



TRANSACTION FORM FOR GROUP ACCOUNTS
 MEMBERSHIP/P.O. BOX 2820 • NEW YORK, NY 10116-2820
 (Please read important information on back before completing this form)
 Employers: See back for sections you must complete
PLEASE PRINT CLEARLY

INTERNAL USE ONLY
 CONTROL NUMBER

I. SUBSCRIBER INFORMATION										
LAST NAME		FIRST NAME			M.I.	TELEPHONE NUMBERS HOME WORK		EMAIL ADDRESS		
HOME ADDRESS		APT. NO.	SOCIAL SECURITY NUMBER (REQUIRED)			GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____		
CITY			STATE	ZIP CODE		PRIMARY LANGUAGE SPOKEN				

II. ENROLLMENT INFORMATION											
LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER (REQUIRED)	GENDER	RELATIONSHIP	MAILING ADDRESS (If different from above)	Required for EH CompreHealth		ADD ✓	DELETE ✓
								PRIMARY CARE PHYSICIAN ID Number	OB/GYN SELECTION ID Number		
SUBSCRIBER						SELF					
SPOUSE											
DEPENDENT											
DEPENDENT											
DEPENDENT											

III. OTHER CARRIER INFORMATION Do you or any of your dependents have other health care coverage? <input type="checkbox"/> Yes Please complete this section <input type="checkbox"/> No GO TO SECTION IV									
NAME OF SUBSCRIBER'S OTHER INSURANCE CARRIER		INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.			POLICY ID. NUMBER	EFFECTIVE DATE
NAME OF SPOUSE'S OTHER INSURANCE CARRIER/MEDICARE		INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.			POLICY ID. NUMBER	EFFECTIVE DATE

IV. DID YOU HAVE PRIOR HEALTH COVERAGE? <input type="checkbox"/> YES Please provide a 12-month history of all coverage in this section (Use additional pages if you need more space) <input type="checkbox"/> NO GO TO SECTION V						
NAME AND ADDRESS OF INSURER	TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER		POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY

V. PRE-EXISTING CONDITIONS

Pre-existing conditions will not be covered during the first twelve (12) months of enrollment in the EmblemHealth CompreHealth program or during the first eleven (11) months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth InBalance EPO, EmblemHealth InBalance PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice or treatment was recommended or received during the six (6) month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the twelve (12) month or eleven (11) month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed sixty-three (63) days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a certificate of creditable coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

Please call EmblemHealth at 1-877-VIA-EMBLEM (1-877-842-3625) for more information about the pre-existing condition limitation.

VI. SUBSCRIBER AUTHORIZATION	
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.	
If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to EmblemHealth.	
Your signature is required to process this form. Your signature attests that you have read the above, and the reverse side of this form.	
_____	_____
Applicant must sign here	Date

VII. EMPLOYER INFORMATION - TO BE COMPLETED BY EMPLOYER (SMALL GROUP EMPLOYERS MUST READ AND COMPLETE SECTION BELOW)

SUBSCRIBER EMPLOYMENT STATUS			EMPLOYEE WAITING PERIOD		
<input type="checkbox"/> Employed	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> COBRA: <input type="checkbox"/> 18 mo. <input type="checkbox"/> 36 mo.	<input type="checkbox"/> Retiree/RDS - Effective Date _____	<input type="checkbox"/> YES NUMBER OF WAITING PERIOD DAYS _____
				<input type="checkbox"/> NOT APPLICABLE	NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____
Check one: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Individual Policy STATUS CHANGE: <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Reason for Change: _____ TRANSFER: <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
NAME OF GROUP		GROUP NUMBER: MED/HOSPITAL: DENTAL		SELECT ONE: <input type="checkbox"/> EmblemHealth CompreHealth (small groups only) <input type="checkbox"/> EmblemHealth PPO <input type="checkbox"/> EmblemHealth ConsumerDirect PPO <input type="checkbox"/> EmblemHealth CompreHealth EPO (large groups only) <input type="checkbox"/> EmblemHealth InBalance EPO <input type="checkbox"/> EmblemHealth ConsumerDirect EPO <input type="checkbox"/> EmblemHealth EPO <input type="checkbox"/> EmblemHealth InBalance PPO	
REQUESTED EFFECTIVE DATE MEDICAL: _____ DENTAL: _____		HIRE DATE	DATE SUBMITTED TO EMBLEMHEALTH	APPROVED BY (Group Plan Administrator)/Title	TYPE OF COVERAGE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD

Instructions to Group Plan Administrator: For Groups with 50 employees or less, you **MUST** complete the following documentation section. Required documentation **MUST** be attached to this Transaction Form to be processed.

