renewal date (MMDDYY)
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2. GROUP INFORMATION

Group name			
Group mailing street address			
City		State	ZIP code (5+4)
County	Phone	Fax	

AUTHORIZED GROUP CONTACTS

Group contact last name	First name	Title
E-mail address (Benefit administrator) - mandatory		
Billing contact		Billing phone
Billing mailing street address (if different)		
City		State ZIP code (5+4)
County	Federal employer identification no.	
Type of industry		

Is your group a subsidiary/division affiliated with another company? Yes No

If yes, name	No. of employees
Do you currently have group coverage with Empire? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is group no?

3. EMPLOYER ONLINE SERVICES (IF APPLICABLE)

I want to manage my group's health plan information online. Please send log-on information to my e-mail address.

FOR EMPIRE USE ONLY

Sales representative last name	First name	Representative code
Group no.	Sub-group no.	Sub-group no.

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.) Yes No

If yes, insurance carrier

Coverage type (ex: HMO, POS, PPO)

Coverage start date (MMDDYY)

Coverage end date (MMDDYY)

5. GROUP ELIGIBILITY**WAIVER OF WAITING PERIODS**

- 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
 Other (specify) _____

ELIGIBILITY DATES (COMPLETE BOTH A & B)**A. Initial Enrollment of Group – All employees' and dependents' coverage will be in effect:**

All enrollment forms must be received no later than thirty (30) days following the member's eligibility date.

- On group effective date
 After new employee eligibility is satisfied (see B)

B. New Employees (after initial enrollment of group) – New employees will be eligible for coverage:

- Date of hire
 First day following: First of the month following: Other _____
 _____ day(s) following date of hire _____ day(s) following date of hire
 _____ month(s) following date of hire _____ month(s) following date of hire

All enrollment forms must be received no later than sixty (60) days following the member's eligibility date.

C. Employee Reinstatement Policy: Employees who are re-hired to the company are eligible for coverage:

- Date of hire

Other

DOMESTIC PARTNERSHIP SELECTION (PLEASE SELECT ONE)

- Same sex only Same sex and opposite sex No domestic partnership coverage

REGIONS OF RESIDENCE (SELECT ALL THAT APPLY)

If you are choosing Direct POS or DirectShareSM POS, please check all regions in which your enrolling employees reside.

- Albany:** Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties
 Connecticut Contiguous Counties: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham counties
 Mid-Hudson: Dutchess, Putnam, Orange, Sullivan and Ulster counties
 New Jersey Contiguous Counties: Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex and Union counties
 New York: Bronx, Kings, Queens, New York, Nassau, Rockland, Westchester, Richmond and Suffolk counties

If you are choosing HMO or Direct HMO, please check all regions in which your enrolling employees reside.

- Downstate I:** Bronx, Kings, Rockland, Richmond
 Downstate II: New York, Queens, Suffolk, Nassau
 Capital: Albany, Schenectady, Rensselaer
 Mid-Hudson: Dutchess, Orange, Putnam, Sullivan, Ulster, Westchester
 Upstate I: Columbia, Delaware, Greene, Montgomery, Schoharie, Saratoga, Warren, Washington
 Upstate II: Clinton, Essex, Fulton
 Connecticut Contiguous Counties: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham counties
 New Jersey Contiguous Counties: Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex and Union counties

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 SECTION (PLEASE SELECT THE VISION PRODUCT AND COVERAGE OPTIONS YOU WISH TO PURCHASE)

Yes, complete the information below No

<input type="checkbox"/> Blue View VisionSM - Exam Only Benefits	Exam Frequency	Exam Copay
	<input type="checkbox"/> Every 12 months	<input type="checkbox"/> \$0
	<input type="checkbox"/> Every 24 months	<input type="checkbox"/> \$5
		<input type="checkbox"/> \$10
		<input type="checkbox"/> \$15

<input type="checkbox"/> Blue View VisionSM - Exam and Material Benefits	Frequency - Exam/Lenses/Frames	Copay - Exam/Lenses	Frame/Contact Lens Allowance
	<input type="checkbox"/> 12/12/12 months	<input type="checkbox"/> \$5/\$0	<input type="checkbox"/> \$130
	<input type="checkbox"/> 12/12/24 months	<input type="checkbox"/> \$10/\$0	<input type="checkbox"/> \$100
	<input type="checkbox"/> 12/24/24 months	<input type="checkbox"/> \$10/\$10	<input type="checkbox"/> \$80
	<input type="checkbox"/> 24/24/24 months	<input type="checkbox"/> \$10/\$20	
	<input type="checkbox"/> \$20/\$20		

