Group Information

I. Doing Business As (DBA) Name_____

II. Full Legal Name of Group_____

III. Primary Address of Group_____

City_____ State_____ Zip_____ County_____

Phone Number_____ Email Address_____

IV. Tax Identification Number:_____

V. Plan Administrator/Contact:

1. Name_____
2. Title_____
3. Address_____

   City_____ State_____ Zip_____ County_____
4. Phone Number_____
5. Fax Number_____
6. Email Address_____
7. Additional Contact_____
8. Additional Phone Number_____

Billing Information (only if different than above)

I. Send Billing Statements to:

1. Name_____
2. Title_____
3. Address_____

   City_____ State_____ Zip_____ County_____
4. Phone Number_____
5. Fax Number_____
6. Email Address_____

II. Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):

_____

Group Administration

To be eligible for small group coverage, your employees must live, work or reside within [Bronx, Brooklyn (Kings), Nassau, New York, Queens, Staten Island (Richmond), Suffolk, or Westchester] county (the "Service Area") where CareConnect Insurance Company, Inc. products are available. Eligibility requirements for coverage of members outside the service area vary by State. Your application will be reviewed and you will be contacted if there are any questions regarding your employee census. Groups must have between 1 and 100 full-time equivalent employees.

1. Requested effective date: _____
   (Note: With respect to the group's policy, only a first of the month effective date is permitted)
2. How many total Full Time Equivalent [FTE] employees does this group have?_____

   Total FTE employees means the average number of employees, including seasonal and/or part time employees, during the prior calendar year, as calculated by 26 U.S.C. Section 4980H (c) (2).
3. How many eligible employees does this group have?_____

   Eligible employees are active employees of the employer and of all subsidiaries or affiliates of a corporate employer who work 20 or more hours per week and are eligible for health benefits through the employer's group health plan. Eligible employees include any person who is a common law employee and who performs services for the company.

   An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours and occupational duties. Employees who work less than 20 hours per week are not eligible employees and may not enroll in any CareConnect Insurance Company, Inc. products. If coverage is limited to specific class(es) of employees, the classes must be specified in response to question 11 below.

   Eligible employees must live, work or reside in the Service Area OR live, work or reside in certain states outside of the Service Area so long as certain criteria are met.
4. Total number of eligible employees who live, work or reside in the Service Area being offered coverage through this product: _____

   If you have eligible employees living, working or residing outside the Service Area, please contact us to discuss whether we will cover some or all of those employees.
5. If the employer offers retiree coverage, how many eligible retired former employees does this group have?
   _____

   Integration with Medicare benefits: If the group offers retiree coverage, health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over who have elected Medicare.

6. Total number of employees and former employees enrolling:_____

   Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage with any CareConnect product.

   a. Of those former employees enrolling, how many are retired?_____

   b. Of those former employees enrolling, how many are enrolling through COBRA or state continuation?

   _____

7. Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)? ☐ Yes ☐ No

8. Is the Employer offering other group or HMO coverage to employees who are eligible for coverage in a CareConnect Insurance Company, Inc. product*? ☐ Yes ☐ No

9. List past group health or HMO coverage offered by Employer*:

   _____

10. Waiting period/classes

    If coverage is being limited to particular class(es) of employees, specify class definition(s) below. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Although an Employer may establish a class of employees who work less than 20 hours per week, CareConnect Insurance Company, Inc. products are not available to employees who work less than 20 hours per week.

    If classes and waiting periods are not specified below, all eligible employees who work 20 or more hours per week will be eligible for group health benefits under a CareConnect Insurance Company, Inc. policy without a waiting period.

*Coverage will not be denied based on the responses to these questions.

CLASS I

Definition of Class I:_____

A) Eligibility/Effective Date of Coverage and Termination

Please choose one of the following two choices:

☐ Employees are eligible for coverage as of the date on which the employee completes _____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the date of termination of employment.

☐ Employees are eligible for coverage as of the first day of the calendar month coinciding with or next following the date on which the employee completes_____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the last day of the calendar month.

B) Waiting Period for Rehires

Maximum Waiting Period is 90 days.

Waiting Period waived for Rehires? ☐ Yes ☐ No

If yes, waived if rehired within_____months (cannot exceed 90 days)

CLASS II

Definition of Class II:_____

A) Eligibility/Effective Date of Coverage and Termination

Please choose one of the following two choices:

☐ Employees are eligible for coverage as of the date on which the employee completes _____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the date of termination of employment.

☐ Employees are eligible for coverage as of the first day of the calendar month coinciding with or next following the date on which the employee completes_____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the last day of the calendar month.

B) Waiting Period for Rehires

Maximum Waiting Period is 90 days.

Waiting Period waived for Rehires? ☐ Yes ☐ No

If yes, waived if rehired within_____months (cannot exceed 90 days)

CareConnect EPO Plan Selection*

Choose a plan—please check one of the following:

☐ Standard Platinum	☐ Standard Gold	☐ Standard Silver	☐ Standard Bronze
☐ Tradition Platinum 30/30	☐ Tradition Gold Copay	☐ Tradition Gold 30/50/1000	☐ Tradition Gold 40/60
☐ Tradition Silver HSA 100%	☐ Tradition Bronze HSA 100%	☐ Value Platinum	☐ Value Gold 20/50
☐ Value Gold 45/45	☐ Value Silver	☐ Access Platinum 30/30	☐ Access Gold Copay
☐ Access Silver 40/60	☐ Access Silver HSA 100%	☐ Access Bronze HSA 70%	☐ Access Value Platinum
☐ Access Value Gold 20/50	☐ Access Value Gold 45/45	☐ Access Value Silver	

☐ Other _____

Accumulation period for deductible and max OOP: ☐ Contract year ☐ Calendar year

Include age 29 rider (if you intend to cover a dependent over age 26 this is required): ☐ Yes ☐ No

Domestic partner and family planning benefits are included in each plan. Any changes must be made by calling our dedicated sales number at 855-228-0541.