DOCUMENTATION BASED ON GROUP SIZE (To be completed by Small Group Plan Administrator)					
ACTION Check (✓) One	Qualifying Event	Group Type (Check One) Documentation Required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sole Proprietorship or One Subscriber Group	Association of Two or More Employees	Small Group - Less Than 50 Employees
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent copy of NYS45 showing this subscriber as an employee or copy of payroll documentation reflecting the date, employee's name and Social Security # or the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage Court Order	<input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Dependent	Birth Adoption Court Order	<input type="checkbox"/> Birth Certificate or <input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers or <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			

Note: No retroactive enrollments will be allowed. Members must be enrolled within 30 days from the qualifying event.

FOR EMBLEMHEALTH USE ONLY		
PROCESSED BY _____	RECEIVED DATE _____	PROCESSED DATE _____

IMPORTANT INFORMATION

1. The subscriber must complete sections I through VI. The group plan administrator must complete section VII, and, if for a small group, the documentation section above.
2. All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
3. For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of these conditions: He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma.
To enroll the dependent as a full-time student, attach a completed Student Verification Parent Affidavit Form. See your group plan administrator or go to the EmblemHealth Web site at www.emblemhealth.com for a Student Verification Parent Affidavit Form.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.



SMALL EMPLOYER GROUP APPLICATION

EmblemHealth insurance programs are underwritten by
(GHI) Group Health Incorporated and (HIP) HIP Health Plan of New York.



PRINT IN INK

SECTION I: GROUP INFORMATION

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. () _____ Fax No. () _____

Company Officer's Name _____ E-Mail Address _____

Title _____

Group Contact _____ Title _____ Telephone No. () _____

E-Mail Address _____

Address Same as above _____

Additional Office Locations _____

Taxpayer ID Number _____

SECTION II: BILLING

Premium invoices should be sent to: _____

Telephone No. () _____ E-Mail Address _____

Address _____

Contact Person *(if different than above)* _____

Telephone No. () _____ E-Mail Address _____

SECTION III: GROUP ADMINISTRATION

1. Please check all applicable class(es) and number of employees eligible for the EmblemHealth coverage for which you are applying (note that classes must be based upon conditions pertaining to employment):

Management Non-Management Union Part Time Other

If you checked "Other" above, please identify the other class(es): _____

NOTE: Employees must work at least 20 hours per week for applicant in order to be eligible for EmblemHealth coverage. Retirees are not eligible for coverage under EmblemHealth small group programs.

Employer's quarterly report of wages paid to each employees (NYS-45) must be supplied to EmblemHealth within 15 days after it is filed with New York State.

2. For EmblemHealth skip to question 3. If your Group is an association, chamber of commerce or fund comprised of one or more employees or labor unions, please identify the total number of member groups by the following group size(s):

_____ Total number of member groups with 50 or fewer eligible employees.

_____ Total number of member groups with 51 and above eligible employees.

3. Please specify the current number of COBRA Participants: _____

4. Indicate number of enrollees eligible for EmblemHealth by coverage type: _____

Individual _____ Employee/Spouse _____ Employee/Child(ren) _____ Family

5. Pre-Existing Condition Limitation:

There will be a waiting period of up to 12 months for benefits for any condition for which medical advice, diagnosis care or treatment was recommended or received during the six-month period ending on a member's enrollment date. This waiting period will be reduced to the extent that a member is entitled by law to a credit for prior continuous creditable coverage. The certificate of insurance or certificate of coverage will contain more information about the pre-existing condition waiting period and the types of coverage that qualify as prior continuous creditable coverage. The CompreHealth program applies a 12 month pre-existing condition limitation. Other EmblemHealth small group products apply an 11 month pre-existing condition limitation.

6. What is the nature of the Business or Organization? _____

Which of the following describes your Company or Organization?

Employer/Employee Group Business Association Fraternal/Religious Organization

Sole Proprietor Partnership Non-Profit Organization

Other Group, please describe _____

Which of the following describes your type of Association?

Trade Association Labor Union and Employer Trust

Professional Association Chamber of Commerce

Credit or Bank Association Special Association (Approved by Department of Insurance)

7. Is your Company or Organization a Subsidiary, Division or an Affiliate of another Company?

Yes No

SECTION IV: OTHER COVERAGE

OTHER GROUP HEALTH OR HMO COVERAGE

Please complete the information below for your other group health coverage which is still in force or which was terminated within the past 12 months.

Name and Address of Insurer	Type of Coverage	Effective Date of Policy	Termination Date of Policy

Was your group health coverage terminated for non-payment of premiums in the last 12 months?

