



PROFESSIONAL GROUP PLANS, INC.
Specializing in Employee Benefits

**Horizon Healthcare of New York
New Business Submission
Checklist**

- Small Group Sold Case Checklist**
- Employer Application**
- Copy of Sold Proposal**
- Employee Enrollment Form(s)**
- Employee Waiver Form(s)**
- NYS-45 Form**
- Prior Carrier Bill**
- Late Paperwork Form** (Required if paperwork is submitted less than 15 days prior to the effective date)
- Spouse's Business Statement** (Required for a group of 3 with 2 eligible who are married & each are taking single coverage.)
- First Month's Premium Check Payable to :**
Horizon Healthcare of NY
- Forms Must Be Submitted to PGP Office**
Prior to the effective date.
- New York Agent Agreement**
(For first time case submission need licensing forms)

First time case submission needs licensing forms.

If you have any questions, please contact your PGP representative.

Updated 07/28/03

NEW YORK SMALL GROUP SOLD CASE CHECKLIST

This form is required for all new business submission.

Group Name: _____

General Agent: _____

Writing Agent: _____

General Agent Correspondent: _____

General Agent Fax #: _____

Verify Requested Effective Date

Employer Master Group Application

Waiting Period

General Agent ID#

Employer Contribution Level

Federal Tax ID#

Applicable Agent Codes

Complete Company Address

Effective Date

Small Employer/Waiver Form

First Month's Premium Check

(must be company check payable to Horizon Healthcare of New York)

Group's Most Recent Billing Statement From Prior Carrier

NYS45TT (Quarterly Wage & Statement)

Copy of Rate Quote

Employee Enrollment/Application Forms - (dependents not listed will not be covered)

Dates of Hire

Employee's Signature

Employer's Name

Social Security Number

All Listed Data Fields

All Dependent Information

Late paperwork (if Necessary)

Agent Licensing Information

SMALL EMPLOYER GROUP APPLICATION INSTRUCTIONS

This form should be completed with the assistance of your authorized Broker or Horizon Healthcare of New York Sales Representative.

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

Ensure that all areas requiring a signature and date are completed.

Completed enrollment application forms should be submitted to your authorized Broker or Horizon Healthcare of New York 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. Application for a Small Employer Health Benefits Policy
2. Small Employer Health Benefits Waiver Coverage*
(1 form needed for each employee waiving coverage)
3. Spouses' Business Statement (only for groups where the only employees are husband & wife)
4. Employee Enrollment Change/Deletion Form (to be completed for product conversions)
5. Late Paperwork form for groups received by Horizon Healthcare of New York within 14 days of the requested effective date.

*Additional Forms may be photocopied, if needed, based on number of employees.

In addition to the above forms being completed, the following items must also be attached to this package:

1. Enrollment application/Change Form (1 per each employee enrolling). Your Sales Representative will provide these forms.
2. All new cases must be submitted with a company check for the first month's premium made payable to Horizon Healthcare of New York. If a case is submitted without a premium check, the case will be returned.
3. If replacing group medical coverage submit a copy of the Prior/Current Carrier's most recent billing statement.
4. The rate quote generated for the group must be included with the submission and should match the product selected in Section II of the group application.

The rate quotation is an estimate based on information provided by your authorized Broker or Horizon Healthcare of New York Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon Healthcare of New York.

**HORIZON HEALTHCARE OF NEW YORK
SALES DEPARTMENT
1180 AVENUE OF THE AMERICAS, 8TH FLOOR
NEW YORK, NY 10036**

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Group Name: _____

General Agent: _____

Writing Agent: _____

General Agent Correspondent: _____

General Agent Fax #: _____

Verify Requested Effective Date

Employer Master Group Application

Waiting Period

General Agent ID#

Employer Contribution Level

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Group's Most Recent Billing Statement From Prior Carrier

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Copy of Rate Quote

Employee Enrollment/Application Forms - (dependents not listed will not be covered)

Dates of Hire

Employee's Signature

Employer's Name

Social Security Number

All Listed Data Fields

All Dependent Information

Late paperwork (if Necessary)

Agent Licensing Information



APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type New Policy Change in Policy Policy No. _____ Requested Effective Date _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____
Group Health Plan Name, if any: _____

2. Tax Identification Number: _____ 3. Email Address _____

4. Main Address: _____
Street City State Zip Code County

Mailing Address (Billing): _____
Street City State Zip Code

Telephone: _____ Facsimile: _____

5. Name of Correspondent: _____ Title: _____

6. Type of Organization: Corporation Partnership Proprietorship Other (explain): _____

7. Nature of Business (specify): _____ SIC Code: _____

8. Employee Eligibility: All permanent, full-time employees who work at least _____ hours per week (minimum 20 hours/week).

