







**5. MEDICARE INFORMATION** For Medicare eligible only.

Please provide a copy of your Medicare (HIB) card. If a copy is not attached, we cannot process your Medicare benefits request.

I understand that if I become Medicare eligible while I am covered under this contract, any benefits I am entitled to under this contract will be reduced by any amounts paid by Medicare for those services, whether or not I apply for or submit a claim to Medicare.

Applicant Last Name

First Name

MI

Medicare ID Number

HIB Suffix

Part A Hospital Coverage Start Date (MMDDYY)

Part B Medical Coverage End Date (MMDDYY)

Spouse/Dependent's Last Name (if different)

First Name

MI

Medicare ID Number

HIB Suffix

Part A Hospital Coverage Start Date (MMDDYY)

Part B Medical Coverage End Date (MMDDYY)

**6. EMPLOYER INFORMATION** This section must be filled in by your group benefits administrator.

Group Name

Address

City

State

Zip

Applicant's Start Date of Full Time Employment (MMDDYY) Payroll/Department Location



Employee Number

Group Number

Group Sub Number

**7. SIGNATURES** I have read the certification and fraud statement below.

Applicant Signature

Date (MMDDYY)

Printed Name and Signature of Authorized Group Benefits Administrator

<b>Print</b>	<b>Signature</b>
<input type="text"/>	<input type="text"/>

Date (MMDDYY)

I certify that I am electing coverage as an employee, or former employee, retiree, current or former dependent of an active employee, or retiree, and am eligible for group coverage under the terms and conditions of the group's contract. I make this election on behalf of all eligible dependents and myself. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependent's, status; such change may result in a change of insurance status with Empire and that failure to make such notification may result in cancellation of the coverage by Empire.

Any other Empire coverage will end upon issuance of this coverage. If I do not agree to transfer my other coverage with Empire to this coverage, I understand that this application will not be accepted by Empire.

I authorize any healthcare provider, healthcare payor or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for use by Empire to administer the terms of my health benefits contract. I also authorize Empire to disclose such information to an Empire designee, my PCP and other providers, other payors, and the group contract holder, for purposes of continuity of care and medical management, disease management, health benefits contract administration, financial audits, and as otherwise required by law.

All statements and answers in this notice of election are true and are representations made to induce the issuance of the coverage. Any material misrepresentation may result in Empire's cancellation of coverage.

**Insurance Fraud Statement:** Any person who knowingly and with intent to defraud an 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 thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.



www.empireblue.com

# SMALL GROUP APPLICATION/CHANGE FORM (2-50 eligible employees)

Thank you for choosing Empire. Please fill out **all** items below and **print clearly in black or blue ink** in order for us to quickly and accurately process your group's application. Once you've completed this form, please sign in the space provided in **Section 11**.

Current Group Number (if applicable)

## 1. REASON FOR APPLICATION/CHANGE

(fill in one only)

New

Requested Effective Date (MMDDYY)

Change Existing Benefits

Revision or Renewal Date (MMDDYY)

Sales Representative Last Name

First Name

## 2. GROUP INFORMATION

Group Name (as it appears on documents attached)

Doing Business As

Group Mailing Address

City

State

ZIP (5+4)

County

Phone

Fax

Authorized Group Contacts

Primary Group Contact Last Name

Primary Group Contact First Name

Title

E-mail Address (Benefit Administrator) — mandatory

Secondary Group Contact Last Name

Secondary Group Contact First Name

Title



ENR6000BPB01



## 4. GROUP ELIGIBILITY

Note: Eligible persons are defined as employees (on the group's payroll, K1, etc.) whose regular work schedule is at least 20 hours per week under this group contract.

### Number of Employees

(a) Number of employees at all locations (include owners and partners, exclude COBRA)\*

(b) Number of retirees eligible for coverage

(c) Number of ineligible employees (check reason for ineligibility)

Temporary  Union  Part-Time

Other

(d) Number of net eligible employees (a + b - c)

Number of enrolling employees (include retirees and COBRA)

Employer contribution to retiree coverage

   %

Have you ever employed more than 20 employees?