Rate Information

All new groups are subject to the four-tier rate structure below. Rates must be included in the spaces below for application processing. Please note that all four categories must be completed.

Plan #1 Rates

Single	Couple	Parent/Child(ren)	Family

Plan #2 Rates (if applicable)

Single	Couple	Parent/Child(ren)	Family

Broker/GA Information

	Broker	Co-Broker	General Agent
Name of Payee			
CareConnect's Broker and/or General Agency Code			
NYS License #			
Payee's SS # or Federal Tax ID #			
Commission Split			
Sales Representative			

*Summary of Benefits and Coverage documents (SBCs) for all CareConnect plans are available at CareConnect.com.

Broker Consent

Authorization for Broker to Act as Benefits Administrator

The undersigned hereby requests CareConnect Insurance Company, Inc. to accept the Brokers or General Agents named above as an authorized Benefits Manager for purposes of processing any enrollment transactions for my company's CareConnect Insurance Company, Inc. policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations). This authorization shall be effective immediately and shall (check one only):

- ☐ Remain in place until it is expressly revoked by me in writing.
- ☐ Remain in place until_____

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Member. I acknowledge that I must notify CareConnect Insurance Company, Inc. in writing to void this agreement in the event of a change in my company's Broker of Record.

Applicant Agreement

This Application and the premium rates proposed by CareConnect Insurance Company, Inc. are subject to approval, in writing, by CareConnect Insurance Company, Inc. We reserve the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. We also retain the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example due to an intentional misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above named company (the "Applicant") am applying for small group health coverage and understand that the information provided will be used to determine eligibility for coverage, premium rates and for other purposes. I confirm that all information gathered herein is accurately represented, complete, and that the Applicant is not aware of any material information that was not disclosed.

The Applicant confirms that it employed no more than 100 full-time equivalent employees and no fewer than 1 eligible active permanent employees over the previous calendar year.

The Applicant understands that this Application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after enrollment. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group did not meet underwriting requirements, the group will not be enrolled (audit completed prior to enrollment) or will be terminated (audit completed post enrollment).

The Applicant understands that other audits may be conducted while the Group Policy and Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this application does not constitute any obligation by CareConnect Insurance Company, Inc. to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by the CareConnect Insurance Company, Inc. entity underwriting the coverage. The Applicant hereby confirms that it will not cancel any current health coverage it may currently have in anticipation that this application will be accepted by CareConnect Insurance Company, Inc. Final rates will be based on enrollment data as of the Policy effective date.

No contract of insurance is to be implied in any way on the basis of completion and/or submission of this Application. If coverage is formally accepted, the Applicant understands that this application and any subsequent addenda (including, but not limited to, any member application forms and renewal certifications) will become part of the Group Policy and Group Enrollment Agreement issued by CareConnect Insurance Company, Inc.

Any material intentional misrepresentation within the application or the addenda may subject the group to termination or other action permitted by law. By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement. The plan documents (including, but not limited to, the application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependents who are eligible for coverage will be enrolled.

By signing below, you are signing the group application on behalf of the group applying for coverage and stating that
(1) I am the Applicant or the agent for the Applicant and am authorized to sign this Group Application and
(2) the Applicant will be legally bound by the terms and conditions of the application, this authorization and the plan documents.

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 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 $5,000 dollars and the stated value of the claim for each violation.

Dated at:_____this_____day of_____20_____

Full legal name of firm:_____

Signature of Authorized Company Representative:_____

Title:_____

Witness Duly Licensed Resident Agent/Broker:_____

CareConnect
Attention: Group Enrollment
2200 Northern Blvd., Suite 104, East Hills, NY 11548
P: 855-706-7545 F: 844-266-4343 CareConnect.com

CareConnect Insurance Company, Inc. ("CareConnect") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CareConnect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CareConnect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CareConnect's Senior Director, Quality Improvement.

If you believe that CareConnect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CareConnect

Senior Director, Quality Improvement

2200 Northern Blvd., Suite 104, East Hills, NY 11548

Phone: 855-706-7545

TTY: 855-226-7318

Fax: 844-447-2525

Email: CareConnectAppeals@nslijcc.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Senior Director, Quality Improvement is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building, Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-226-7318 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-226-7318 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務. 請致電 1-855-226-7318 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-226-7318 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-226-7318 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-226-7318 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-226-7318 (TTY: 711).

אטענטיאן: אויב איר רעדט ייִדיש, זענען פֿאַראַנטוואָרטלעך שפּראַך הילף סערוויסעס פֿאַר אײַך, פֿריי פֿון אָפּצאָל. רופֿט 1-855-226-7318 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-226-7318 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-226-7318 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-226-7318 (رقم هاتف الصم والبكم: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-226-7318 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-226-7318 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-226-7318 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-226-7318 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-226-7318 (TTY: 711).