Yes No

SECTION V: PRODUCT SELECTION

EMBLEMHEALTH PRODUCTS

Desired Effective Date: _____

PPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will the Program replace another group health coverage program? Yes No

Inbalance EPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will the Program replace another group health coverage program? Yes No

CompreHealth

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will the Program replace another group health coverage program? Yes No

EPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will the Program replace another group health coverage program? Yes No

CONSUMER DIRECT PPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will the Program replace another group health coverage program? Yes No

INBALANCE PPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will the Program replace another group health coverage program? Yes No

CONSUMER DIRECT EPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will the Program replace another group health coverage program? Yes No

EMBLEMHEALTH DENTAL

SECTION VI: ENROLLMENT POLICIES CLASS

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth Program premiums for your employees and their dependents.

Employee: _____ % or \$ _____ **Family:** _____ % or \$ _____

Other: _____

NEW HIRE ELIGIBILITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth Program.

Date of Hire First of the month following date of hire

PLUS:

30 Days 60 Days 90 Days Other: _____

Waived for Rehire? Yes No If rehired within _____ days of rehire.

If more than one class of employees will covered, please complete **Section (VI-A)** on next page.

SECTION VI-A: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth Program premiums for your employees and their dependents.

Employee: _____ % or \$ _____

Family: _____ % or \$ _____

Other: _____

NEW HIRE ELIGIBILITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth Program.

Date of Hire

First of the month following date of hire

PLUS:

30 Days

60 Days

90 Days

Other: _____

Waived for Rehire? Yes No If rehired within _____ days of rehire.

For additional classes, please continue on a separate piece of paper.

SECTION VII

A. For employer groups comprised of one or more employees, please check your current employer status below to ensure proper coordination of benefits for your Medicare Eligible Active Employees (you must check one of the two boxes below)

Employed fewer than twenty (20) full time or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).

Employed twenty (20) or more full or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year)

NOTE: All employers that are treated as a single employer under Internal Revenue Code Section 52 must be treated as a single employer for purpose of the Medicare secondary payer rules. According to Internal Revenue Code Section 52, all employees of all corporations that are members of the same controlled group of corporations must be treated as employed by a single employer. This means that if a parent company owns at least fifty percent (50%) of a subsidiary, then the number of employees of the parent and the subsidiary must be combined for purposes of determining the 20-employee threshold. Similarly, brother-sister corporations may be combined in some cases if the parent corporation owns at least fifty percent (50%) of the brother-sister corporations.

B. Please check here if your group is a large group health plan. A large group health plan is a plan of, or contributed to by, an employer or employee organization to provide health benefits that cover the employees of at least one (1) employer that normally employed at least one hundred (100) employees on a typical business day during the preceding calendar year.

SECTION VIII

The group agrees to do the following:

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York, or Group Health Incorporated the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify HIP Health Plan of New York, and/or Group Health Incorporated of the termination or addition of any Member(s) covered or to be covered by HIP or GHI.
- Promptly provide HIP Health Plan of New York, or Group Health Incorporated with any information necessary to properly administer the coverage.
- Ensure compliance with ERISA/TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to group's coverage, as applicable.

It is understood that:

- If an acceptable employee enrollment form is received prior to the eligibility date, coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt.
- All group applications are subject to approval by HIP Health Plan of New York, and/or Group Health Incorporated.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and/or Group Health Incorporated, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the eligibility of the actual enrollees. Any material misrepresentation within this group application or the enrollee transaction and application form, whether intentional or unintentional, may cause termination of this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents; and I will provide to an enrollment form or a waiver of coverage form signed by each eligible employee within thirty (30) days of his/her eligibility date.

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. The premium deposit submitted with this application will be refunded if coverage does not become effective.

Subject to applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from the effective date of this Contract.

All statements in this application for coverage under a Contract for insurance shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at: _____

On the _____ Day of _____, 20_____

By: _____ Title: _____

By: _____

Please return this completed application and the following items:

- *Employer's Quarterly Report of Wages Paid to Each Employee (NYS-45)*
- Copy of a 12 month old (or more recent, if necessary) billing statement
- First month's premium
- Product Check-off Sheet

To: **EmblemHealth**
New Business/Sales
Attn: BrokerAdministrative Rep.
55 Water Street New York, NY 10041

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING

SECTION IX

To be completed by EmblemHealth General Agent or Selling Agent.

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. () _____ Fax No. () _____

Group Contact _____ E-Mail Address _____

Desired Effective Date _____

Effective Date Changed Since Original Application? Yes No

Master Agency _____ MA No. _____ Override _____

EmblemHealth Group No. _____ Marketing Rep _____

Deposit Check Attached Yes No Amount: \$ _____

Proof of Employment Yes No

Last Paid Premium Invoice from Current Carrier Yes No

COBRA Letters of Election Yes No

Proof of Medicare Eligibility, Part A and B Yes No

GA Authorized Signature _____

Date _____

