



Employer Notice of Election

HealthPass

4409 Parkbreeze Court
Orlando, FL 32808-2101
P: (888) 313-7277
F: (888) 354-7277

A Company Information

Full Name of Company _____

Federal Tax I.D. Number _____

Date Company Founded _____

/ /

Street Address (P.O. Box not acceptable) _____

Suite _____

City _____

State _____

Zip _____

County or Borough _____

Billing Street Address (if different) _____

City/State/Zip _____

Contact Person (Last, First, Middle) _____

E-Mail Address (required) _____

Business Phone _____

Ext. _____

Fax _____

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Do you currently offer group health insurance? Yes No If yes, name of current insurance company. _____

Employer Industry Health High Tech Legal Mfg. Retail Service Tourism Other _____

B Eligibility Requirements

Desired Effective Date ____ / ____ / ____ (Must be 1st or 15th of the month)

To be eligible for coverage employees must work _____ hours per week.

Must be between 20 and 40 hours and must be uniformly applied to all employees

What is your waiting period before employees become eligible for coverage? 0 days 30 days 60 days 90 days

Total Number of Employees (full and part-time) _____ Number of Eligible Employees _____

Must attach NYS-45 or applicable tax form from most recent quarter; 75% of eligible employees must participate in either HealthPass or another health plan

Number of Enrollments with HealthPass _____ Number of employees who have other health coverage _____

Number of employees covered by collective bargaining agreement _____

What dollar amount are you contributing toward employee-only medical premium? _____ dependent coverage? _____

Are any former employees covered under COBRA/State Continuation? Yes No If yes, how many? _____

C Medical Plan Options

Select a tier structure for Medical:

Mixed Tier (Two Tier rates for GHI, HIP and Horizon; Four Tier rates for Health Net and PerfectHealth) Four Tier (All carriers)

Select a pharmacy option (will be included in each employee's coverage; the exception to this rule is embedded Rx)

\$5 generic, \$15 preferred brand, \$35 brand \$10/\$20/\$40 with \$50 deductible and \$2000 calendar year cap
 \$10 generic, \$20 preferred brand, \$40 brand No pharmacy benefit

D Dental Plan Options

If you enroll on the 15th of the month, your Dental coverage will be effective the subsequent 1st of the month.

Note that if you choose not to offer Dental at this time, current and future employees will be unable to enroll until your next open enrollment.

Would you like to offer Dental coverage? Yes No If yes, have you had group dental coverage in place over the last 63 days? Yes No

Select a tier structure for Dental:

Two Tier (Employee Only, Family) Four Tier (Employee Only, Employee and Spouse, Employee and Child(ren), Family)

Select the desired dental coverage type. If selecting DentalGuard Preferred (Dual Option DMO/PPO), 75% of enrolling employees, excluding waivers, must participate and at least one of the eligible employees must enroll in the DMO option.

Managed DentalGuard Number of employees enrolling in DMO _____

DentalGuard Preferred Number of employees enrolling in DMO _____ PPO _____

E EverGuard Option

If you enroll in medical coverage on the 15th of the month, your EverGuard coverage will be effective the subsequent 1st of the month.
Would you like to offer EverGuard coverage? Yes No

F COBRA Administration

Would you like to enroll in COBRA Administration Services? Yes No

If yes, the annual fee will be determined by the number of enrolling employees: 2-10 = \$100 11-20 = \$150 21-50 = \$250 51+ = \$500
Please add your annual fee to the initial premium payment for your HealthPass coverage. You will be charged \$1 per month per enrolled employee.

G Broker Information

Broker commission splits must total 100%.

Pay Commission To: Name _____ HealthPass ID# _____ % _____

Pay Commission To: Name _____ HealthPass ID# _____ % _____

General Agency Name (if applicable) _____ GA # _____

H Employer Certification — I attest that:

