



# THE PERFECTHEALTH INSURANCE COMPANY

## Employer Request for Coverage

**Firm Information**

|   |             |             |                           |                          |         |       |
|---|-------------|-------------|---------------------------|--------------------------|---------|-------|
| Group Number                                    |             |             |                           | Requested Effective Date |         |       |
| Exact Legal Name of Firm                        |             |             |                           |                          |         |       |
| Legal/Corporate street address of firm          |             |             |                           |                          |         |       |
| City  |             | State       | Zip                       | County                   |         |       |
| Mailing address of firm if different than above |             |             |                           |                          |         |       |
| City  |             | State       | Zip                       | County                   |         |       |
| Telephone                                       |             | Fax         |                           | E-Mail                   |         |       |
| Organization Type<br>(Check one)                | Corporation | Partnership | Sole Prop.                | Association              | Trustee | Other |
| Federal Tax Identification Number               |             |             | No. of years in business: |                          |         |       |
| Nature of Business                              |             |             |                           | SIC Code                 |         |       |
| Benefits Administrator                          |             |             |                           | Title                    |         |       |
| Telephone                                       |             | Fax         |                           | E-Mail                   |         |       |

**Firm Relationships** (please indicate any relationship with other Firms):

|           |         |                      |                            |
|-----------|---------|----------------------|----------------------------|
| Firm Name | Address | Ownership percentage | Electing cov.<br><br>Y / N |
|-----------|---------|----------------------|----------------------------|

**Eligibility**

|   |  |   |  |
|---|--|---|--|
| Total Number Employed at the firm all locations...  |  | Total number waiving due to coverage through spouse.... |  |
| Total Number working 30 or more hours a week.....   |  | Total number waiving due to coverage through other..... |  |
| Total number working less than 30 hours a week..... |  | Total number covered by Management-Labor contract....   |  |
| Total number of employees in waiting period.....    |  | Total number not actively at work.....                  |  |
| Total number covered by Taft-Hartley agreement..... |  | Total number covered under COBRA/State Continuance.     |  |
|   |  | Total number enrolling under PerfectHealth.....         |  |
| Class of Employees to be excluded: _____            |  | Total number of Employees: _____                        |  |

**Additional Information**

|  |   |    |             |                          |
|--|---|----|-------------|--------------------------|
| Employee Contributions   | Employee  | \$ | or          | %                        |
|  | Dependent   | \$ | or          | %                        |
| Employment Waiting Period (Insurance becomes effective on the first of the month following the date of eligibility unless otherwise noted) |   |    |             |                          |
|  |   |    | Applies to: |                          |
| <input type="checkbox"/>   | First of the month following date of hire               |    |             | <input type="checkbox"/> |
| <input type="checkbox"/>   | First of the month following 30 days from date of hire  |    |             | <input type="checkbox"/> |
| <input type="checkbox"/>   | First of the month following 60 days from date of hire  |    |             | <input type="checkbox"/> |
| <input type="checkbox"/>   | First of the month following 90 days from date of hire  |    |             | <input type="checkbox"/> |
| <input type="checkbox"/>   | First of the month following 6 months from date of hire |    |             | <input type="checkbox"/> |
| Firm Information:  |   |    |             |                          |
| List your prior carrier and last date of coverage  |   |    |             |                          |
|  |   |    | Term date:  | <input type="text"/>     |

**Choose your plan by marking an "X" in the appropriate box, signing the Proposal and attaching the signed Proposal to this Employer Request for Coverage.**

|                 |  |                               |  |
|-----------------|--|-------------------------------|--|
| Plan 1 PPO      |  | Plan 7 PPO Value Option       |  |
| Plan 2 PPO Plus |  | Plan 8 PPO Plus Value Option  |  |
| Plan 3 PPO      |  | Plan 9 PPO                    |  |
| Plan 4 PPO Plus |  | Plan 10 PPO Plus              |  |
| Plan 5 PPO      |  | Plan 11 PPO Value Option      |  |
| Plan 6 PPO Plus |  | Plan 12 PPO Plus Value Option |  |
| Other           |  |                               |  |

By supplying the information requested in this application, the applicant applies for one or more of the group health benefit plans offered by The PerfectHealth Insurance Company ("PerfectHealth"). PerfectHealth shall not be bound by any term or provision herein. PerfectHealth shall not be obligated to issue any insurance coverage to applicant or any eligible person(s) until all required information is submitted. Such information must be approved by PerfectHealth in writing by an authorized employee at its home office in Staten Island, New York.

**Signature Agreement**

No agent may set an effective date, make, modify or waive any term or provision of any contract or policy of insurance for PerfectHealth, or extend the time for premium payment without the written agreement of PerfectHealth. Such agreement must be signed by an officer or authorized employee of PerfectHealth at its home office in Staten Island, New York.

