



Health Net of the Northeast, Inc.
 One Far Mill Crossing
 Shelton, CT 06484

**Application for Group Health Coverage
 And Plan Specifications – New York**

<i>Please Print</i>		Plan Number (Health Net Use only):		
<input type="checkbox"/> New Plan <input type="checkbox"/> Change of Plan		Requested Effective Date:		
SECTION I: PLANHOLDER INFORMATION				
Planholder (full legal name of company)		Tax ID#:		
Mailing Address (street, apt/suite):				
Mailing Address (city, state, zip):				
Email Address:		Fax #: ()	Phone #: ()	
Name of Contact:		Title:	Phone #: ()	
Type of organization: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (explain):				
Total # of employees:		Total # of full-time employees:	Total # of full-time employees to be insured:	
Amount of Binder Check: \$		(one month's premium)	Nature of Business (specify):	Date established: SIC:
Waiting Period for future employees: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days				
Do you have any affiliates, subsidiaries or branches? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Affiliate, subsidiaries or branches (legal name & location)		Nature of business	# of full-time employees in company	# of full-time employees to be insured
A Full-time employee means one who regularly works the number of hours in the normal workweek established by this planholder (not less than 20 hours per week for groups with 2-50 employees) at the planholder's normal place of business.				
Are all full-time employees to be included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no" indicate class or classes to be excluded:				
Percentage of employer contributions for medical coverage: Employee Coverage: _____ % Dependent Coverage: _____ %				
# of Eligible Employees: _____ # of Employees on COBRA: _____ # of Total Employees: _____				
# of Covered Employees: _____ # of Waivers: _____				
SECTION II: SUPPLEMENTARY INFORMATION (All questions must be answered)				
1) Has this planholder or any of its affiliates, either under its present name or any other name, ever applied for group insurance with Health Net? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," furnish year, name of employer, plan number and date of cancellation:				
2) If present carrier provided life insurance, are extended benefits provided in case of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
3) Does your planholder have any other insurance plan: a) Now in force and to be continued? <input type="checkbox"/> Yes <input type="checkbox"/> No b) That you are currently applying for? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," give description of plan and name of carrier(s):				
4) Name of prior group health carrier:			Cancellation date:	
5) To the best of your knowledge, are there any current and former employees or their eligible dependents whose health insurance is being continued? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide the following information on health continuation for each current/former employee or dependent:				
Employee/Dependent	Date of Birth	Continuation State/Federal	Continuation due to Disability / Non-Disability	Continuation Dates Start / Expiration

**Be certain to read this entire application/plan specification:
 then sign, date, and have it witnessed on page 3.**

SECTION III: AGENT/PRODUCER INFORMATION

Agent / Broker Name: _____ Health Net Agent Number / Tax ID / SSN: _____
Agency Name: _____ % of Credit: _____
Phone #: (____) _____ Fax #: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Signature: _____ Date: _____ Email Address: _____

Agent / Broker Name: _____ Health Net Agent Number / Tax ID / SSN: _____
Agency Name: _____ % of Credit: _____
Phone #: (____) _____ Fax #: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Signature: _____ Date: _____ Email Address: _____

General Agent Name: _____ Health Net Agent Number / Tax ID / SSN: _____
Agency Name: _____ % of Credit: _____
Phone Number: (____) _____ Fax Number : (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Signature: _____ Date: _____ Email Address: _____

SECTION IV: CERTIFICATION: (For Groups of 2-50 Employees Only)

A Small Employer is any person, firm, corporation, partnership or association actively engaged in business with corporate headquarters located in the State of New York who, on their APPLICATION DATE of coverage, employed AT LEAST TWO, BUT NOT MORE THAN FIFTY eligible employees. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return will be considered a single employer. Please be advised that the total number of employees should also include you as the employer.

COMPLETE IF YOU DO MEET THE DEFINITION OF A SMALL GROUP EMPLOYER:

I certify that I **qualify** as a Small Group Employer in that on the date of application for Major Medical coverage, we employ no less than two and no more than fifty employees.

I have reviewed the statements made by me on the supplement, and to the best of my knowledge and belief, they are true and complete.

Initial of Officer, Partner or Proprietor: _____

----- **WE MUST HAVE A COPY OF YOUR MOST RECENT STATE/FEDERAL QUARTERLY WAGE REPORT** -----

COMPLETE IF YOU DO NOT MEET THE DEFINITION OF A SMALL GROUP EMPLOYER:

I certify that I **am not** a Small Employer in the State of New York in accordance with New York AB 12350-A.

Initial of Officer, Partner or Proprietor: _____

Please check the appropriate reason why you do not meet the definition of a Small Employer:

- Employs less than two or more than 50 employees
- Corporate Headquarters is located outside of the State of New York
- Other (please explain): _____

FOR HEALTH NET USE ONLY

PLAN CODE: _____ Passport/HMO	PLAN CODE: _____ Charter/HMO
PLAN CODE: _____ Passport/POS	PLAN CODE: _____ Charter/POS
PLAN CODE: _____ PPO	PLAN CODE: _____ Indemnity

Please complete below if the following individual(s) is different from the contact person listed on page 1 of application:

<i>VIP Correspondent:</i> _____	Email: _____
Title: _____	Phone: _____
<i>Billing Correspondent:</i> _____	Email: _____
Title: _____	Phone: _____
<i>Benefit Correspondent:</i> _____	Email: _____
Title: _____	Phone: _____

CONTINGENCIES:

- We reserve the right to change rates during the policy year to account for federal or state mandates that may be enacted.
- Signature of this application implies that all information on the application is accurate to the best of your knowledge.
- Coverage is not in effect until this application is accepted by Health Net. Coverage is subject to all of the terms and conditions of all the plan documents.