healthfirst
Health Insurance for New Yorkers

Healthfirst Insurance Company, Inc.

Small Group Employer Enrollment Application

1–100 FTE Employees

Mailing Address: Healthfirst Insurance Company, Inc., P.O. Box 1566, New York, NY 10008-1516
Broker Services: 1-855-456-3668
Employer Services: 1-855-949-3668

Please print neatly using black or blue ink, complete the enrollment form in full, and sign the last page. Incomplete or unsigned forms will not be processed.

Section 1 | Group Information

Full Legal Name of Company		Doing Business As (DBA)		Tax ID
Owner/CEO				
Primary Business Address		City	State	Zip Code
County	Phone Number		Fax	
Benefit Administrator/Contact's Full Name				
Address	City	State	Zip Code	County
Phone Number	Email			
Additional Contact Name		Additional Phone Number		
Additional Email				

What is the nature of your business/organization?

Which of the following describes your business/organization?

☐ Employer/Employee Group ☐ Business Association ☐ Fraternal/Religious Organization ☐ Partnership

☐ Sole Proprietor ☐ LLC ☐ LLP ☐ S Corp ☐ C Corp

☐ Nonprofit ☐ Other Group (please describe): _____

Is your company or organization a subsidiary, division, or affiliate of another company? ☐ Yes ☐ No

Full legal name of each subsidiary and/or affiliate company whose employees are to be covered (if applicable)	Tax ID

Section 2 | Billing Information

Send Billing Invoices to:				
Contact Name		Title		
Address (if different from Section 1)	City	State	Zip Code	County
Phone Number	Fax	Email		

Section 3 | Group Administration

To be eligible for small group coverage, the group must be in New York state and have employees who live, work, or reside in the Healthfirst Insurance Company, Inc. service area (Bronx, Kings, Nassau, Suffolk, New York, Queens, and Richmond counties).

Groups must have had between 1 and 100 FTE employees over the prior calendar year.
Sole proprietors are not eligible unless there is a minimum of two (2) individuals enrolling and one of the enrolling W-2s is a non-owner/non-spouse employee.

Please contact Broker or Employer Services with any questions.
Healthfirst Insurance Company, Inc. does not offer retiree coverage except in those instances where required by Federal law.

1. Requested Effective Date _____/_____/_____
   Note: Must be 1st of the month. Actual effective date will be assigned by Healthfirst if application is approved.
2. Total number of Full-Time Equivalent [FTE] employees? _____
   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. Total number of eligible employees who live, work, or reside in the Healthfirst Insurance Company, Inc. service area being offered coverage through this product: _____
   Eligible employees are active employees of the employer and all of subsidiaries or affiliates of a corporate employer who work 20 hours or more 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.
4. Total number of active employees enrolling: _____
5. If enrolling former employees, how many are enrolling through COBRA or state continuation?
   _____
6. Total number enrolling into coverage: _____
   Enrolling means the total number of active employees, COBRA, or State Continuation Enrollees (if applicable) accepting coverage.
7. Total number of employees with valid waivers of coverage: _____
   Please complete and submit the Waiver of Coverage Form for each applicable employee.
8. 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
9. Have you received a SHOP eligibility determination from NY State of Health (NYSOH) for this coverage year? ☐ Yes ☐ No
   If not, would you like Healthfirst to send your information to the NY State of Health Marketplace's Small Business Marketplace so they can determine your SHOP eligibility? ☐ Yes ☐ No

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 fewer than 20 hours per week, Healthfirst Insurance Company, Inc. products are not available to employees who work fewer than 20 hours per week.

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

New Employee Eligibility/CLASS I

Definition of Class I: _____

A) Eligibility/Effective Date of Coverage and Termination

Please choose one of the following two options:

☐ Employees are eligible for coverage as of the date on which the employee completes:
☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days 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 following the date on which the employee completes ☐ 0 days ☐ 30 days ☐ 60 days
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

Waiting period waived for rehires? ☐ Yes ☐ No
If yes, waived if rehired within: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
If no, continue to the next section. Maximum waiting period is 90 days.

New Employee Eligibility/CLASS II

Definition of Class II: _____

A) Eligibility/Effective Date of Coverage and Termination

Please choose one of the following two options:

☐ Employees are eligible for coverage as of the date on which the employee completes:
☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days 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 following the date on which the employee completes ☐ 0 days ☐ 30 days ☐ 60 days
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

Waiting period waived for rehires? ☐ Yes ☐ No
If yes, waived if rehired within: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
If no, continue to the next section. Maximum waiting period is 90 days.

Other Group Health Coverage

If you have other group health coverage which is still active or which was terminated within the past 12 months, please complete the information below.