Yes  No

If yes, please indicate the last year you had 20 or more employees

\*Empire requires proof of employment (i.e., NYS-45, payroll, etc.)

See small group underwriting guidelines for more info

### Eligibility Dates (complete both A & B)

#### A. Initial Enrollment of Group

All employees' and dependents' coverage will be in effect:

- On Group Effective Date
- After new employee eligibility is satisfied (see B)

All enrollment forms must be received no later than thirty (30) days following the new group effective date.

#### B. New Employees (after initial enrollment of group)

New employees will be eligible for coverage:

- Date of hire
- First day following:
- day(s) following date of hire
- month(s) following date of hire; or
- First of the month following:
- day(s) following date of hire
- month(s) following date of hire

All enrollment forms must be received no later than sixty (60) days following the member's eligibility date.

#### C. Employee Reinstatement Policy

Employees who are re-hired to the company are eligible for coverage:

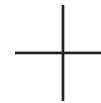
- Date of hire
- Other

Please specify: \_\_\_\_\_

### Regions of Residence

If you are choosing HMO, Direct HMO, Empire Total Blue<sup>SM</sup> with HSA, Direct POS or DirectShare<sup>SM</sup> POS, please check all regions your enrolling employees reside in from the list below.

- New York:** Bronx, Kings, Queens, New York, Nassau, Rockland, Westchester, Richmond and Suffolk counties.
- Mid-Hudson:** Dutchess, Putnam, Orange, Sullivan and Ulster counties.
- Albany:** Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.
- New Jersey Contiguous Counties:** Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex and Union counties.
- Connecticut Contiguous Counties:** Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham counties



## 5. PAYMENT SECTION Group's Contribution, if any.

% Employee only

% 2-Party

% Employee & Spouse

% Parent & Child(ren)

% Family

If your group has multiple locations, do you wish to receive (fill in one):

- Separate invoices for each location.  A summary invoice combining all locations.

If you are requesting quarterly billing, please indicate here; otherwise, group will be billed monthly.

\_\_\_\_\_

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## 6. MEDICAL BENEFITS SECTION

Please select all of the coverage options you wish to use, and then fill out the details under the coverage sections.

- HMO\*   
  Direct HMO\*   
  Direct POS\*   
  DirectShare<sup>SM</sup> POS   
  PPO   
  EPO   
  Value EPO  
 Comprehensive Hospital/Medical   
  Empire Total Blue<sup>SM</sup> with HSA   
  Empire Prism EPO   
  Other \_\_\_\_\_

\*HMO benefits provided by Empire HealthChoice HMO, Inc.

### HMO / DIRECT HMO

Please select only one product:     HMO     Direct HMO

#### Co-payment Options (fill in one only)

Co-payment Options	Inpatient Co-pay	PCP/Primary Home/Office Co-pay	Specialist Home/Office Co-pay	ER Co-pay	Ambulatory/OP Surgery Co-pay
<input type="radio"/> Opt 11	\$500	\$30	\$50	\$100	\$100
<input type="radio"/> Opt 12	\$1,000	\$30	\$50	\$150	\$150

\*per admission/family maximum per calendar year

#### Prescription Drug (includes contraceptives\*)

##### Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$10	\$35	\$70
<input type="radio"/>	\$10	50%	N/A <sup>†</sup>
<input type="radio"/>	\$15	N/A	N/A <sup>†</sup>

##### Deductible\*\* (fill in one only)

- \$0   
  \$50   
  \$100   
  \$150  
 \$250\*\*\*   
  \$500\*\*\*  
 No prescription drug coverage

\*Groups exempt from purchasing contraceptives must attach a signed affidavit.

\*\*Not applicable to mail-order program.

