

SMALL GROUP APPLICATION/CHANGE FORM (2-50 eligible employees)



www.empireblue.com

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 11**.

1. REASON FOR APPLICATION/CHANGE - choose one only

New Requested Effective Date

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Change Existing Benefits Revision or Renewal Date

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2. GROUP INFORMATION

Group Name (as it appears on documents attached) _____

Doing Business As _____

Group Mailing Address _____

City _____ State _____ Zip _____ County _____

Group Contact Last Name _____ Group Contact First Name _____ Phone _____

Title _____ Fax _____

E-mail Address (Benefit Administrator) _____

Billing Contact and Telephone _____

Billing Address, if Different _____

City _____ State _____ Zip _____ County _____

Federal Employer Identification Number _____ Type of Industry _____

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

If yes,

Name	Number of Employees
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Do you currently have group coverage with Empire? Yes No If yes,

Group Number

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.

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	Coverage end date
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5. GROUP ELIGIBILITY

Note: Eligible persons are defined as employees (on the group's payroll, K1, etc.) whose regular work schedule is at least 20 hours per week under this group contract.

Number of Employees

- (a) _____ Number of employees at all locations
(include owners and partners, exclude COBRA)*
- (b) _____ Number of retirees eligible for coverage
- (c) _____ Number of ineligible employees
(check reason for ineligibility)
- Seasonal Union Part-Time
- Other _____
- (d) _____ Number of net eligible employees (a + b - c)
_____ Number of enrolling employees
(include retirees and COBRA)
- Employer contribution to retiree coverage ____%

*Empire requires proof of employment (i.e., NYS-45, payroll, etc.)

Eligibility Dates (complete both A & B)

- A. Initial Enrollment of Group**
All employees' and dependents' coverage will be in effect:
- On Group Effective Date
- After new employee eligibility is satisfied (see B)
- All enrollment forms must be received no later than thirty (30) days following the new group effective date.
- B. New Employees (after initial enrollment of group)**
New employees will be eligible for coverage:
- Date of hire
- First day following:
- _____ day(s) following date of hire
- _____ month(s) following date of hire; or
- First of the month following:
- _____ day(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.

Regions of Residence

- If you are choosing HMO, Direct HMO or POS, please check all regions your enrolling employees reside in from the list below.
- New York:** Bronx, Kings, Queens, New York, Nassau, Rockland, Westchester, Richmond and Suffolk counties.
- Mid Hudson:** Dutchess, Putnam, Orange, Sullivan and Ulster counties.
- Albany:** Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.
- For POS only:**
- New Jersey Contiguous Counties:** Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex and Union counties.
- Connecticut:** Fairfield and Litchfield counties.

For Empire Office Use Only

Group #	Sub-Group #	Sub-Group #	Sub-Group #	Sales Representative Last Name	Sales Representative First Name	Rep. Code
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6. 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 (check one) Separate invoices for each location A summary invoice combining all locations

If you are requesting quarterly billing, please check here. otherwise, group will be billed monthly.

7. 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* POS* PPO EPO Comprehensive Hospital/Medical Other _____

*HMO benefits provided by Empire HealthChoice HMO, Inc.

HMO OPTIONS

Co-payment Options (check one only)

Co-payment Options	Inpatient Co-pay	Home/Office/Outpatient Co-payment
<input type="checkbox"/> Option 1	\$0 Co-pay	\$5 Co-pay
<input type="checkbox"/> Option 2	\$0 Co-pay	\$10 Co-pay
<input type="checkbox"/> Option 3	\$250/\$625 Co-pay*	\$10 Co-pay
<input type="checkbox"/> Option 4	\$500/\$1,250 Co-pay*	\$15 Co-pay
<input type="checkbox"/> Option 5	\$0 Co-pay	\$20 Co-pay
<input type="checkbox"/> Option 6	\$500/\$1,250 Co-pay*	\$20 Co-pay

*per admission/family maximum per calendar year

Rating Structure (check one only)

2-Tier 3-Tier 4-Tier

Vision Co-pay (check one only)

- \$5 Co-payment (1 exam every 24 months)
 \$5 Co-payment (1 exam every 24 months)
\$10 Co-payment for frames
\$25 Co-payment for contact lenses
\$35 Allowance for non-plan frames
- No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (check one only)

	Generic	Brand	Non-Formulary
1 <input type="checkbox"/>	\$5	\$15	\$25
2 <input type="checkbox"/>	\$5	\$20	\$40
3 <input type="checkbox"/>	\$10	\$20	\$30
4 <input type="checkbox"/>	\$10	\$20	\$40
5 <input type="checkbox"/>	\$10	\$25	\$50

Deductible (check one only)

\$0 \$100 \$150

6 No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

Miscellaneous Options

(check all of the following options you wish to purchase)