9. Number of eligible employees in your company: _____

10. Number of eligible employees to be insured: _____

11. Insurance request for: Employees Only Employees and Dependents

12. Are you subject to the requirements of COBRA? Yes No TEFRA Eligible? Yes No

13. Waiting period before employees become insured: (May not exceed 6 months) Present: _____ New / Rehire: _____

14. Premium Paid: Monthly Quarterly

15. What percentage of the premium will the employer pay: _____ (Minimum of 10% required)

16. Class or classes to be excluded: _____ Number of excluded: _____

Premium will be due as of the effective date.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. of eligible employees in this company	No. of eligible employees to be insured	Type of organization	Nature of Business

SECTION II: SPECIFICATIONS FOR COVERAGE (Health Benefits Selection)

1. Plan Design:

	HORIZON EPO		
	100/0	100/90	90/80
\$0			
\$10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$15			
\$20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$25			
\$30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	HORIZON PPO			
	100/80	100/70	100/90/70	90/80/60
\$0			<input type="checkbox"/>	<input type="checkbox"/>
\$10	<input type="checkbox"/>	<input type="checkbox"/>		
\$15				
\$20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$25				
\$30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HORIZON HMO PCP SPECIALIST

Co-Pay (Select One) \$10/10 \$15/15 \$10/20 \$20/20

2. Deductible 250 500 1000 2000 3000

3. Per Admission Deductible 0 500 (applicable to 100/0 EPO)

4. Stop Loss 5K 10K

5. Rx Options:

- \$5/\$12/\$25 \$10/\$20/\$40 No Rx
- \$7/\$15/\$30 \$10/\$25/\$50

6. Rx Deductible: 0 50 100 150 200 2500 *Rx Deductible is per person

7. Tier Options: 4

SECTION III: PRODUCT/PLAN DESIGN

1. Continuation of Coverage: Are there any former employees who have been paying you for coverage since they stopped working for you. (Either COBRA or State Continuation Provisions) Yes No

If yes, please specify who those individuals are, and attached correspondence (Name, qualifying event and date)

Name of present or prior group carrier: _____ Cancellation Date: _____ Start Date: _____

Is the coverage applied for in this application replacing other group insurance: Yes No

If yes give reason: _____

SECTION IV: APPLICATION AGREEMENT

This application and the premium rates proposed by Horizon Healthcare of New York are subject to Home Office approval in writing by Horizon Healthcare of New York and may change due to difference in selection of benefits as determined by Horizon Healthcare of New York. The Application hereby acknowledges that this application does not constitute any obligation by Horizon Healthcare of New York to offer coverage to the Applicant until such application is accepted in writing by Horizon Healthcare of New York. The Application hereby confirms that it will not cancel any health coverage it may currently have in anticipation that this Application will be accepted by Horizon Healthcare of New York and that Horizon Healthcare of New York shall have no obligation to provide coverage to Applicant unless this Application is formally accepted in writing by Horizon Healthcare of New York. Further, I hereby certify on behalf of the Applicant that the Applicant has not had group health coverage terminated within the past 12 months due to failure to pay premiums.

Dated at: _____ this _____ day of _____ Yr _____

(Full Legal Company Name)

The above name company confirms that we employ no more than 50 full-time non-union employees and no fewer than 2 full-time non-union employees. 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 concerning and fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000. dollars and the stated value of the claim for each violation.

X _____
Signature of Authorized Officer of the Company Date

X _____
Print Name Date

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name: _____

Employee Name: _____
Last First MI

Marital Status: Single Married Widowed Divorced

Date of Employment: _____ Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Healthcare of New York. I *refuse* the following:

- Employee, Spouse, and Child(ren) coverage
- Spouse coverage
- Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

- Other group coverage sponsored by this employer (Must provide carrier & group #)
- Other group coverage sponsored by my spouse's employer (Must provide carrier & group #)
- Other group coverage sponsored by another organization
- Other reasons (please explain) _____

Please provide name of carrier and policy number: _____

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

Signature of Employee

Date

Signature of Witness

Date

LATE PAPERWORK FORM

Agents: If you are submitting group enrollment paperwork 14 calendar days (or less) prior to the group's requested effective date, this form must be filled out by the group administrator, signed and submitted with their **complete** paperwork.

Group: _____

Address: _____

We the undersigned understand that we are requesting a coverage date that will put our enrollment paperwork in Horizon Healthcare's home office(s) 14 days (or less) prior to our effective date, and that delivery of our I.D. cards and system activation will occur after our effective date.