\*\*\*Available with 10/35/70 co-pay only

<sup>†</sup> Mandatory \$0 deductible

#### Rating Structure (fill in one only)

- 2-Tier   
  3-Tier   
  4-Tier

#### Miscellaneous Options (fill in all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 Inpatient rehabilitation for alcohol/substance abuse 30 days in-network  
 Waive waiting period for pre-existing conditions  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

## EMPIRE TOTAL BLUE<sup>SM</sup> COVERAGE W/ HSA OPTIONS

Option	In-Network				Out-of-Network			
	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Maximum	Out-of-Pocket Maximum Individual/Family	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Out-of-Pocket Maximum Individual/Family
<input type="radio"/> 1	\$1,250/ \$2,500	80/20%	\$10,000/ \$20,000	\$2,000/ \$4,000	\$5,000/ \$10,000	60/40%	\$25,000/ \$50,000	\$10,000/ \$20,000
<input type="radio"/> 2	\$1,500/ \$3,000	80/20%	\$17,500/ \$35,000	\$3,500/ \$7,000	\$3,000/ \$6,000	60/40%	\$17,500/ \$35,000	\$7,000/ \$14,000
<input type="radio"/> 3	\$2,000/ \$4,000	80/20%	\$15,000/ \$30,000	\$3,000/ \$6,000	\$3,500/ \$7,000	60/40%	\$17,500/ \$35,000	\$7,000/ \$14,000
<input type="radio"/> 4	\$2,000/ \$4,000	80/20%	\$15,000/ \$30,000	\$3,000/ \$6,000	\$10,000/ \$20,000	50/50%	\$40,000/ \$80,000	\$20,000/ \$40,000
<input type="radio"/> 5	\$2,500/ \$5,000	80/20%	\$12,500/ \$25,000	\$2,500/ \$5,000	\$4,500/ \$9,000	60/40%	\$20,000/ \$40,000	\$8,000/ \$16,000
<input type="radio"/> 6	\$3,000/ \$6,000	80/20%	\$10,000/ \$20,000	\$2,000/ \$4,000	\$10,000/ \$20,000	50/50%	\$40,000/ \$80,000	\$20,000/ \$40,000
<input type="radio"/> 7	\$5,000/ \$10,000	100%	N/A	N/A	\$10,000/ \$20,000	70/30%	\$66,667/ \$133,334	\$20,000/ \$40,000
<input type="radio"/> 8	\$3,000/ \$6,000	100%	N/A	N/A	\$6,000/ \$12,000	60/40%	\$30,000/ \$60,000	\$12,000/ \$24,000

#### Prescription Drug Option

- Drug Coverage (Generic \$10, Brand \$30, Non-Formulary \$50 after deductible\* and includes contraceptives\*\*)   
  No Drug Coverage at all

\*Rx Co-pays do not apply to Options 7 and 8 but drug option must be selected to receive coverage

\*\*Eligible groups exempt from purchasing contraceptives must submit a signed affidavit for consideration.

### Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)   
  Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network   
  Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 Group will establish HSA, but DOES NOT want Empire to facilitate   
  No additional options

## 6. MEDICAL BENEFITS SECTION (continued)

### DIRECT POS COVERAGE OPTIONS

	In-Network			Out-of-Network			
	PCP/Primary Home/Office Co-payment	Specialist Home/Office Co-payment	Inpatient Co-payment	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
<input type="radio"/> Option 1	\$15	\$15	\$0	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 2	\$15	\$15	\$250/\$625*	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 3	\$20	\$20	\$0	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 4	\$20	\$20	\$250/\$625*	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 5	\$20	\$20	\$500/\$1,250*	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 6	\$20	\$20	\$0	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 7	\$20	\$20	\$250/\$625*	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 8	\$20	\$20	\$500/\$1,250*	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 9	\$15	\$15	\$0	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
<input type="radio"/> Option 10	\$15	\$15	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
<input type="radio"/> Option 11	\$20	\$20	\$0	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
<input type="radio"/> Option 12	\$20	\$20	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
<input type="radio"/> Option 13	\$25	\$40	\$0	\$1,000/\$2,500	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> Option 14	\$25	\$40	\$0	\$1,500/\$3,750	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> Option 15	\$25	\$40	\$0	\$2,000/\$5,000	60%/40%	\$20,000/\$50,000	\$8,000/\$20,000
<input type="radio"/> Option 16	\$25	\$40	\$500/\$1,250*	\$2,000/\$5,000	60%/40%	\$15,000/\$37,500	\$6,000/\$15,000
<input type="radio"/> Option 17	\$30	\$50	\$1000/\$2,500*	\$2,000/\$5,000	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250

