

# Small Group Application/Change Form 2-50 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 13.

## 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)
Sales representative last name		First name	Current group no. (if applicable)

## 2. GROUP INFORMATION

Group name (as it appears on documents attached)			
Doing business as			
Group mailing street address			
City		State	ZIP code (5+4)
County	Phone	Fax	

## AUTHORIZED GROUP CONTACTS

Primary group contact last name		First name	Title
E-mail address (Benefit administrator) - mandatory			
Secondary group contact last name		First name	Title
Tertiary group contact last name		First name	Title
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, name			No. of employees

### 3. 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, PPO)

Coverage start date (MMDDYY)

Coverage end date (MMDDYY)

### 4. GROUP ELIGIBILITY

#### NO. OF EMPLOYEES

**A. No. of employees at all locations** (include owners, partners, officers and paid Board members you wish to enroll, exclude COBRA)\*

**B. No. of retirees eligible for coverage**

**C. No. of ineligible employees** (check reason for ineligibility)

Part-time  Temporary  Union  Other

**D. Employee Eligibility\*\***

All full-time, permanent employees who work at least  hours per week (minimum 20 hours/week) are eligible.

**E. No. of net eligible employees** (A + B - C)

No. of enrolling employees (include retirees and COBRA)

Employer contribution to retiree coverage (%)

The following information is needed to determine TEFRA status. Employers may need to consult a tax expert to determine TEFRA status.

**1. Will (or did) your group have at least 20 full-time and part-time employees for at least 20 weeks:**

In the current calendar year?  
If yes, list no. of employees:  Yes  No

In the last calendar year? If yes, list no. of employees:  
(Include owners and partners. Count all locations. Weeks do not have to be consecutive.)  Yes  No

**2. Is your group subject to Federal COBRA or NY State Continuation of Coverage (fewer than 20 employees) (check one box to the right)** (See this site for additional COBRA information: [www.dol.gov/ebsa/cobra](http://www.dol.gov/ebsa/cobra))

Federal COBRA  
 NY State Continuation of Coverage

\*At least two eligible, active, full-time employees must be enrolled. Empire requires certain forms of eligibility. See small group underwriting guidelines for more info regarding eligibility categories and required forms of proof.

\*\*Empire reserves the right to request a current payroll register to confirm number of hours worked when verifying group size/eligibility participation.

#### 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 new group effective 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:  
 \_\_\_\_\_ 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

**GROUP PRIMARY LOCATION (SELECT ONE)**

If you are choosing Empire Total Blue<sup>SM</sup> with HSA, please check one:

- Albany:** Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties
- Mid-Hudson:** Dutchess, Putnam, Orange, Sullivan and Ulster counties
- New York:** Bronx, Kings, Queens, New York, Nassau, Rockland, Westchester, Richmond and Suffolk counties

If you are choosing Prism EPO, Value EPO, HMO, Direct HMO, Empire EPO Essential, or Empire EPO Stepped, please check one:

- 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

**5. PAYMENT SECTION (GROUP'S CONTRIBUTION, IF ANY)**

% Employee only	% 2-Party	% Employee & spouse	% Parent & child(ren)	% Family

If your group has multiple locations, do you wish to receive (select one):

- A summary invoice combining all locations. **OR**  Separate invoices for each location.
- If you are requesting quarterly billing, please indicate here; otherwise, group will be billed monthly.

**6. MEDICAL BENEFITS SECTION**

Please select all of the coverage options you wish to use, and then fill out the details under the coverage sections.

- HMO\*  Direct HMO\*  Empire Value EPO  Empire EPO Essential  Empire EPO Stepped

- Empire Total Blue<sup>SM</sup> with HSA  Empire Prism EPO  Other

\*HMO benefits provided by Empire HealthChoice HMO, Inc.

**HMO/DIRECT HMO**

Please select only one product:  HMO  Direct HMO

Copay Options (select one)	Inpatient Copay	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	ER Copay	Ambulatory/ OP Surgery Copay
<input type="checkbox"/> 12	\$1,000/\$2,500*	\$30	\$50	\$150	\$150

\*Per admission/maximum per calendar year

**Prescription Drug** (includes contraceptives\*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$100	\$10	35% Coinsurance	50% Coinsurance
<input type="checkbox"/>	\$0	Generic \$10	Mandated Brand†	50% Coinsurance

No prescription drug coverage

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to Retail Tier 1 generics or mail-order program.

†Mandated brand-name drugs without a generic equivalent.