Upon approval of our request for insurance, we acknowledge that the delivery of our group I.D. cards and system activation may occur after our effective date.

Name (please print): _____

Signature: _____

Date: _____

SPOUSE'S BUSINESS STATEMENT

WE CERTIFY THAT WE BOTH WORK A MINIMUM OF 20 HOURS PER WEEK IN OUR BUSINESS

(_____)

FOR WHICH WE RECEIVE COMPENSATION.

DATE _____

(HUSBAND) SIGNATURE _____

(WIFE) SIGNATURE _____

GROUP COVERAGE EMPLOYEE ENROLLMENT APPLICATION

For Products:
HORIZON EPO
HORIZON PPO
VISTA
VISTA PLUS

PLEASE PRINT CLEARLY, COMPLETE ALL PERTINENT SECTIONS TO AVOID PROCESSING DELAYS.

SUBSCRIBER INFORMATION						
1. EMPLOYEE'S LAST NAME	FIRST	MI	2. PHONE-WORK ()	3. HOME ()	4. EMPLOYEE NUMBER	5. CONTRACT TYPE-HEALTH
6. ADDRESS-STREET		CITY, STATE		ZIP	COUNTY	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child
7. EMPLOYER NAME AND LOCATION (CITY AND STATE)				8. DATE OF HIRE	9. WORKING STATUS <input type="checkbox"/> Active <input type="checkbox"/> Retired	PRESCRIPTION <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> HW <input type="checkbox"/> PC
10. MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated				11. PRODUCT <input type="checkbox"/> HORIZON EPO <input type="checkbox"/> HORIZON PPO <input type="checkbox"/> VISTA <input type="checkbox"/> VISTA PLUS		DENTAL, IF OFFERED <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> HW <input type="checkbox"/> PC

ELIGIBLE PERSONS TO BE ENROLLED						
12. SELF - LAST NAME	FIRST	MI	13. RELATION Self	14. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	15. BIRTHDATE	16. SOC. SEC. NO.
DEPENDENT #1 - LAST NAME	FIRST	MI	RELATION <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE	SOC. SEC. NO.
DEPENDENT #2 - LAST NAME	FIRST	MI	RELATION <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE	SOC. SEC. NO.
DEPENDENT #3 - LAST NAME	FIRST	MI	RELATION <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE	SOC. SEC. NO.
DEPENDENT #4 - LAST NAME	FIRST	MI	RELATION <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE	SOC. SEC. NO.

17. DO YOU HAVE A DISABLED CHILD DEPENDENT? YES NO
IF DEPENDENT IS DISABLED, PLEASE ATTACH MEDICAL DOCUMENTATION (FROM EMPLOYER) TO DETERMINE COVERAGE BEYOND YOUR EMPLOYER'S MAXIMUM DEPENDENT AGE.

COORDINATION OF BENEFITS

YOUR HORIZON HEALTHCARE CONTRACT CONTAINS A COORDINATION OF BENEFITS (C.O.B.) PROVISION. COORDINATION OF BENEFITS IS IN EFFECT WHEN MORE THAN ONE GROUP HEALTHCARE PLAN OR PROGRAM COVERS A PERSON. IF YOU OR ANY FAMILY MEMBER ARE COVERED BY ANOTHER GROUP HEALTHCARE PLAN PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM WHERE APPLICABLE.

