

# 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 11.

## 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 	



**REGIONS OF RESIDENCE (SELECT ALL THAT APPLY)**

If you are choosing Empire Total Blue<sup>SM</sup> with HSA, Direct POS or DirectShare<sup>SM</sup> 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 Prism EPO, Value EPO, 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

**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\*       Direct POS\*       DirectShare<sup>SM</sup> POS       PPO       Value EPO
- 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)

Option	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)	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$10	\$35	\$70
<input type="checkbox"/>	Generic \$15 <sup>†</sup>	Brand N/A	

Deductible\*\* (select one)

- \$0       \$50       \$100       \$250       No prescription drug coverage

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to mail-order program. † Mandatory \$0 deductible

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

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

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- 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
- Waive waiting period for pre-existing conditions
- No additional options

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

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

Calendar Year     Plan Year

Option	In-network			Out-of-network		
	Deductible*	Coinsurance	Coinsurance Out-of-Pocket Max*	Deductible*	Coinsurance	Coinsurance Out-of-Pocket Max*
<input type="checkbox"/> 1	\$1,250	80%/20%	\$2,000	\$5,000	60%/40%	\$10,000
<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"/> 4	\$2,000	80%/20%	\$3,000	\$10,000	50%/50%	\$20,000
<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
<input type="checkbox"/> 7	\$5,000	100%	N/A	\$10,000	70%/30%	\$20,000
<input type="checkbox"/> 8	\$3,000	100%	N/A	\$6,000	60%/40%	\$12,000

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

**Prescription Drug**

- Drug coverage (Tier 1-\$10, Tier 2-\$30, Tier 3-\$50 Copayments, after deductible\*, also includes contraceptives\*\*)
- No prescription drug coverage

\*If you select Options 7 and 8 with prescription drug benefits, there are no prescription drug copayments after the deductible is met.

\*\*Groups exempt from contraceptive coverage must submit a signed affidavit.

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

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- 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
- Waive waiting period for pre-existing conditions
- No additional options

**DIRECT POS COVERAGE OPTIONS**

Option	In-network			Out-of-network		
	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	Inpatient Copay	Deductible**	Coinsurance	Coinsurance Out-of-Pocket Max**
<input type="checkbox"/> 1	\$15	\$15	\$0	\$500	70%/30%	\$3,000
<input type="checkbox"/> 2	\$15	\$15	\$250/\$625*	\$500	70%/30%	\$3,000
<input type="checkbox"/> 3	\$20	\$20	\$0	\$1,000	70%/30%	\$3,000
<input type="checkbox"/> 4	\$20	\$20	\$250/\$625*	\$1,000	70%/30%	\$3,000
<input type="checkbox"/> 5	\$20	\$20	\$500/\$1,250*	\$1,000	70%/30%	\$3,000
<input type="checkbox"/> 6	\$20	\$20	\$0	\$1,500	70%/30%	\$4,500
<input type="checkbox"/> 7	\$20	\$20	\$250/\$625*	\$1,500	70%/30%	\$4,500
<input type="checkbox"/> 8	\$20	\$20	\$500/\$1,250*	\$1,500	70%/30%	\$4,500
<input type="checkbox"/> 9	\$15	\$15	\$0	\$2,000	60%/40%	\$6,000
<input type="checkbox"/> 10	\$15	\$15	\$500/\$1,250*	\$2,000	60%/40%	\$6,000
<input type="checkbox"/> 11	\$20	\$20	\$0	\$2,000	60%/40%	\$8,000
<input type="checkbox"/> 12	\$20	\$20	\$500/\$1,250*	\$2,000	60%/40%	\$8,000
<input type="checkbox"/> 13	\$25	\$40	\$0	\$1,000	70%/30%	\$3,000
<input type="checkbox"/> 14	\$25	\$40	\$0	\$1,500	70%/30%	\$4,500
<input type="checkbox"/> 15	\$25	\$40	\$0	\$2,000	60%/40%	\$8,000
<input type="checkbox"/> 16	\$25	\$40	\$500/\$1,250*	\$2,000	60%/40%	\$6,000
<input type="checkbox"/> 17	\$30	\$50	\$1,000/\$2,500*	\$2,000	70%/30%	\$4,500

Note: ER Copay: Options 1-12-\$50 Options 13-16-\$75 Ambulatory/OP Surgery Copay: Option 16 - \$75

\*per admission/maximum per calendar year

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

**Out-of-network UCR Option** (Usual, Customary and Reasonable Fee Reimbursement)

70%     80%

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

Copay Options (select one)	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$5	\$20	\$40
<input type="checkbox"/>	\$10	\$20	\$40
<input type="checkbox"/>	\$10	\$25	\$50
<input type="checkbox"/>	\$10	\$35	\$70
	<b>Generic</b>	<b>Brand</b>	
<input type="checkbox"/>	\$10 <sup>†</sup>	50%	
<input type="checkbox"/>	\$15 <sup>†</sup>	N/A	