- Rating Structure** (select one)  Tier 2 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 3 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 4 (all rating regions)

**Miscellaneous Options** (select all of the following options you wish to purchase)

- Dependent children age increases through 29 (for eligible dependents)
- Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
- Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- No additional options

**EMPIRE TOTAL BLUE<sup>SM</sup> COVERAGE WITH HSA**

**Cost-Sharing and Benefit Maximum Calculation Period** (select one)  Calendar Year  Plan Year

Option	In-network		Coinsurance Out-of-Pocket Max*	Out-of-network		Coinsurance Out-of-Pocket Max*
	Deductible*	Coinsurance		Deductible*	Coinsurance	
<input type="checkbox"/> 2	\$1,500	80%/20%	\$3,500	\$3,000	60%/40%	\$7,000
<input type="checkbox"/> 3	\$2,000	80%/20%	\$3,000	\$3,500	60%/40%	\$7,000
<input type="checkbox"/> 5	\$2,500	80%/20%	\$2,500	\$4,500	60%/40%	\$8,000
<input type="checkbox"/> 6	\$3,000	80%/20%	\$2,000	\$10,000	50%/50%	\$20,000

\*Family coverage is 2 times the individual coverage amount shown.

**Prescription Drug**

- Drug coverage** – Tier 1-\$10, Tier 2-\$30, Tier 3-\$50; Copayments apply after integrated Deductible is met; also includes contraceptives. Groups exempt from contraceptive coverage must submit a signed affidavit.
- No prescription drug coverage**

**Miscellaneous Options** (select all of the following options you wish to purchase)

- Dependent children age increases through 29 (for eligible dependents)
- Inpatient rehabilitation for alcohol/substance abuse 30 days combined in-network and out-of-network
- Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- Group will establish HSA, but DOES NOT want Empire to facilitate.
- No additional options

**VALUE EPO**

**Cost-Sharing and Benefit Maximum Calculation Period** (select one)  Calendar Year  Plan Year

Option	In-network	PCP/Primary Home/Office	Specialist Home/Office	Deductible*	Coinsurance	Coinsurance Out-of-Pocket Max*
	Copay	Copay				
<input type="checkbox"/> 1		\$30	\$30	\$1,000	90%/10%	\$2,000
<input type="checkbox"/> 2		\$30	\$30	\$1,500	90%/10%	\$2,000
<input type="checkbox"/> 3		\$30	\$30	\$2,000	80%/20%	\$2,000
<input type="checkbox"/> 4		\$30	\$30	\$500	80%/20%	\$4,000
<input type="checkbox"/> 5		\$30	\$30	\$3,000	80%/20%	\$2,000
<input type="checkbox"/> 6		\$30	\$30	\$250	90%/10%	\$2,750
<input type="checkbox"/> 7		\$30	\$30	\$250	80%/20%	\$2,750
<input type="checkbox"/> 8		\$30	\$30	\$500	90%/10%	\$2,500
<input type="checkbox"/> 9		\$30	\$50	\$1,000	90%/10%	\$2,000
<input type="checkbox"/> 10		\$30	\$50	\$1,500	90%/10%	\$2,000
<input type="checkbox"/> 11		\$30	\$50	\$2,000	80%/20%	\$2,000
<input type="checkbox"/> 12		\$30	\$50	\$500	80%/20%	\$4,000
<input type="checkbox"/> 13		\$30	\$50	\$3,000	80%/20%	\$2,000
<input type="checkbox"/> 14		\$30	\$50	\$250	90%/10%	\$2,750
<input type="checkbox"/> 15		\$30	\$50	\$250	80%/20%	\$2,750
<input type="checkbox"/> 16		\$30	\$50	\$500	90%/10%	\$2,500

Note: ER copay \$150 \*Family coverage is 2.5 times the individual coverage amount shown.

**Prescription Drug** (includes contraceptives\*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$50	\$10	\$35	35% Coinsurance
<input type="checkbox"/>	\$100	\$10	35% Coinsurance	50% Coinsurance
		Generic	Mandated Brand†	
<input type="checkbox"/>	\$0	\$10	50% Coinsurance	

- No prescription drug coverage**

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to Retail Tier 1 generics or mail-order program.

†Mandated brand-name drugs without a generic equivalent.

**Rating Structure (Select one)**  Tier 2 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 3 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 4 (all rating regions)

**Miscellaneous Options** (select all of the following options you wish to purchase)

- Dependent children age increases through 29 (for eligible dependents)
- Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
- Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- 4th Quarter Carryover Deductible Credit
- No additional options

**EMPIRE PRISM EPO**

Is Empire the sole carrier offered by the group?  Yes  No

Select the following new Copay Options and prescription drug card choice if applicable.

