This form should be completed with the assistance of your authorized Broker or CIGNA HealthCare Sales Representative.

Please be sure that all necessary forms are completed in their entirety and printed clearly in ink or typed.

Please be sure that all areas requiring a signature and date are completed.

Completed enrollment application forms should be submitted to your authorized Broker or CIGNA HealthCare Sales Representative at least fifteen (15) calendar days prior to the requested effective date of coverage.

Attached are the forms that must be completed and submitted with each New York Small Employer Group applying for Standard health insurance coverage:

1. All new cases must be submitted with company check for the first month's premium made payable to CIGNA HealthCare. If a case is submitted without a premium check, the case will be returned.

2. If replacing group medical coverage, submit a copy of the Prior/Current Carrier's most recent billing statement.

3. The rate quote generated for the group must be included with the submission and should match the product selected in Section V of the group application.

4. Most recent quarterly wage & tax – NYS45.

5. ERISA # and SIC code # must be included.

The rate quotation is an estimate based on information provided by your authorized Broker of CIGNA HealthCare State Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based upon our review of the paperwork submitted to CIGNA HealthCare.

CIGNA

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SMALL EMPLOYER GROUP APPLICATION

New York (2-50)

I. COMPANY INFORMATION

Requested Effective Date________________________ **Tax ID #** ____________________ **ERISA #** ________________

Full name of company ____

Address ____

City/State/Zip ____

Phone ____________________________________ Fax ____________________________________

Nature of business ______________________________ How Long in Business __________ **SIC Code** __________

Contact person ________________________________ Title ________________________________

Billing Information (if different from above)

Name____

Address ____

City/State/Zip ____

II. ELIGIBILITY

Number of eligible employees (20 Hrs./Wk.)__________Number of enrollments__________

Do you have any individuals on COBRA?__________ Please list names and extension effective dates on a separate sheet.

Class or classes to be excluded ____

NEW HIRE POLICY/WAITING PERIOD

☐ None ☐ 30 Days
☐ 60 Days ☐ 90 Days
☐ Other (Please Specify)______________

EMPLOYER CONTRIBUTION: % or $

Employee: ______________________
Dependent: ______________________

III. AFFILIATES, SUBSIDIARIES OR BRANCHES

Legal Name & Location	Number of Eligible Employees in this Company	Number of Eligible Employees to be Insured	Type of Organization	Nature of Business

IV. CARRIER INFORMATION

Will CIGNA be the only health care insurer? ☐ YES ☐ NO

If No, who is/are the other insurer(s)? ____

What is/are the plan design(s)? ☐ HMO ☐ PPO ☐ POS ☐ Indemnity

Who is your current insurer? ______________________________Termination Date if Applicable __________________

What is/are the plan design(s)? ☐ HMO ☐ PPO ☐ POS ☐ Indemnity

V. PLAN DESIGN (PLEASE REFER TO PROPOSAL FOR PLAN DETAILS)

OAP PLAN OPTION

☐ OAP A ☐ OAP B
☐ OAP C ☐ OAP D
☐ OAP E ☐ OAP F
☐ OAP G ☐ OAP J
☐ OAP K ☐ OAP L
☐ OAP M ☐ OAP N

HMO PLAN OPTION

☐ HMO O
☐ HMO P

CDH PLAN OPTIONS

☐ CDHP 1 ☐ CDHP 2
☐ CDHP 3 ☐ CDHP 4

VI. ADITIONAL COVERAGE - TIMOTHY'S LAW

Under New York legislation know as "Timothy's Law" New York Employers have the option to purchase additional coverage, at an extra cost, that will provide full parity of benefits for severe emotional disturbances in children and for biologically based mental illness. Do you wish to purchase this coverage? ☐ YES ☐ NO

VII. BROKER INFORMATION

Broker #1

Broker name ______________________________

Firm name ______________________________

Account name ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone ______________________________

Fax ______________________________

Group # *(to be completed by CIGNA)* ______________________________

Effective date ______________________________

% share if other than 100% ______________________________

Broker #2 (If applicable)

Broker name ______________________________

Firm name ______________________________

Account name ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone ______________________________

Fax ______________________________

Group # *(to be completed by CIGNA)* ______________________________

Effective date ______________________________

% share if other than 100% ______________________________

VIII. EMPLOYER CERTIFICATION OF ELIGIBLE EMPLOYEE/DEPENDENT WAIVER

I, ______________________________ (NAME OF ADMINISTRATOR), representing the organization of ______________________________ (COMPANY NAME)

as ______________________________ (TITLE), certify that we have offered the CIGNA Healthcare medical plan to all our eligible employees and their dependents. I also certify that the enrollment cards for all those eligible employees and dependents which have elected the CIGNA Healthcare medical plan are being included with our submission materials requesting coverage by CIGNA HealthCare. I understand that this certification is made in place of the completion of waiver cards for all of the employees of this organization whom have chosen to waive their and their dependent's right to enroll under this plan. I, also understand that, except in the case of an excused late entrant (defined as a member adding a dependent spouse within 31 days of marriage, dependent child within 31 days of marriage, dependent child within 31 days of birth/adoption or an involuntary loss of coverage), any existing eligible employees and/or dependent that is not enrolled at this time will NOT be able to enroll in the plan until such time as the first open enrollment period occurs, which is defined as the 30 day period preceding the anniversary date, the anniversary date being one year from the coverage effective date.

______________________________ (SIGNATURE OF OFFICER, OWNER OR PARTNER) __________ (DATE) ______________________________ (WITNESS) __________ (DATE)

For the purpose of this application, "you" and "your" and "applicant" and "company" shall be used to refer to the company submitting this application. The completion of this application form does not guarantee acceptance in to the CIGNA HealthCare plan. You also agree to provide CIGNA HealthCare with any additional information requested by CIGNA HealthCare in its processing of this application. Moreover, should CIGNA HealthCare accept your application and offer you coverage, such acceptance and offer of coverage shall be made solely upon information you provided. If it is subsequently determined that such information was inaccurate, you do hereby agree that CIGNA HealthCare shall have the right to terminate with 30 days notice, any coverage(s) offered as a result of this application. This right to terminate shall survive this application and shall be in addition to any provisions set forth in any subsequent agreement entered into by and between you and CIGNA HealthCare.

Your signature below constitutes your appointment as "Broker of Record" of the broker(s) identified in section VII of this application and offer you coverage(s) as a result of this application, you do hereby authorize CIGNA HealthCare to communicate to the broker and/or agency identified above, and information relative to your coverage, and you further authorize CIGNA HealthCare to rely upon you. This application must be signed for it to be valid. Any unsigned applications will be discarded. CIGNA HealthCare underwriting department will make reasonable efforts to verify all of the above information.

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 act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

IX. SIGNATURE OF INDIVIDUAL AUTHORIZED BY COMPANY TO EXECUTE THIS APPLICATION

Name ______________________________ Title ______________________________, Duly Authorized

Signature ______________________________ Date ______________________________