Out of Network UCR Option (Usual, Customary and Reasonable Fee Reimbursement)  70%  80%

Note: ER co-pay: Options 1–12 — \$50 Options 13–16 — \$75 Ambulatory/OP Surgery co-pay: Option 16 — \$75 \*per admission/family maximum per calendar year

#### Prescription Drug (includes contraceptives\*)

##### Co-pay Options (fill in one only)

Generic	Brand	Non-Formulary
<input type="radio"/> \$5	\$20	\$40
<input type="radio"/> \$10	\$20	\$40
<input type="radio"/> \$10	\$25	\$50
<input type="radio"/> \$10	\$35	\$70
<input type="radio"/> \$10	50%	N/A <sup>†</sup>
<input type="radio"/> \$15	N/A	N/A <sup>†</sup>

##### Deductible\*\* (fill in one only)

- \$0     \$50     \$100  
 \$150     \$250     \$500  
 No prescription drug coverage

\* Groups exempt from purchasing contraceptives must attach a signed affidavit.

\*\* Not applicable to mail-order program.

<sup>†</sup> Mandatory \$0 deductible

#### Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network  
 Waiver for pre-existing conditions  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

## 6. MEDICAL BENEFITS SECTION (continued)

### DIRECTSHARE<sup>SM</sup> POS OPTIONS Co-payment Options (fill in one only)

		PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	In-patient Co-Pay*	In-Network				Out-of-Network			
					Deductible*	Coinsurance*	Coinsurance Stop Loss*	Out-of-Pocket Coinsurance Max*	Deductible*	Coinsurance	Coinsurance Stop Loss*	Out-of-pocket Coinsurance Max
<input type="radio"/>	Option 1	\$25	\$40	Ded + Coins	\$ 250	90%/10%	\$10,000	\$1,000	\$1,500	70%/30%	\$10,000	\$3,000
<input type="radio"/>	Option 2	\$30	\$50	Ded + Coins	\$ 500	90%/10%	\$10,000	\$1,000	\$1,000	70%/30%	\$10,000	\$3,000
<input type="radio"/>	Option 3	\$30	\$50	Ded + Coins	\$ 500	80%/20%	\$10,000	\$2,000	\$1,000	60%/40%	\$10,000	\$4,000
<input type="radio"/>	Option 4	\$30	\$50	Ded + Coins	\$ 750	80%/20%	\$12,500	\$2,500	\$1,500	60%/40%	\$12,500	\$5,000
<input type="radio"/>	Option 5	\$30	\$50	Ded + Coins	\$1,000	80%/20%	\$15,000	\$3,000	\$2,000	60%/40%	\$15,000	\$6,000

Out of Network UCR Option (Usual, Customary and Reasonable Fee Reimbursement)  70%  80%

Note: ER co-pay \$75 \*Family coverage is 2.5 times the individual coverage amount.

#### Prescription Drug (includes contraceptives\*) Co-pay Options (fill in one only)

Generic	Brand	Non-Formulary	
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$30	\$50
<input type="radio"/>	\$10	\$35	\$70
<input type="radio"/>	\$10	50%	N/A <sup>†</sup>
<input type="radio"/>	\$15	N/A	N/A <sup>†</sup>

#### Deductible\*\* (fill in one only)

- \$0     \$50     \$100  
 \$150     \$250     \$500  
 No prescription drug coverage

\* Groups exempt from purchasing contraceptives must attach a signed affidavit.

\*\* Not applicable to mail-order program.