- Inpatient mental and behavioral healthcare increases from 30 to 45 days
- Outpatient mental and behavioral healthcare increases from 20 to 40 visits
- Skilled nursing facility increases from 60 to 120 days
- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
- Remove waiting period for pre-existing conditions
- No additional options

DIRECT HMO OPTIONS

Co-payment Options (check one only)

Co-payment Options	Inpatient Co-pay	Home/Office/Outpatient Co-payment
<input type="checkbox"/> Option 1	\$0 Co-pay	\$5 Co-pay
<input type="checkbox"/> Option 2	\$0 Co-pay	\$10 Co-pay
<input type="checkbox"/> Option 3	\$250/\$625 Co-pay*	\$10 Co-pay
<input type="checkbox"/> Option 4	\$500/\$1,250 Co-pay*	\$15 Co-pay
<input type="checkbox"/> Option 5	\$0 Co-pay	\$20 Co-pay
<input type="checkbox"/> Option 6	\$500/\$1,250 Co-pay*	\$20 Co-pay

*per admission/family maximum per calendar year

Rating Structure (check one only)

2-Tier 3-Tier 4-Tier

Vision Co-pay (check one only)

- \$5 Co-payment (1 exam every 24 months)
 \$5 Co-payment (1 exam every 24 months)
\$10 Co-payment for frames
\$25 Co-payment for contact lenses
\$35 Allowance for non-plan frames
- No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (check one only)

	Generic	Brand	Non-Formulary
1 <input type="checkbox"/>	\$5	\$15	\$25
2 <input type="checkbox"/>	\$5	\$20	\$40
3 <input type="checkbox"/>	\$10	\$20	\$30
4 <input type="checkbox"/>	\$10	\$20	\$40
5 <input type="checkbox"/>	\$10	\$25	\$50

Deductible (check one only)

\$0 \$100 \$150

6 No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

Miscellaneous Options

(check all of the following options you wish to purchase)

- Inpatient mental and behavioral healthcare increases from 30 to 45 days
- Outpatient mental and behavioral healthcare increases from 20 to 40 visits
- Skilled nursing facility increases from 60 to 120 days
- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
- Remove waiting period for pre-existing conditions
- No additional options

POS COVERAGE OPTIONS

In-Network

Out-of-Network

	Home/Office Co-payment	Inpatient Co-payment	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
<input type="checkbox"/> Option 1	\$15	\$0	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="checkbox"/> Option 2	\$15	\$250/\$625*	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="checkbox"/> Option 3	\$20	\$0	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="checkbox"/> Option 4	\$20	\$250/\$625*	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="checkbox"/> Option 5	\$20	\$500/\$1,250*	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="checkbox"/> Option 6	\$20	\$0	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="checkbox"/> Option 7	\$20	\$250/\$625*	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="checkbox"/> Option 8	\$20	\$500/\$1,250*	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="checkbox"/> Option 9	\$15	\$0	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
<input type="checkbox"/> Option 10	\$15	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
<input type="checkbox"/> Option 11	\$20	\$0	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
<input type="checkbox"/> Option 12	\$20	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000

*per admission/family maximum per calendar year

Vision Co-payment (check one only)

- \$5 Co-payment (1 exam every 24 months)
- \$5 Co-payment (1 exam every 24 months)
- \$10 Co-payment for frames
- \$25 Co-payment for contact lenses
- \$35 Allowance for non-plan frames
- No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (check one only)

	Generic	Brand	Non-Formulary
<input type="checkbox"/>	\$5	\$20	\$40
<input type="checkbox"/>	\$10	\$20	\$40
<input type="checkbox"/>	\$10	\$25	\$50

Deductible (check one only)

- \$0 \$100 \$150
- \$250 \$500

No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network
- Waiver for pre-existing conditions
- No additional options

EPO COVERAGE OPTIONS

In-Network Options (check one only)

Vision Co-payment (check one only)

- \$5 Co-payment (1 exam every 24 months)
- \$5 Co-payment (1 exam every 24 months)
- \$10 Co-payment for frames
- \$25 Co-payment for contact lenses
- \$35 Allowance for non-plan frames
- No vision coverage

Office Visit Co-payment \$12 \$20 \$30

Prescription Drug (includes contraceptives*)

Co-pay Options (check one only)

	Generic	Brand	Non-Formulary
<input type="checkbox"/>	\$10	\$20	\$40
<input type="checkbox"/>	\$10	\$25	\$50

Deductible (check one only)

- \$0 \$100 \$150

No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse—30 days in-network
- No additional options

PPO COVERAGE OPTIONS

In-Network Options (check one only)

Office Visit Co-payment \$12 \$20 \$30

Out-of-Network Options (check one only)

