Small Group Employer Enrollment Application[1]

Empire BlueCross BlueShield
An Anthem Company

Consult the Booklet or Certificate of Coverage for details regarding subscriber eligibility and coverage terms. For more information about Empire BlueCross BlueShield (Empire), its products and services, visit www.empireblue.com. Please complete in black ink only and use extra paper if necessary.

The Group understands that this Application may be chosen for review to confirm the information provided. These reviews, or audits, may take place before or after enrollment. If documents reviewed or submitted during an audit show that the information provided was not correct or that the group does not meet eligibility requirements, the group will not be enrolled (audit review completed before enrollment) or will be terminated (audit review completed after enrollment).

Section A: Application Type			
☐ New enrollment	Requested effective date (MM/DD/YYYY): / /		
Section B: Company Information			
Legal company name		Employer tax ID no. (required)	
Doing Business As (DBA) (if applicable)		SIC code — Required	
Company street address	City	State	ZIP code
Billing address — If different from above	City	State	ZIP code

Email address _____

Employer is providing its email address because it wants to receive information about its group's coverage by email or electronically. This may include the contract/policy, billing, required notices and other information related to my group's plan. I will make sure Empire has my most up to date email. Employer understands it can revoke this authorization at any time or request a free copy of specific materials by mail by contacting Empire to do either.

Company contact name	Primary phone no.
Additional company contact name	Email address

If you have ownership in another company, you may be considered a Single Employer with common ownership under IRS section 414, subsection (b), (c), (m), or (o).

Do you qualify as a Single Employer with common ownership under IRS section 414? ☐ Yes ☐ No If yes, please complete below.

Legal name	Federal tax ID no.	No. of employees employed

1 A small group must have at least one active full-time equivalent employee that meets the definition of employee in 42 U.S.C 300gg-91(d)(5) but no more than 100 employees. At least one full-time common law employee must be enrolled. Groups where the only enrollees would be the sole owner of a business or the owner and/or his/her spouse are not eligible.

Employer tax ID no. (Required) _____

Section C: Type of Coverage

1. Medical Coverage — All medical plans include pediatric dental coverage (up to age 19).

Indicate the percentage you wish to contribute each month to your employee's medical premium. Employer contributions are voluntary and no minimum is required.

Contribution Option: Contribution Option may be from 0% to 100% and may differ by category:
_____% Employee _____% Employee & Spouse/Domestic Partner _____% Employee & Child(ren) _____% Family

For employers providing a Health Savings Account (HSA) option (only **one** choice is allowed)
Do you want Empire to disclose your group's data to its banking services provider to establish Health Savings Accounts?
☐ Yes (Requires completion of the Consumer Driven Health Plans (CDHP) questionnaire) ☐ No

For employers offering a Health Savings Account (HSA) compatible PPO or EPO plan: We, the employer, understand that the High Deductible plan is designed for Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO) usage, and that using non-participating providers will result in significantly higher out-of-pocket costs. Please refer to your Booklet or Certificate of Coverage for additional details. We understand that having this coverage does not establish an HSA. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the covered individual and a bank or other qualified institution. An applicant must be an "eligible individual" under IRS regulations to receive HSA tax benefits. Consultation with a tax advisor is recommended.

Medical Plans — Indicate the contract code(s) for the medical plan(s) selected. The codes can be found on your Empire proposal/quote.

	Plan option 1	Plan option 2	Plan option 3	Plan option 4
Medical plan name				
Medical contract code				

2. Dental Coverage — Indicate the contract code(s) for the dental plan(s) selected. The codes can be found on your Empire proposal/quote.

Empire Dental Prime, Empire Dental Complete, and Empire Essential Choice with product families including Value, Classic, Enhanced, and Voluntary, and Enhanced Care PLUS (managed care) do not include certified pediatric dental essential health benefits.

Dental contract code 1: _____ Dental contract code 2: _____

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No
If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (Managed Care Dental, EPO, PPO)	Effective date (MM/DD/YYYY)	Proposed termination date (MM/DD/YYYY)
		/ /	/ /
		/ /	/ /

3. Vision Coverage — Indicate the contract code for the vision plan selected. The codes can be found on your Empire proposal/quote.