**Deductible\*\*** (select one)

- \$0       \$50       \$100       \$150       \$250       \$500  
 No prescription drug coverage

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to mail-order program. † Mandatory \$0 deductible

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

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 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  
 Waive waiting period for pre-existing conditions  
 No additional options

**DIRECTSHARE<sup>SM</sup> POS OPTIONS**

Option	In-network		Out-of-network		
	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	Deductible*	Coinsurance	Coinsurance Out-of-Pocket Max*
<input type="checkbox"/> 1	\$25	\$40	\$250	90%/10%	\$1,000
<input type="checkbox"/> 2	\$30	\$50	\$500	90%/10%	\$1,000
<input type="checkbox"/> 3	\$30	\$50	\$500	80%/20%	\$2,000
<input type="checkbox"/> 4	\$30	\$50	\$750	80%/20%	\$2,500
<input type="checkbox"/> 5	\$30	\$50	\$1,000	80%/20%	\$3,000

Note: ER Copay \$75 \*Family coverage is 2.5 times the individual coverage amount.

**Out-of-network UCR Option** (Usual, Customary and Reasonable Fee Reimbursement)  70%  80%**Prescription Drug** (includes contraceptives\*)

Copay Options (select one)	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$10	\$20	\$40
<input type="checkbox"/>	\$10	\$30	\$50
<input type="checkbox"/>	\$10	\$35	\$70
	<b>Generic</b>	<b>Brand</b>	
<input type="checkbox"/>	\$10 <sup>†</sup>	50%	
<input type="checkbox"/>	\$15 <sup>†</sup>	N/A	

**Deductible\*\*** (select one)

- \$0       \$50       \$100       \$150       \$250       \$500  
 No prescription drug coverage

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to mail-order program. † Mandatory \$0 deductible

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

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 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  
 Waive waiting period for pre-existing conditions  
 No additional options

**VALUE EPO OPTIONS**

In-network	PCP/Primary Home/Office	Specialist Home/Office			Coinsurance Out-of-Pocket
Option	Copay	Copay	Deductible*	Coinsurance	Max*
<input type="checkbox"/> 1	\$30	\$30	\$1,000	90%/10%	\$1,000
<input type="checkbox"/> 2	\$30	\$30	\$1,500	90%/10%	\$1,000
<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%	\$1,000
<input type="checkbox"/> 10	\$30	\$50	\$1,500	90%/10%	\$1,000
<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 co-pay \$100 \*Family coverage is 2.5 times the individual coverage amount shown.

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

Copay Options (select one)	Tier 1	Tier 2	Tier 3
<input type="checkbox"/>	\$10	\$25	\$50
<input type="checkbox"/>	\$10	\$35	\$70
<input type="checkbox"/>	Generic \$15 <sup>†</sup>	Brand N/A	

Deductible\*\* (fill in one only)

- \$0     \$50     \$100\*\*\*     No prescription drug coverage

Note: \*\*\*Available with \$10/35/70 Prescription Drug Copay option only.

\*Groups exempt from contraceptive coverage must attach a signed affidavit. \*\*Not applicable to mail-order program. † Mandatory \$0 deductible

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

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

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- 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
- Waive waiting period for pre-existing conditions
- No additional options

**PPO COVERAGE OPTIONS**

**In-network Options** (select one)

Office Visit Copay     \$12     \$20     \$30

**Out-of-network Options** (select one)

Options	Deductible*	Coinsurance	Coinsurance Out-of-Pocket Max*
<input type="checkbox"/> 1	\$500	70%/30%	\$1,500
<input type="checkbox"/> 2	\$500	70%/30%	\$3,000
<input type="checkbox"/> 3	\$750	70%/30%	\$4,500
<input type="checkbox"/> 4	\$1,000	70%/30%	\$7,500

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

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

<b>Copay Options</b> (select one)	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>		
<input type="checkbox"/>	\$10	\$20	\$40		
<input type="checkbox"/>	\$10	\$25	\$50		
<b>Deductible**</b> (select one)	<input type="checkbox"/> \$0	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150	<input type="checkbox"/> No prescription drug coverage

\*Groups exempt from contraceptive coverage must attach a signed affidavit.

\*\*Not applicable to mail-order program.