	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
<input type="checkbox"/> 1	\$500/\$1,250	70%/30%	\$5,000/\$12,500	\$1,500/\$3,750
<input type="checkbox"/> 2	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="checkbox"/> 3	\$750/\$1,875	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="checkbox"/> 4	\$1,000/\$2,500	70%/30%	\$25,000/\$62,500	\$7,500/\$18,750

Vision Co-payment (check one only)

- \$5 Co-payment (1 exam every 24 months)
- \$5 Co-payment (1 exam every 24 months)
- \$10 Co-payment for frames
- \$25 Co-payment for contact lenses
- \$35 Allowance for non-plan frames
- No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (check one only)

	Generic	Brand	Non-Formulary
<input type="checkbox"/>	\$10	\$20	\$40
<input type="checkbox"/>	\$10	\$25	\$50

Deductible (check one only)

- \$0 \$100 \$150

No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- Inpatient rehabilitation for alcohol/substance abuse 30 days in-network
- No additional options

COMPREHENSIVE HOSPITAL AND EXTENDED MEDICAL OPTIONS

Deductible and Coinsurance Applies to Hospital and Extended Medical

Deductible, Coinsurance and Stop Loss Options

Check the deductible you desire in the "Deductible" column below. Then move to the right of your selection and choose one of the coinsurance and stop loss level you wish. (check one only)

Annual Deductible (Individual/Family)	Options: Coinsurance and Stop Loss (Individual/Family)			
<input type="checkbox"/> \$200/\$500	<input type="checkbox"/> 80% Coinsurance to \$2,000/\$5,000 Stop Loss	<input type="checkbox"/> 80% Coinsurance to \$4,000/\$10,000 Stop Loss	<input type="checkbox"/> 80% Coinsurance to \$10,000/\$25,000 Stop Loss	<input type="checkbox"/> 80% Coinsurance with No Stop Loss
<input type="checkbox"/> \$500/\$1,000	<input type="checkbox"/> 80% Coinsurance to \$2,000/\$5,000 Stop Loss	<input type="checkbox"/> 80% Coinsurance to \$4,000/\$10,000 Stop Loss	<input type="checkbox"/> 80% Coinsurance to \$10,000/\$25,000 Stop Loss	
<input type="checkbox"/> \$1,000/\$2,000	<input type="checkbox"/> 80% Coinsurance to \$4,000/\$10,000 Stop Loss	<input type="checkbox"/> 80% Coinsurance to \$10,000/\$25,000 Stop Loss	<input type="checkbox"/> 100% Coinsurance	
<input type="checkbox"/> \$2,000/\$5,000	<input type="checkbox"/> 80% Coinsurance to \$10,000/\$25,000 Stop Loss	<input type="checkbox"/> 100% Coinsurance		

Rating Structure (check one only) 2-Tier 4-Tier

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

- Alcohol and substance abuse—7 days detox and 30 days inpatient rehab per calendar year
- Private duty nursing (\$10,000 per year maximum; \$50,000 per lifetime maximum)
- Dependent college student age increases to 25 end of calendar year
- Nonpar hospital paid as par
- Speech and occupational therapy—unlimited visits
- Additional outpatient services (7 outpatient visits per person per calendar year for mental and nervous care; 60 additional outpatient visits per person per calendar year for alcohol and substance abuse)

8. DENTAL BENEFITS SECTION

No Coverage

Please select the dental product and coverage options you wish to purchase.

PREMIUM CARE PPO (check one only)

Coinsurance In-Network	Coinsurance Out-of-Network
<input type="checkbox"/> 100%/80%/50%	<input type="checkbox"/> 100%/80%/50%
<input type="checkbox"/> 100%/80%/50%	<input type="checkbox"/> 80%/60%/50%

PREVENTIVE CARE/PREVENTIVE CARE PLUS* (check one only)

- Preventive Care—\$10 co-payment on diagnostic and preventive procedures only
- Preventive Care Plus—Adds Basic Restorative coverage

PROGRESSIVE DENTAL

- Age 23/25 Rider

* If adding these products to an existing group, attach a member listing with PCD selection.

Deductible (check one only)
 \$25/\$75 \$50/\$150

Orthodontics**

OPEN ACCESS—VOLUNTARY (check one only)

Coinsurance	Deductible	Orthodontics**
<input type="checkbox"/> 100%/50%/50%	\$25	<input type="checkbox"/> Child only
<input type="checkbox"/> 100%/50%/30%	\$50	Not Available
<input type="checkbox"/> 100%/50%/0%	\$50	Not Available

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

Group's Contribution, 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	Coverage end date

9. PLEASE ATTACH COPY OF RATE PROPOSALS

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.

1st BROKER

Commissions: % of split _____

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

2nd BROKER

Commissions: % of split _____

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.

11. 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.