SIGNATURE

18. PLEASE READ THE FOLLOWING AND SIGN IN THE SPACE PROVIDED.
I HEREBY APPLY FOR HORIZON HEALTHCARE COVERAGE FOR ME AND MY ELIGIBLE DEPENDENTS WHO ARE LISTED ON THIS APPLICATION. I UNDERSTAND AND AGREE THAT OUR COVERAGE WILL BE CONTROLLED BY THE WRITTEN AGREEMENT BETWEEN HORIZON HEALTHCARE OF NEW YORK AND MY EMPLOYER. I AUTHORIZE MY EMPLOYER TO MAKE DEDUCTIONS FROM MY EARNINGS, IF REQUIRED, FOR MY HORIZON HEALTHCARE COVERAGE. THE UNDERSIGNED HEREBY AUTHORIZE ANY HEALTH CARE FACILITY OR PROVIDER TO RELEASE TO HORIZON HEALTHCARE ALL INFORMATION RELATING TO PAST, PRESENT, AND FUTURE HEALTH CARE EXAMINATIONS OR TREATMENTS RECEIVED BY EACH PERSON COVERED BY THIS APPLICATION. I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS COMPLETE AND ACCURATE AND THAT EACH PERSON COVERED BY THIS APPLICATION RESIDES WITHIN A HORIZON HEALTHCARE SERVICE AREA. I UNDERSTAND THAT ANY CLAIM BY ME OR ONE OF MY ELIGIBLE DEPENDENTS MAY BE DENIED AND OUR COVERAGE CANCELLED WITHOUT WRITTEN NOTICE IF I HAVE USED MATERIALLY FALSE INFORMATION IN THIS APPLICATION. I ALSO UNDERSTAND THAT SUCH A TERMINATION WILL BE RETROACTIVE TO THE EFFECTIVE DATE OF OUR COVERAGE. IF HORIZON HEALTHCARE ADVANCES PAYMENT TO ANY PROVIDER FOR COVERED SERVICES, I THE UNDERSIGNED WILL RETURN ANY REIMBURSEMENT RECEIVED FOR THESE PREPAID SERVICES TO HORIZON HEALTHCARE.
"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, HEALTH MAINTENANCE ORGANIZATION 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 A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE (NOT MANDATORY)	DATE
SIGNATURE OF DEPENDENT AGE 18 OR OVER (NOT MANDATORY)	DATE	SIGNATURE OF DEPENDENT AGE 18 OR OVER (NOT MANDATORY)	DATE

EMPLOYER USE ONLY		HORIZON HEALTHCARE USE	
REASON FOR APPLICATION <input type="checkbox"/> NEW HIRE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> REHIRE <input type="checkbox"/> COBRA <input type="checkbox"/> OTHER	GROUP NUMBER:	EFFECTIVE DATE:	SALES REP:
	EMPLOYER NAME:	EMPLOYER PHONE #:	PROCESSED BY:
	EMPLOYER ADDRESS:		DATE:
	EMPLOYER SIGNATURE:	DATE:	HMU:

ARE YOU: 1. SINGLE 2. MARRIED 3. SEPARATED 4. DIVORCED

IF YOU CHECKED 1, 2 OR 3 COMPLETE SECTION I.

IF YOU CHECKED 4, COMPLETE SECTIONS I & II.

PLEASE SIGN AND DATE.

IS ANY MEMBER OF YOUR FAMILY COVERED BY ANOTHER GROUP HEALTHCARE PLAN?

YES - IF YES, COMPLETE THE FOLLOWING QUESTIONS.

NO - IF NO, COMPLETE SECTION II IF APPLICABLE.

SECTION I

POLICY HOLDER NAME _____

DEPENDENT'S NAMES _____

EMPLOYER'S NAME _____ ADDRESS _____

NAME OF INSURANCE CO. _____ ADDRESS _____

GROUP / POLICY NUMBER _____ SOCIAL SECURITY NO. _____

EFFECTIVE / CANCEL DATES _____

TYPE OF COVERAGE SINGLE FAMILY PARENT / CHILD HUSBAND / WIFE

TYPE OF PLAN POS PPO BASIC HOSPITAL BASIC MED-SURGE

MAJOR MEDICAL WRAPAROUND COMPREHENSIVE DENTAL

FATHER'S BIRTHDAY _____ MOTHER'S BIRTHDAY _____

POLICY HOLDER NAME _____

DEPENDENT'S NAMES _____

EMPLOYER'S NAME _____ ADDRESS _____

NAME OF INSURANCE CO. _____ ADDRESS _____

GROUP / POLICY NUMBER _____ SOCIAL SECURITY NO. _____

EFFECTIVE / CANCEL DATES _____

TYPE OF COVERAGE SINGLE FAMILY PARENT / CHILD HUSBAND / WIFE

TYPE OF PLAN POS PPO BASIC HOSPITAL BASIC MED-SURGE

MAJOR MEDICAL WRAPAROUND COMPREHENSIVE DENTAL

SECTION II

IS THERE A COURT ORDER REGARDING HEALTH CARE COVERAGE FOR YOUR CHILDREN?

NO COURT ORDER COURT ORDER FATHER COURT ORDER MOTHER

WHO HAS CUSTODY? FATHER MOTHER OTHER, SPECIFY _____

HAS THE CUSTODY PARENT REMARRIED? YES NO

NAME OF NEW SPOUSE _____

FATHER'S BIRTHDAY _____ MOTHER'S BIRTHDAY _____

LIST THE CHILDREN THAT THE ABOVE INFORMATION APPLIES TO _____

IF ANY EXCEPTIONS, EXPLAIN _____

MEMBER SIGNATURE _____ DATE _____