Copay Options (select one) Option	Inpatient Copay	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	ER Copay	Ambulatory/ OP Surgery Copay
<input type="checkbox"/> 2	\$500 per day; 3 day max/\$3,750*	\$35	\$50	\$150	\$300
<input type="checkbox"/> 3	\$500 per day; 3 day max/\$3,750*	\$45	\$45	\$150	\$300
<input type="checkbox"/> 4	\$500 per day; 3 day max/\$3,750*	\$45	\$60	\$150	\$300
<input type="checkbox"/> 5	\$500 per day; 3 day max/\$3,750*	\$30	\$45	\$150	\$200

\*Per admission/maximum per calendar year

**Prescription Drug** (includes contraceptives\*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$50	\$10	\$35	35% Coinsurance
<input type="checkbox"/>	\$100	\$10	35% Coinsurance	50% Coinsurance
		Generic	Mandated Brand†	
<input type="checkbox"/>	\$0	\$10	50% Coinsurance	
<input type="checkbox"/> No prescription drug coverage				

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to Retail Tier 1 generics or mail-order program.

†Mandated brand-name drugs without a generic equivalent.

**Rating Structure** (select one)  Tier 2 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 3 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 4 (all rating regions)

**Miscellaneous Options** (select all of the following options you wish to purchase)

- Dependent children age increases through 29 (for eligible dependents)
- Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
- Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- No additional options

**EMPIRE EPO STEPPED**

**Cost-Sharing and Benefit Maximum Calculation Period** (select one)  Calendar Year  Plan Year

Select the following new Copay Options and prescription drug card choice if applicable.

Copay Options (select one) Option	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	Deductible*	Coinsurance	Total Out-of-Pocket Max*
<input type="checkbox"/> 1	\$30	\$50	\$500	90%/10%	\$3,000
<input type="checkbox"/> 2	\$30	\$50	\$1,000	80%/20%	\$4,000

\*Family coverage is 2.5 times the individual coverage amount shown.

Note: ER Copay: Options 1 - 2 \$150 Ambulatory/Facility OP Surgery Copay: Options 1 \$200 Options 2 \$300 Office Surgery PCP /Specialist Copay Applies

**Prescription Drug** (includes contraceptives\*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$50	\$10	\$35	35% Coinsurance
<input type="checkbox"/>	\$100	\$10	35% Coinsurance	50% Coinsurance
<input type="checkbox"/>	\$0	Generic	Mandated Brand†	50% Coinsurance

No prescription drug coverage

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to Retail Tier 1 generics or mail-order program.

†Mandated brand-name drugs without a generic equivalent.

**Rating Structure** (select one)

- Tier 2 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  
 Tier 3 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 4 (all rating regions)

**Miscellaneous Options** (select all of the following options you wish to purchase)

- Dependent children age increases through 29 (for eligible dependents)  
 Inpatient rehabilitation for alcohol/substance abuse 30 days in-network  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

**EMPIRE EPO ESSENTIAL**

**Cost-Sharing and Benefit Maximum Calculation Period** (select one)  Calendar Year  Plan Year

Select the following new Copay Options and prescription drug card choice if applicable.

In-network Option	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	Deductible*	Coinsurance	Total Out-of-Pocket Max*
<input type="checkbox"/> 1	\$30	\$50	\$1,000	80%/20%	\$4,000
<input type="checkbox"/> 2	\$30	\$50	\$1,000	80%/20%	\$6,000
<input type="checkbox"/> 3	\$30	\$50	\$1,500	80%/20%	\$4,500
<input type="checkbox"/> 4	\$30	\$50	\$2,000	80%/20%	\$4,000
<input type="checkbox"/> 5	\$30	\$50	\$2,000	80%/20%	\$6,000
<input type="checkbox"/> 6	\$30	\$50	\$2,000	80%/20%	\$8,000
<input type="checkbox"/> 7	\$30	\$50	\$3,000	80%/20%	\$6,000
<input type="checkbox"/> 8	\$30	\$50	\$3,000	80%/20%	\$8,000
<input type="checkbox"/> 9	\$30	\$50	\$3,000	80%/20%	\$10,000
<input type="checkbox"/> 10	\$30	\$50	\$4,000	80%/20%	\$10,000

\*Family coverage is 3 times the individual coverage amount shown.

**Prescription Drug** (includes contraceptives\*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$50	\$10	\$35	35% Coinsurance
<input type="checkbox"/>	\$100	\$10	35% Coinsurance	50% Coinsurance
<input type="checkbox"/>	\$0	Generic	Mandated Brand†	50% Coinsurance

No prescription drug coverage

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to Retail Tier 1 generics or mail-order program.

†Mandated brand-name drugs without a generic equivalent.