<sup>†</sup> Mandatory \$0 deductible

#### Miscellaneous Options

(check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network  
 Waiver for pre-existing conditions  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

### EPO COVERAGE OPTIONS

In-Network Options (fill in one only) Office Visit Co-payment  \$12     \$20     \$30

#### Prescription Drug (includes contraceptives\*) Co-pay Options (fill in one only)

Generic	Brand	Non-Formulary	
<input type="radio"/>	\$10	\$20	\$40
<input type="radio"/>	\$10	\$25	\$50

#### Deductible\*\* (fill in one only)

- \$0     \$50     \$100  
 \$150     No prescription drug coverage

\* Groups exempt from purchasing contraceptives must attach a signed affidavit.

\*\* Not applicable to mail-order program.

#### Miscellaneous Options (check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

## 6. MEDICAL BENEFITS SECTION (continued)

### VALUE EPO OPTIONS Co-payment Options (fill in one only)

	In-Network						
	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	In-patient Co-Pay*	Deductible*	Coinsurance*	Coinsurance Stop Loss*	Out-of-Pocket Coinsurance Max*
<input type="radio"/> Option 1	\$30	\$30	Ded + Coins	\$1,000	90%/10%	\$10,000	\$1,000
<input type="radio"/> Option 2	\$30	\$30	Ded + Coins	\$1,500	90%/10%	\$10,000	\$1,000
<input type="radio"/> Option 3	\$30	\$30	Ded + Coins	\$2,000	80%/20%	\$10,000	\$2,000
<input type="radio"/> Option 4	\$30	\$30	Ded + Coins	\$500	80%/20%	\$20,000	\$4,000
<input type="radio"/> Option 5	\$30	\$30	Ded + Coins	\$3,000	80%/20%	\$10,000	\$2,000

Note: ER co-pay \$100 \*Family coverage is 2.5 times the individual coverage amount.

### Prescription Drug (includes contraceptives\*) Co-pay Options (fill in one only)

Generic	Brand	Non-Formulary
<input type="radio"/> \$10	\$25	\$50
<input type="radio"/> \$10	\$35	\$70
<input type="radio"/> \$10	50%	N/A†
<input type="radio"/> \$15	N/A	N/A†

### Deductible\*\* (fill in one only)

- \$0     \$50     \$100  
 \$150     \$250     \$500  
 No prescription drug coverage

\*Groups exempt from purchasing contraceptives must attach a signed affidavit.

† Mandatory \$0 deductible

\*\* Not applicable to mail-order program.

### Miscellaneous Options (check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 4th Quarter Deductible Carry Over  
 Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

### PPO COVERAGE OPTIONS

In-Network Options (fill in one only) Office Visit Co-payment  \$12     \$20     \$30

Out-of-Network Options (fill in one only)

	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
<input type="radio"/> 1	\$500/\$1,250	70%/30%	\$5,000/\$12,500	\$1,500/\$3,750
<input type="radio"/> 2	\$500/\$1,250	70%/30%	\$10,000/\$25,000	\$3,000/\$7,500
<input type="radio"/> 3	\$750/\$1,875	70%/30%	\$15,000/\$37,500	\$4,500/\$11,250
<input type="radio"/> 4	\$1,000/\$2,500	70%/30%	\$25,000/\$62,500	\$7,500/\$18,750

### Prescription Drug (includes contraceptives\*) Co-pay Options (fill in one only)

Generic	Brand	Non-Formulary
<input type="radio"/> \$10	\$20	\$40
<input type="radio"/> \$10	\$25	\$50

### Deductible\*\* (fill in one only)

- \$0     \$50     \$100  
 \$150     No prescription drug coverage

\* Groups exempt from purchasing contraceptives must attach a signed affidavit.

\*\* Not applicable to mail-order program.

### Miscellaneous Options (check all of the following options you wish to purchase)

- Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)  
 Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage  
 No additional options

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## 6. MEDICAL BENEFITS SECTION (continued)

### EMPIRE PRISM EPO OPTIONS

Is Empire the sole carrier offered by the group?  Yes  No

Select the following new Copay Options and prescription drug card choice if applicable.