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

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- 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
- Waive waiting period for pre-existing conditions
- No additional options

**EMPIRE PRISM EPO OPTIONS**Is Empire the sole carrier offered by the group?  Yes  No

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

<b>Copay Options</b> (select one)	<b>PCP/Primary</b>	<b>Specialist</b>	<b>ER Copay</b>	<b>Ambulatory/OP Surgery Copay</b>	
Option	Inpatient Copay	Home/Office Copay	Home/Office Copay		
<input type="checkbox"/> 1	\$500/\$1,250*	\$25	\$40	\$100	\$150
<input type="checkbox"/> 2	\$750/\$1,875*	\$35	\$50	\$100	\$300
<input type="checkbox"/> 3	\$500 per day; 3 day max/\$3,750*	\$45	\$45	\$100	\$300
<input type="checkbox"/> 4	\$500 per day; 3 day max/\$3,750*	\$45	\$60	\$100	\$300

\*per admission/maximum per calendar year

**Prescription Drug** (includes contraceptives)

<b>Copay Options</b> (select one)	<b>Tier 1</b>	<b>Tier 2</b>	<b>Tier 3</b>	
<input type="checkbox"/>	\$10	\$35	\$70*	
<input type="checkbox"/>	\$10	\$35	\$70 (\$2,000 max)	
<input type="checkbox"/>	<b>Generic</b>	<b>Brand</b>		
	\$15 <sup>†</sup>	N/A		
<b>Deductible**</b> (select one)	<input type="checkbox"/> \$0	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100	<input type="checkbox"/> No prescription drug coverage

\*\$0 Deductible not allowed †Mandatory \$0 deductible

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

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- 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
- Waive waiting period for pre-existing conditions
- No additional options

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



**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
- 12/12/24 months
- 12/24/24 months
- 24/24/24 months

- \$5/\$0
- \$10/\$0
- \$10/\$10
- \$10/\$20
- \$20/\$20

- \$130
- \$100
- \$80

**Employer contribution to Vision Premium:**

50% or more

Less than 50%

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

2 Tier

3 Tier

4 Tier

**9. 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.

**1<sup>ST</sup> 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

1<sup>st</sup> Broker Signature

Date (MMDDYY)

**2<sup>ND</sup> 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

2<sup>nd</sup> Broker Signature

Date (MMDDYY)

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:

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.

#### **9. AGENT/BROKER DECLARATION AND INFORMATION CONTINUED**

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

Group hereby designates the broker(s) listed on this application as the broker(s) of record for the Group (the "BOR"), and agrees that notice to the BOR constitutes notice to the Group. Further, the Group has agreed that the BOR will be paid the commission specified in #9 above in compliance with Empire's applicable commission schedule. Further the Group agrees that the BOR designation and the commission rate will continue until expressly terminated in writing by the Group.

The commission rate or other compensation that may be received by your broker does not change your premium rate. Small group brokers who provide specific additional administrative services may also receive an additional payment from Empire. You can obtain additional information regarding Empire's standard commission scale applicable to your product and any applicable broker compensation programs by visiting [www.empireblue.com](http://www.empireblue.com) or by contacting your Empire representative.

\_\_\_\_\_  
Authorized Group Signature

\_\_\_\_\_  
Date (MMDDYY)

\_\_\_\_\_  
Print name

\_\_\_\_\_  
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.

**11. OPTIONAL EMPLOYER ONLINE SERVICES DELEGATION FORM**

Empire BlueCross BlueShield is offering Group Benefit Administrators an opportunity to delegate the administration of their accounts to their Broker of Record. The Broker of Record will perform the administrative duties assigned to him or her by the Group Benefits Administrator via Empire's secure Broker Online Services website at [www.empireblue.com](http://www.empireblue.com).

Please complete this form and the Terms and Conditions Letter Agreement (the "Agreement") if you would like to permit your Broker of Record to administer your account for you. Please be sure to discuss this delegation with your broker prior to submission.

**Please mail or fax this form to:** Broker Relations  
 15 MetroTech Center, 4th Fl.  
 Brooklyn, NY 11201  
**Fax:** 718-312- 6006

Please note: By filling out this form and the Agreement and giving your Broker of Record access to manage your account, you are not giving up your right to access your account through Employer Online Services or to administer your account.

**PLEASE CHECK IF YOU WOULD LIKE TO:**

- Delegate administration of your account to your Broker of Record to
  - Manage only existing sub-groups
  - Manage all existing and future sub-groups
- Delegate to your Broker of Record the ability to add/cancel users
- Change your Broker of Record's access level
- Terminate a Broker of Record's administrative rights to manage your account\*

**PLEASE CHECK ALL ACTIVITIES THAT YOU WOULD LIKE TO DELEGATE TO YOUR BROKER OF RECORD:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Basic Employee Admin                            | <input type="checkbox"/> Basic Group Admin   | <input type="checkbox"/> Perform Demographic/Dependent Changes |
| <input type="checkbox"/> Enroll Employees and Perform Enrollment Changes | <input type="checkbox"/> Request ID Cards    | <input type="checkbox"/> View Billing                          |
| <input type="checkbox"/> View Claims                                     | <input type="checkbox"/> View Employee Forms | <input type="checkbox"/> View Roster (2-500)                   |
| <input type="checkbox"/> View Group Forms                                |  |  |