**Rating Structure** (select one)

- Tier 2 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  
 Tier 3 (Capital, Mid-Hudson, excluding Westchester county, Upstate I, Upstate II)  Tier 4 (all rating regions)

**Miscellaneous Options** (select all of the following options you wish to purchase)

- Dependent children age increases through 29 (for eligible dependents)  
 Inpatient rehabilitation for alcohol/substance abuse 30 days in-network  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

**7. DENTAL BENEFITS SECTION (PLEASE SELECT THE DENTAL PRODUCT AND COVERAGE YOU WISH TO PURCHASE)**

**No Coverage**

**Managed Dental Programs\*** (select one)

Preventive Care – \$10 Copay on diagnostic and preventive procedures only

Preventive Care Plus – Adds Basic Restorative coverage

Comprehensive Care

Comprehensive Care Plan       Plan 1       Plan 2       Plan 3

Office visit Copays       \$0       \$5       \$10

Orthodontics\*\*       Child only       Child and adult

Ortho Copay max per member       \$2,000       \$2,500       \$3,000

\*Existing groups can attach member listing with PCD selection. \*\*Contact your Sales Representative for availability of this option.

**Progressive Dental**

**Open Access – Voluntary** (select one)

Coinsurance

Deductible

Orthodontics\*

100%/50%/50%

\$25

Child only

100%/50%/30%

\$50

N/A

100%/50%/0%

\$50

N/A

\*Contact your Sales Representative for availability of this option.

**Rating Structure** (for standalone dental; if sold with medical, dental tier will match medical):     Tier 2     Tier 3     Tier 4

**Miscellaneous Options** (for stand alone dental only; if sold with medical, options will match medical)

Dependent children age increases through 29 (for eligible dependents)

**Employer contribution to Dental Premium, if any**

% Employee only

% 2-Party

% Employee & spouse

% Parent & child(ren)

% Family

**Other Coverage**

Does your group currently have dental coverage from any carrier, including Empire?       Yes     No

If yes, Insurance Carrier

Coverage type (ex: DHMO, PPO, Indemnity)

Coverage start date (MMDDYY)

Coverage end date (MMDDYY)

**8. VISION BENEFITS SECTION (PLEASE SELECT THE VISION PRODUCT AND COVERAGE OPTIONS YOU WISH TO PURCHASE)**

**No Coverage**

**Blue View Vision<sup>SM</sup> – Exam Only Benefits**

Exam Frequency

Exam Copay

Every 12 months

\$0

Every 24 months

\$5

\$10

\$15

**Blue View Vision<sup>SM</sup> – Exam and Material Benefits**

Frequency – Exam/Lenses/Frames

Copay – Exam/Lenses

Frame/Contact Lens Allowance

12/12/12 months

\$5/\$0

\$130/\$130

24/24/24 months

\$5/\$5

\$100/\$100

\$5/\$5

\$80/\$80

\$10/\$0

\$130/\$130

\$10/\$10

\$130/\$130

\$10/\$20

\$130/\$130

\$10/\$10

\$100/\$100

\$10/\$10

\$80/\$80

\$20/\$20

\$130/\$130

12/12/24 months

\$5/\$0

\$130/\$130

12/24/24 months

\$10/\$0

\$130/\$130

\$10/\$10

\$130/\$130

\$10/\$20

\$130/\$130

\$20/\$20

\$130/\$130

**Employer contribution to Vision Premium:**     50% or more     Less than 50% (eligible for Exam only Benefit options)

**Rating Structure** (for standalone vision; if sold with medical, vision tier will match medical):     2 Tier     3 Tier     4 Tier

## 9. GROUP 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, 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:

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, 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/domestic partner 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 30 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.

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](http://www.empireblue.com).

**10. 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.

<b>1<sup>ST</sup> BROKER</b>		<b>COMMISSION % OF SPLIT</b>	
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
<b>X</b>			
<b>2<sup>ND</sup> BROKER</b>		<b>COMMISSION % OF SPLIT</b>	
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
<b>X</b>			

**11. EMPLOYER FUNDING LIMITATIONS**

**NOTE:** In order for this application to be accepted by Empire, your group (i) may NOT subsidize any portion of your covered members' cost-sharing responsibilities, such as copayments and/or member coinsurance (sometimes referred to as a "Gap Plan") and (ii) may NOT fund more than 50% toward the member deductible amount. The offer of either a Gap Plan or funding of more than 50% toward member deductible disqualifies a group from eligibility for Empire small group coverage. By signing below, you are certifying that you do not offer a "Gap Plan" or fund more than 50% of the member deductible amount.

**12. 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.

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

Authorized group signature		Date
<b>X</b>		
Printed name	Title	