#### Co-payment Options (fill in one only)

Co-Payment options	Inpatient Co-Pay	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	ER Co-Pay	Ambulatory/ OP Surgery Co-Pay
<input type="radio"/> Option 1	\$200/\$500*	\$25	\$25	\$100	\$150
<input type="radio"/> Option 2	\$500/\$1,250*	\$35	\$35	\$100	\$300
<input type="radio"/> Option 3	\$500 per day; 3 day max	\$45	\$45	\$100	\$300

\* per admission/family maximum per calendar year

#### Prescription Drug (includes contraceptives)

##### Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
<input type="radio"/>	\$10	\$35	\$70*
<input type="radio"/>	\$10	\$35	\$70 (\$2,000 max)
<input type="radio"/>	\$10	50%	N/A <sup>†</sup>
<input type="radio"/>	\$15	N/A	N/A <sup>†</sup>

##### Deductible (fill in one only)

- \$0       \$50  
 \$100       \$250  
 \$500

\* \$0 Deductible not Allowed

<sup>†</sup> Mandatory \$0 Deductible.

##### Miscellaneous Options

(fill in all of the following options you wish to purchase)

- Dependent children/student age increase from 19/23 to 23/25 (end of calendar year)  
 Inpatient rehabilitation for alcohol/substance abuse 30 days in-network  
 Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage

#### Rating Structure (fill in one only)

- 2-Tier (Upstate & Mid-Hudson regions)     
  3-Tier (Upstate & Mid-Hudson regions)     
  4-Tier (All rating regions)

## 7. DENTAL BENEFITS SECTION

Please select the dental product and coverage options you wish to purchase.

No Coverage

Premium Care PPO

(fill in one only)

Coinsurance In-Network	Coinsurance Out-of-Network
---------------------------	-------------------------------

100%/80%/50%     100%/80%/50%

100%/80%/50%     80%/60%/50%

Deductible (fill in one only)

\$25/\$75     \$50/\$150

Annual Maximum (fill in one only)

\$1,000     \$1,500

Orthodontics\*\*

\*\* Contact your Sales representative for availability of this option.

Managed Dental Programs\* (fill in one only)

Preventive Care—\$10 co-payment on diagnostic and preventive procedures only

Preventive Care Plus—Adds Basic Restorative coverage

Comprehensive Care

Plan 1     Plan 2     Plan 3

Office visit co-pays

\$0     \$5     \$10

Orthodontics\*\*

Child only     Child and adult

Ortho co-pay max per member

\$2,000     \$2,500     \$3,000

Dependent/student age

19/23 ECY     23/25 ECY

\* Existing groups can attach member listing with PCD selection.

\*\* Contact your Sales Representative for availability of this option.

Progressive Dental

Age 23/25 Rider

Open Access—Voluntary

(fill in one only)

Coinsurance	Deductible	Orthodontics**
-------------	------------	----------------

100%/50%/50%    \$25     Child only

100%/50%/30%    \$50    Not Available

100%/50%/0%    \$50    Not Available

\*\*Contact your Sales Representative for availability of this option.

Group's Contribution, if any.

% Employee only

% 2 Party

% Employee & Spouse

% Parent & Child(ren)

% Family

Other coverage

Does your group currently have dental coverage from any carrier, including Empire?

Yes     No

If yes, Insurance Carrier

Coverage Type (ex: DHMO, PPO, Indemnity)

Coverage start date (MMDDYY)

Coverage end date (MMDDYY)

## 8. VISION BENEFITS SECTION

Please select the vision product and coverage options you wish to purchase.

No Coverage

Blue View Vision — Exam Only Benefits

Exam Frequency

Every 12 Months

Every 24 Months

Exam Co-Pay

\$0

\$5

\$10

\$15

Blue View Vision — Exam and Material Benefits

Frequency - Exam/Lenses/Frames

12/12/12

12/12/24

12/24/24

24/24/24

Co-Pay - Exam/Lenses

\$5/\$0

\$10/\$0

\$10/\$10

\$10/\$20

\$20/\$20 Co-Pay

Includes a \$130 Frame or Contact Lenses Allowance

Group's Vision Contribution

% Employee only

% 2 Party

% Employee & Spouse

% Parent & Child(ren)

% Family

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## 9. AGENT/BROKER DECLARATION AND INFORMATION

To the best of my knowledge, all the statements/responses in this application are true and complete. I have no knowledge about the Applicant, his/her employees, the dependents of such employees or an individual who is receiving continuation of coverage under federal or state laws which is not fully stated in this application.