**PLEASE COMPLETE YOUR CONTACT INFORMATION:**

Last name	First name		
Company name			
E-mail address (optional)			
Renewal date (MMDDYY)	Base group no.	Phone	

**PLEASE PROVIDE YOUR BROKER OF RECORD'S CONTACT INFORMATION:**

Last name	First name	License no.
E-mail address (optional)		Date of birth (MMDDYY)

\* You will not be able to assign a new Broker of Record using this form. Please check the box only if you would like to terminate your current Broker of Record's administrative rights.

This Terms and Conditions Letter Agreement (the "Agreement") sets forth the understandings and agreement between \_\_\_\_\_ ("the Group") and Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross BlueShield and Empire HealthChoice HMO, Inc., d/b/a Empire BlueCross BlueShield HMO (together referred to as "Empire"), to permit access to Empire's interactive Employer Online Services website ("website") for use by the Broker of Record, or an authorized designee of the Broker of Record (together referred to as "brokers"), designated by the Group, to facilitate the administration of the health benefit plan(s) (the "plan(s)") purchased by the Group from Empire pursuant to a separate Contract (the "Contract"). The Group understands and agrees that access to the website granted by Group to its designated brokers is subject to the following terms and conditions:

1. Empire shall provide those brokers designated by the Group access to the Employer Online Services website in accordance with Empire's registration procedures. The Group understands that all designated brokers must agree to the website Terms and Conditions.
2. The Group understands that the purpose of this website is to provide an additional medium for the Group, through its designated brokers, to carry out the certain plan administration functions as delegated by the Group, including the ability to: maintain eligibility files, process enrollment and enrollment changes for members and dependents, select and change PCPs on behalf of and at the request of a member, search for participating providers, view certain claims information on behalf of and at the request of a member, request ID cards and print temporary cards, maintain and update COB information, and view statements of account(s), access billing reports, pay and/or adjust bills, and other functions as may be added from time to time by Empire and delegated by the Group.
3. The Group is solely responsible for the accuracy and authenticity of the information submitted on the website.
4. This agreement relates solely to access by the brokers designated by the Group to the website and does not add, diminish or otherwise change the obligations of the parties, which remain subject to the Contract, any other agreements executed by the parties, the contracts of health insurance coverage issued by Empire, and Empire policies and procedures. In the event of a conflict between this agreement and any of the aforementioned, the aforementioned shall control.
5. The Group shall advise Empire, in writing, of the names and other information as requested by Empire, of its brokers who shall have website access, and shall timely notify Empire of brokers who no longer are authorized to access the website. Notice shall be sent by fax to 718-312-6006.
6. Any data accessed and/or provided to the Group or to its brokers on the website shall remain the property of Empire.
7. Empire is not responsible for the accuracy and completeness of records supplied to Empire by the Group, the brokers or by health care providers.
8. The Group and its representatives shall maintain and preserve the confidential and proprietary nature of all Empire's data to which the Group and its representatives have access. The Group shall not provide either website access, or other access to Empire's proprietary and confidential information available to the Group on the website, to any unauthorized party, or in a manner in conflict with this Agreement.
9. The Group will hold Empire, its officers, directors and agents, harmless from any loss, expense, liability, claim, lawsuit or judgement (including reasonable attorneys' fees) arising directly or indirectly out of Empire's disclosure of the Group's enrollment and/or claims information or from the Group's provision to Empire of enrollment information, or resulting from the Group's failure to abide by the terms of this Agreement.
10. The obligations undertaken herein in Paragraphs 8 and 9 above shall survive the expiration or termination of this Agreement.
11. Nothing contained in this Agreement shall be construed as granting or conferring any rights by license, patent, copyright or any other intellectual property right of one party to the other.
12. This Agreement shall terminate:
  - a. by Empire or the Group upon five (5) business days written notice by facsimile transmission, or as otherwise agreed to by the parties hereto in writing;
  - b. if prohibited by any law or regulation;
  - c. six (6) months after the termination of the Contract.
13. If the Group has more than one health benefits plan under the terms of its Contract, the Group's designated brokers shall have access, if such access is delegated to the brokers, to any of its health benefits plans that may terminate during the term of the Contract, for the earlier of twenty-four (24) months after termination of the specific health benefits plan or six (6) months after the termination of the Contract.

Please sign and date this Agreement in the space provided below to confirm your agreement to these terms and conditions, and return the fully executed original at your earliest convenience.

Acknowledged and Agreed to this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print name

Title: Group Benefits Administrator

Sincerely,



Mark Wagar  
President