17. PRESCRIPTION DRUG COVERAGE SECTION (CHECK ALL APPLICABLE)

Prescription Drug Program Tier 1 \$ _____ Tier 2 \$ _____ Tier 3 \$ _____
 Deductible** \$0 \$50 \$100 \$150
 DPOS, DSPOS, HMO, Direct HMO & Prism Plans Only \$250 \$500
 Waive Preferred Generic Program Provision (option applies to HMO/DHMO Plans Only)
 Other _____ HRA (Fill in co-pays above) HSA (co-pays do not apply)

**not applicable to mail order (mail service) program; not applicable to HRA/HSA.
 Oral Contraceptives are mandatory unless group opts out as permitted by NY Insurance Law.

18. DENTAL BENEFITS SECTION (CHECK BENEFIT AND FILL IN)

No Coverage

Premium Care PPO-100+

	<i>Coinsurance In-Network</i>	<i>Coinsurance Out-of-Network</i>
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	<input type="checkbox"/> 50% <input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	
Reimbursement		
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 _____		

Managed Dental Programs* (select one)

Preventive Care
 Preventive Care Plus
 Comprehensive Care
 Comprehensive Care Plan
 Plan 1 Plan 2 Plan 3
 Riders _____
 Office visit Copays
 \$0 \$5 \$10
 Orthodontics
 Child only Child and adult
 Ortho Copay max per member
 \$2,000 \$2,500 \$3,000

Open Access - Voluntary (select one)

Coinsurance	Deductible
<input type="checkbox"/> 100%/50%/50%	\$25
<input type="checkbox"/> 100%/50%/30%	\$50
<input type="checkbox"/> 100%/50%/0%	\$50
<input type="checkbox"/> Riders _____	

Premium Care PPO - 51-100 (select one)

Option 1
 Option 2
 Riders _____

Other _____

*Existing groups can attach member listing with PCD selection.

23. AGENT BROKER DECLARATION

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, partners, officers or paid Board members (i.e., K-1, notarized statements, payroll records) are a complete 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 credentialing and eligibility requirements, and are in compliance with New York State law, and we issue coverage, the group agrees to the following:

To remit to Empire the charges payable in accordance with the terms of the contract between Empire and the group, and if employee contributions are required, to 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.) The group agrees to permit Empire to audit and/or make copies of any records or information that relate to the administration of this coverage.

The group further agrees: to ensure compliance with HIPAA (45 CFR Parts 160-164) as it relates to health plans, to 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, to ensure prompt conversion to Medicare-related /Carveout coverage of Medicare-eligible actively employed group members and dependents not covered by TEFRA/DEFRA/OBRA legislation; and to ensure prompt conversion to Medicare-related/Carveout coverage for eligible Medicare retirees.

The group agrees to 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/domestic partner status.

If an acceptable enrollment form is received prior to or within 30 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 by giving prior written notice as required by the group contract. 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.

New York insurance law requires that your employees who receive health coverage from an HMO, Direct HMO or Direct POS health plan, be given 30 days prior notice when an increase in the group insurance premium rates results in an increase to their premium contributions. Employers offering other types of health coverage are also encouraged to provide this information to their employees. For more information and to download a sample employee notification letter, visit www.empireblue.com.

24. 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		COMMISSION % OF SPLIT		
Agent or Brokerage of Record Last name		First name		SSN/Tax ID no.
Company name				
E-mail address				
Mailing street address				
City			State	ZIP code (5+4)
County		Phone		Fax

1st Broker Signature

Date (MMDDYY)

24. AGENT/BROKER DECLARATION AND INFORMATION CONTINUED**2ND BROKER****COMMISSION % OF SPLIT**

Agent or Brokerage of Record Last name

First name

SSN/Tax ID no.

Company name

E-mail address

Mailing street address

City

State

ZIP code (5+4)

County

Phone

Fax

2nd Broker Signature_____
Date (MMDDYY)**25. 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.

26. SIGNATURE OF AUTHORIZED REPRESENTATIVE - I HAVE READ THIS ENTIRE APPLICATION AND THE CERTIFICATION AND FRAUD STATEMENT._____
Print name_____
Title

Authorized Group Signature

Date**X**