1st BROKER Commissions: % of split

100

Agent or Brokerage of Record Name

NORMAN J. MICHAELS

Social Security/Tax ID Number

13-3165414

Company Name

NORMAN J. MICHAELS & ASSOCIATES, INC

E-mail Address

PMILLER@MICHAELS-ASSOCIATES.COM

Mailing Address

80 BUSINESS PARK DRIVE, SUITE 306

City

ARMONK

State

NY

ZIP (5+4)

10504

County

WESTCHESTER

Phone

914-273-4723

Fax

914-273-4728

1st Broker Signature

Date (MMDDYY)

2nd BROKER Commissions: % of split

Agent or Brokerage of Record Name

Social Security/Tax ID Number

Company Name

E-mail Address

Mailing Address

City

State

ZIP (5+4)

County

Phone

Fax

2nd Broker Signature

Date (MMDDYY)

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# 11. OPTIONAL EMPLOYER ONLINE SERVICES DELEGATION FORM

Empire BlueCross BlueShield is offering Group Benefit Administrators an opportunity to delegate the administration of their accounts to their Broker of Record. The Broker of Record will perform the administrative duties assigned to him or her by the Group Benefits Administrator via Empire's secure Broker Online Services web site at [www.empireblue.com](http://www.empireblue.com).

Please complete this form and the Terms and Conditions Letter Agreement (the "Agreement") if you would like to permit your Broker of Record to administer your account for you. Please be sure to discuss this delegation with your broker prior to submission.

**Please mail or fax this form to:**

Broker Relations  
 15 MetroTech Center, 4th Fl.  
 Brooklyn, NY 11201  
 Fax: 1-718-312- 6006

Please note: By filling out this form and the Agreement and giving your Broker of Record access to manage your account, you are not giving up your right to access your account through Employer Online Services or to administer your account.

**Please check if you would like to:**

- Delegate administration of your account to your Broker of Record to
  - Manage only existing sub-groups
  - Manage all existing and future sub-groups
- Delegate to your Broker of Record the ability to add/cancel users
- Change your Broker of Record's access level
- Terminate a Broker of Record's administrative rights to manage your account\*

**Please check all activities that you would like to delegate to your Broker of Record:**

- Basic Group Admin
- View Group Forms
- View Claims
- Enroll Employees and Perform Enrollment Changes
- View Roster (2-500)
- Basic Employee Admin
- View Employee Forms
- View Billing
- Request ID Cards
- Perform Demographic/Dependent Changes

**Please complete your contact information:**

Print Last Name	Print First Name	
<input type="text"/>	<input type="text"/>	
Company Name	Base Group Number	
<input type="text"/>	<input type="text"/>	
Renewal Date (MMDDYY)	E-mail Address (optional)	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Please provide your Broker of Record's contact information:**

Print Last Name	Print First Name	
<input type="text" value="MICHAELS"/>	<input type="text" value="NORMAN"/>	
License Number	E-mail Address (optional)	Date of Birth (MMDDYY)
<input type="text" value="LA-649358"/>	<input type="text" value="NMICHAELS@MICHAELS-ASSOCIATES.COM"/>	<input type="text" value="06/20/51"/>

\* You will not be able to assign a new Broker of Record using this form. Please check the box only if you would like to terminate your current Broker of Record's administrative rights.