- My business maintains an active, bona fide business street address in one of the following coverage areas:**
 - One of the 5 Boroughs of NYC (Bronx, Brooklyn, Manhattan, Queens, or Staten Island)
 - Westchester, Rockland, Orange, Nassau, Suffolk, Putnam or Dutchess
- Only full-time employees are eligible for coverage through HealthPass, and:**
 - My business has at least two full-time employees. Full-time is defined by the employer (my business). Full-time employees must work between 20 and 40 hours per week, and this standard must be applied uniformly among all of the employees.
 - My business will offer HealthPass coverage to every full-time employee and my business cannot use age, sex, health status or occupation to determine employee eligibility.
 - I understand that temporary or seasonal employees, consultants, independent contractors, domestic partners, household help, and retirees are not eligible for coverage through HealthPass. Other exclusions may apply.
 - I understand that **75% of eligible employees must participate in either HealthPass or another health plan** (through a spouse's plan, Medicare, Medicaid or an alternate plan offered by the employer).
 - I understand that if the business chooses to pay the full dollar amount of the premium for employee-only coverage (your employees share none of the cost of premium), then all eligible employees must participate. If the business chooses to pay the full dollar premium for employee + dependent coverage, then all dependents must be covered. Note there is no minimum employer dollar contribution requirement.
- My business cannot offer HealthPass coverage to any employee who lives outside of the HealthPass coverage area if more than 10% of eligible employees live outside of the coverage area.** The HealthPass coverage area is New York, New Jersey, Connecticut, and Bucks County, PA. If 10% or less of the eligible employees live outside of the coverage area, then all out-of-coverage area employees can be covered through HealthPass. "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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

HEALTHPASS INSURANCE TRUST

The undersigned employer, in order to establish a plan or plans of Group Health Insurance for its employees and their dependents, hereby requests participation in the New York Health Purchasing Alliance, Inc. HealthPass Insurance Trust (the "Trust") which provides health insurance benefits under Group Contracts issued by several health insurers and health maintenance organizations to the Trustee of the HealthPass Insurance Trust.

If the undersigned employer's participation is approved by the Trustee or the Administrator appointed by the Trustee (the "Administrator"), said employer shall become Participating employer (as defined in Trust Agreement) as of the effective date endorsed hereon by the Trustee or the Administrator. The undersigned employer understands and acknowledges that even if it is approved as Participating Employer in the HealthPass Insurance Trust, its employees and their dependents are not automatically insured, but must each satisfy any eligibility requirements of the Trust and of the applicable Group Contract. The employer agrees to make the coverage under Group Contracts available to all of its present and future eligible employees. The undersigned employer hereby agrees:

1. To be bound by all the terms of the Trust Agreement and of the Group Contract(s) (as each are from time to time amended), copies of which are available from the Trust or the Administrator upon request.
2. To furnish any information requested by the Trustee, Administrator or any of the Insurers or Health Maintenance Organizations which is reasonably required for the proper administration of the Trust or of the Group Contract.
3. To distribute to its eligible employees any materials provided by or on behalf of the Trustee, Administrator, Health Insurer or Health Maintenance Organization describing Trust or the Group Contract.
4. That it has no right, title or interest in or to the Trust Fund created under Trust.
5. Coverage under any Contract through the Trust shall only apply to the extent provided in the Group Contract held by Trustee, and all claims for and benefits provided will be made payable to the insurance company or HMO issuing the Group Contract.
6. The Trustee does not have any obligation under any of the Group Contracts.

HEALTH ADVOCATE

All Medical plan options available through HealthPass include access to Health Advocate.

HEALTHPASS COBRA ADMINISTRATION SERVICES

1. Client must timely and accurately perform all of their responsibilities by providing participant information as outlined in "The ABC's An Administrative Guide to Your Health Insurance Plan".
2. HealthPass COBRA Administration Services will terminate if:
 - a. Client group is mandatory terminated due to non-payment.
 - b. Client does not comply with "The ABC's An Administrative Guide to Your Health Insurance Plan".
 - c. Client ceases to offer HealthPass COBRA Administration Services.
 - d. Client ceases to offer medical insurance via HealthPass.
3. Client agrees to indemnify HealthPass and all personnel involved in the provision of COBRA Administration Services.

I Payment Method — A business check, payable to HealthPass, for the full premium due must accompany this application. If a 15th of the month effective date is requested, you must include payment for 1 1/2 months premium. Applications submitted with less than the full premium amount due or with personal checks will not be processed.

After the first payment, how do you prefer to pay for your coverage?

Please bill me monthly. Please electronically transfer funds (EFT) for monthly payment. **(Must attach a voided business check)**

I hereby authorize HealthPass to initiate electronic funds transfer (EFT) from my account for the payment of my monthly cost of coverage.

I understand the debit transaction will occur the 1st of the month or the first business day following.

In the event that I make changes to my banking arrangements, I understand that I must notify HealthPass to effect the changes for payment collection.

All changes must be reported 20 days prior to the effective date of the change. _____

initials

J Employer Authorization — IN WITNESS hereof, the Employer, by its duly authorized officer, certifies the Employer meets the eligibility requirements and has executed the Trust Participation Agreement under the terms set forth in this form.

By _____ Print Name _____

Title _____ Date _____ / _____ / _____