Name of Insurer				
Address	City	State	Zip Code	County
Type of Coverage				
Effective Date of Policy	Termination Date of Policy			

Is the employer offering other group or HMO coverage to employees who are eligible for coverage in a Healthfirst product?* ☐ Yes ☐ No

List other current or past group health or HMO coverage offered by employer in the last three years:*

_____

_____

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

Section 4 | COBRA Coverage

COBRA/New York State Continuation of Coverage*

Do you have any individuals currently covered by a COBRA continuation? ☐ Yes ☐ No

If yes, how many? _____

Are there any dependents of enrolling employees who are currently disabled or in the hospital?

☐ Yes ☐ No

What is the length of the prior carrier's extension of benefits period for disabled employees or dependents?

_____

_____

*See Employee Form for Start Date and Reason for COBRA eligibility.

Section 5 | Plan Selection

Please write the name(s) of the plan(s) that you would like to offer to your employees.

☐ Healthfirst Pro EPO _____

_____

☐ Healthfirst Pro Plus EPO _____

_____

☐ Age 29 Rider

Eligibility for children covered under the subscriber's certificate of coverage may be extended through age 29 if the young adult is unmarried; is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; and lives, works, or resides in New York State and Healthfirst Insurance Company Inc. service area.

Domestic Partner benefits are included in all plans. Any changes must be made by contacting Healthfirst Insurance Company, Inc.

Does your group qualify for the family planning benefit exemption? ☐ Yes ☐ No

If yes, does your group want to opt out of offering family planning benefits? ☐ Yes ☐ No

Section 6 | 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:

Employee	Employee + Spouse	Employee + Child(ren)	Family

Plan #2 (if applicable):

Employee	Employee + Spouse	Employee + Child(ren)	Family

Plan #3 (if applicable):

Employee	Employee + Spouse	Employee + Child(ren)	Family

Plan #4 (if applicable):

Employee	Employee + Spouse	Employee + Child(ren)	Family

Section 7 | Broker and/or General Agent Information

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk, for all products being applied for, including life insurance, if applicable.

I hereby certify that I am licensed to sell Healthfirst Insurance Company, Inc. Small Group products in the state of New York. I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Healthfirst that the coverage being applied for by this application is accepted.

	Broker	Co-Broker	General Agent
Name of Payee			
National Producer Number (NPN)			
Payee's SSN or Federal Tax ID			
Commission Split			
Sales Representative			
Signature			
Date (MM/DD/YYYY)	____/____/_____	____/____/_____	____/____/_____

Section 8 | Broker and/or General Agent as Benefits Administrator

Authorization

The undersigned hereby requests Healthfirst to accept the Broker(s) and/or General Agent(s) named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's Healthfirst 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 remain in place until it is expressly revoked by me in writing.

Further, I agree that my company will be bound by the actions performed by the herein-named Broker and/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 Healthfirst in writing to void this authorization for Broker and/or General Agent to act as benefits administrator in the event of a change in my company's Broker of Record.

Signature of Authorized Company Representative _____

Section 9 | Applicant Agreement

This application and the premium rates proposed by Healthfirst are subject to approval, in writing, by Healthfirst. We retain the right to correct typographical errors or discrepancies prior to the effective date of coverage and to take other actions (for example, due to a misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above-named company, 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 and complete, and that I am not aware of any material information that was not disclosed.

I confirm that the company employs no more than 100 eligible, active, permanent employees and no fewer than one eligible, active, permanent employee.

I understand 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). I understand that other audits may be conducted while the Group Policy and Group Agreement are in effect, and I agree that all documents or other information that may impact coverage or premiums will be available for inspection.

I hereby acknowledge and understand that this application does not constitute any obligation by Healthfirst to offer coverage and that no insurance will be effective unless and until the application is formally accepted in writing by Healthfirst, the entity underwriting the coverage. I hereby confirm that I will not cancel any group health coverage I may currently have in anticipation that this application will be accepted by Healthfirst. Final rates will be based on enrollment data as of the policy's 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, I understand 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 Agreement.

Any material misrepresentation within the application or the addenda (whether intentional or unintentional) may subject the group to termination or other action permitted by law.

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.

I agree 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.

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.

By signing below, (1) I am authorized to sign this Group Application, and (2) I agree to the terms and conditions of this Small Group Employer Application, the Group Agreement, and the Group Policy.

Signature _____

SUMMARY OF BENEFITS — PLEASE READ AND CHECK BELOW TO CONFIRM

☐ In accordance with my contract with Healthfirst to distribute information related to enrollment/coverage information, I will receive the Summary of Benefits and Coverage (SBC) document associated with the plan information referenced in this application within seven business days. I confirm that I will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timing and delivery.

Applicant Company Name:	Signed at City, State:
Authorized Applicant Signature:	Official Title:
Print Name of Authorized Applicant:	Date:

healthfirst®
Health Insurance for New Yorkers

Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

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

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthfirst** by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone: 1-866-305-0408** (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email: http://healthfirst.org/members/contact/**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone: 1-800-368-1019** (TTY 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
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 1-866-305-0408 (TTY: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821).번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון 1-866-305-0408 (TTY: 1-888-542-3821). אפצאל. רופט	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-866-305-0408 (TTY: 1-888-542-3821).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821).	Urdu