Attached is a check or money order in the amount of \$\_\_\_\_\_. This is advance payment of premium toward the coverage for which this application is made. If this application is accepted by PerfectHealth at its home office, and if the advance payment is more than the first premium due, the excess will be applied to the next premium due under the insurance policy. However, the applicant may opt to have the excess premium returned. If this application is not accepted by PerfectHealth, or if insurance coverage does not become effective, advanced payment will be returned to the applicant. If this application is accepted, coverage will begin on the date that all parts of this application are completed or, if the Requested Effective Date is subsequent to such date, on the Requested Effective Date. Cashing of advanced payment by PerfectHealth shall not constitute acceptance of this application. A completed copy of this application, signed by the agent, shall serve as evidence to PerfectHealth of advance payment. PerfectHealth reserves the right to set all premium rates for insurance coverage in accordance with its underwriting rules and other applicable requirements. The applicant understands that false and /or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims. The undersigned Employer hereby certifies, to the best of its knowledge, and belief, the information herein is true and complete.

**Notice: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

By \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Employer

\_\_\_\_\_  
Name of Agent / Broker (Please Print)

By \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Agent / Broker

Name of Agency: \_\_\_\_\_ General Agent: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_  
 FAX No.: \_\_\_\_\_

**SUBSCRIPTION TO TRUST**  
**Statement and Subscription by Employer**

The undersigned employer hereby subscribes to the Employee Security Program Trust and affirms that it desires to become a Participating Employer under the Employee Security Program.

*Agreement To Be Bound By Trust*

The undersigned employer understands that a copy of said Trust is available upon request and agrees to be bound by its terms, conditions and limitations and any amendments or supplements thereto and to assume the obligations of a Participating Employer.

*Agreement To Be Bound By Policies Issued to Trustee*

The undersigned employer agrees to be bound by all the terms, conditions and limitation of the policies (including any amendments, endorsements or riders thereto) which The PerfectHealth Insurance Company (PerfectHealth) has issued or may issue to the Trustees. The undersigned employer further understands and agrees that:

1. Subscription to the Trust does not assure acceptance as a Participating Employer.
2. Neither this Subscription nor the payment of any monies to be applied to the employer's share of the premium shall cause coverage to become effective on any employee and dependent(s), if applicable. The employer must first be accepted by PerfectHealth as a Participating Employer, and then each employee and dependent(s), if applicable, must satisfy the eligibility requirements of the policy and enroll. Insurance on any employee and dependent(s), if applicable, will then become effective on the date specified by the terms of the policy.
3. It will pay directly to PerfectHealth its share of the premium monthly in advance. In the event of cancellation or termination, it will pay its share of any unpaid premiums due under the policy.

The undersigned employer agrees and understands that:

- a) An employee may contribute toward the cost of his or her insurance, but not the entire cost. The employer will contribute at least 25% of the total cost for employees and dependents.
- b) The information on this request is correct.
- c) In supplying the preceding specifications for the Benefit Plan, the employer has seen a complete description of the coverage elected; and if this request is approved, will receive a copy of this Benefit Plan from PerfectHealth.
- d) Acceptance of this request is subject to PerfectHealth's requirements and to all of the terms of the group policy issued to the Employee Security Program Trust.
- e) PerfectHealth will notify the employer of any approval or disapproval of this request. Any notice of approval will specify the employer's plan and/or plan change effective date. For insured employees, PerfectHealth will issue certificates of insurance summarizing the provisions of the group policy principally affecting the insurance. The insurance is subject in every respect to the group policy which alone constitutes the agreement under which coverage charge payments are made.

I/We have read these statements in the Employer Request for Coverage and they (a) are true and complete to the best of my/our knowledge and belief; (b) were correctly recorded before I/we signed this request; and (c) shall be the basis of any contract.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20

\_\_\_\_\_  
Signature of Agent/Broker

\_\_\_\_\_  
Signature of Employer and Title

### Small Group Regulation Worksheet

In New York, groups of 1-50 eligible employees are subject to Small Group Reform Regulation 145. In order to comply with state regulations and make a determination of whether your firm is subject to this Regulation, we require that the following worksheet be completed.

Plan No.

1. a. Number of permanent employees who work 30 or more hours a week and are not covered under a plan established by a collective bargaining agreement. a. \_\_\_\_\_

b. Number of employees working 20-29 hours a week who are eligible for benefits based on the number of hours worked and are not covered under a plan established by a collective bargaining agreement. b. \_\_\_\_\_

**Total Eligible Employees (a + b)** \_\_\_\_\_

**Please attach a copy of your state or federal filing which reflects the number of employees at your firm.**

2. In what state do the majority of the total full-time employees work? \_\_\_\_\_

3. Did you exclude any class of permanent full-time employees from coverage, such as union or warehouse employees? If yes, please provide the total number of employees excluded. \_\_\_\_\_

4. What percentage of total premium do you contribute to your employee's medical insurance? \_\_\_\_\_

5. In what state is the primary headquarters of your firm located? \_\_\_\_\_

6. How many employees are covered under any other employer sponsored Plan (including HMO)? \_\_\_\_\_

Your group will be certified annually to determine applicability of the Regulation. Your plan may lose the protections of the Regulation if the size of your workforce changes and you no longer qualify as a small employer.

I hereby certify that the above represents a true and accurate account of my firm.

Signed: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Please print above name

\_\_\_\_\_  
Company Name