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**11. TERMS AND CONDITIONS LETTER AGREEMENT FOR ACCESS TO THE EMPIRE EMPLOYER ONLINE DELEGATION** (continued)

This Terms and Conditions Letter Agreement (the "Agreement") sets forth the understandings and agreement between \_\_\_\_\_ ("the Group") and Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross BlueShield and Empire HealthChoice HMO, Inc., d/b/a Empire BlueCross BlueShield HMO (together referred to as "Empire"), to permit access to Empire's interactive Employer Online Services web site ("web site") for use by the Broker of Record, or an authorized designee of the Broker of Record (together referred to as "brokers"), designated by the Group, to facilitate the administration of the health benefit plan(s) (the "plan(s)") purchased by the Group from Empire pursuant to a separate Contract (the "Contract"). The Group understands and agrees that access to the web site granted by Group to its designated brokers is subject to the following terms and conditions:

- 1. Empire shall provide those brokers designated by the Group access to the Employer Online Services web site in accordance with Empire's registration procedures. The Group understands that all designated brokers must agree to the web site Terms and Conditions.
- 2. The Group understands that the purpose of this web site is to provide an additional medium for the Group, through its designated brokers, to carry out the certain plan administration functions as delegated by the Group, including the ability to: maintain eligibility files, process enrollment and enrollment changes for members and dependents, select and change PCPs on behalf of and at the request of a member, search for participating providers, view certain claims information on behalf of and at the request of a member, request ID cards and print temporary cards, maintain and update COB information, and view statements of account(s), access billing reports, pay and/or adjust bills, and other functions as may be added from time to time by Empire and delegated by the Group.
- 3. The Group is solely responsible for the accuracy and authenticity of the information submitted on the web site.
- 4. This agreement relates solely to access by the brokers designated by the Group to the web site and does not add, diminish or otherwise change the obligations of the parties, which remain subject to the Contract, any other agreements executed by the parties, the contracts of health insurance coverage issued by Empire, and Empire policies and procedures. In the event of a conflict between this agreement and any of the aforementioned, the aforementioned shall control.
- 5. The Group shall advise Empire, in writing, of the names and other information as requested by Empire, of its brokers who shall have web site access, and shall timely notify Empire of brokers who no longer are authorized to access the web site. Notice shall be sent by fax to 1-718-312-6006.
- 6. Any data accessed and/or provided to the Group or to its brokers on the web site shall remain the property of Empire.
- 7. Empire is not responsible for the accuracy and completeness of records supplied to Empire by the Group, the brokers or by health care providers.
- 8. The Group and its representatives shall maintain and preserve the confidential and proprietary nature of all Empire's data to which the Group and its representatives have access. The Group shall not provide either web site access, or other access to Empire's proprietary and confidential information available to the Group on the web site, to any unauthorized party, or in a manner in conflict with this Agreement.
- 9. The Group will hold Empire, its officers, directors and agents, harmless from any loss, expense, liability, claim, lawsuit or judgement (including reasonable attorneys' fees) arising directly or indirectly out of Empire's disclosure of the Group's enrollment and/or claims information or from the Group's provision to Empire of enrollment information, or resulting from the Group's failure to abide by the terms of this Agreement.
- 10. The obligations undertaken herein in Paragraphs 8 and 9 above shall survive the expiration or termination of this Agreement.
- 11. Nothing contained in this Agreement shall be construed as granting or conferring any rights by license, patent, copyright or any other intellectual property right of one party to the other.
- 12. This Agreement shall terminate:
  - a. by Empire or the Group upon five (5) business days written notice by facsimile transmission, or otherwise, or as otherwise agreed to by the parties hereto in writing;
  - b. if prohibited by any law or regulation;
  - c. six (6) months after the termination of the Contract.
- 13. If the Group has more than one health benefits plan under the terms of its Contract, the Group's designated brokers shall have access, if such access is delegated to the brokers, to any of its health benefits plans that may terminate during the term of the Contract, for the earlier of twenty-four (24) months after termination of the specific health benefits plan or six (6) months after the termination of the Contract.

Please sign and date this Agreement in the space provided below to confirm your agreement to these terms and conditions, and return the fully executed original at your earliest convenience.

Sincerely,



Mark Wagar  
President

Acknowledged and Agreed to

This \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: Group Benefits Administrator



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