Vision contract code: _____ ☐ Employer-Sponsored Plans ☐ Voluntary Plans

Employer tax ID no. (Required) _____

Section D: Eligibility[1]

1. Average number of full-time equivalent (FTE) employees during the prior calendar year (including employed owners/officers, part-time employees, excluding COBRA): _____
2. Number of ELIGIBLE full-time employees as defined in 42 U.S.C. 300gg-91(d)(5). To help with this calculation, see Empire worksheet "Determining Group Size": _____
3. Number of INELIGIBLE employees: (For additional information, please contact your Broker or Empire representative.) _____
4. Total number of employees waiving coverage (for non-HMO coverage only): _____
5. Total number of employees ENROLLING: _____
6. Probationary period/waiting period for **new employees**:

   ☐ None (Date of Hire[2]) ☐ 1 month ☐ 30 days
   ☐ 2 months ☐ 60 days ☐ 90 days

   Effective date for newly eligible employees[3]:

   ☐ First of month following completion of waiting period/ probationary period (not applicable for "90 days" option)

   ☐ Day following completion of waiting period/probationary periods (not applicable for "None (Date of Hire[2])" option)
7. Probationary period/waiting period for **rehired employees**:

   Coverage is reinstated back to the date of the loss of coverage if rehired within 31 days of the loss of employment. If re-hire date is within 92 days of lay-off or termination of employment, the probationary period will be waived and the employee's coverage will be effective the date of rehire. If the employee is hired back after 92 days, then the employee must serve the group's probationary period for new employees.
8. Do you wish to offer Dependent child coverage from age 26 through age 29 for eligible dependents? ☐ Yes ☐ No
9. Do you wish to offer coverage for Domestic Partners? ☐ Yes ☐ No

The following information is needed to determine TEFRA[4] status. Employers may need to consult a tax expert to determine TEFRA status.

10. Is your group TEFRA eligible?
    Will (or did) your group have at least 20 full-time and part-time employees for at least 20 weeks? ☐ Yes ☐ No
11. Is this employer offering other group health insurance coverage to employees who are eligible for coverage under an Empire product (does not affect eligibility)? Select no if group only offers other HMO coverage: ☐ Yes ☐ No
12. Is your group subject to Federal COBRA or NY State Continuation of Coverage (fewer than 20 employees)? (select one box) See this site for additional COBRA information:

    www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra

    ☐ Federal COBRA ☐ NY State Continuation of Coverage

1 Empire requires certain forms of proof to establish eligibility. See the small group guide for more details regarding eligibility categories and required forms of proof. For non-HMO products, 60% of total eligible employees must enroll, except during an annual waiver period pursuant to 45 C.F.R. 147.104. Empire reserves the right to request additional documentation to verify group size/eligibility for participation. Temporary employees; consultants; independent contractors; directors and officers who are not an owner, partner or employee; and union members covered by a union sponsored health plan are not eligible unless they meet the definition of "employee" in NY Ins Law Sect. 4235(d) as amended to have the meaning of "employee" set forth in 42 USC 300gg-91(d)(5).

2 First day of active employment for pay.

3 Newly eligible employees include new employees and rehired employees. Newly eligible employees have 31 days from date of eligibility to enroll in coverage.

4 TEFRA stands for the Tax Equity and Fiscal Responsibility Act of 1982. Under TEFRA, when an employer has 20 or more full-time and/or part-time employees on its payroll for 20 weeks in the current or preceding calendar year, the group becomes the primary payer and Medicare becomes the secondary payer for the remainder of the calendar year and the following calendar year. This applies to claims of working-aged employees and their Spouses age 65+ even if they go below the 20/20 threshold. The 20 weeks in a calendar year do not have to be consecutive to reach the 20/20 threshold. Employees of affiliated service groups and controlled groups of businesses should also be counted. Employers may need to consult a tax expert to determine TEFRA status.

Also, under OBRA (Omnibus Budget Reconciliation Act), when an employer has 100 or more full-time and/or part-time employees on its payroll for 26 weeks in a calendar year, the group becomes the primary payer and Medicare becomes the secondary payer for the remainder of the calendar year and the following calendar year for claims of actively working employees and their dependents under the age of 65 that are Medicare eligible because of a disability.

Employer tax ID no. (Required) _____

Section E: Access of Group Information by Designated Agent/Producer/Broker/Agency/Brokerage/General Agency

We the employer hereby authorize our designated agent, producer, broker, agency, brokerage, general agency and their respective employees currently on file with Empire (Agent) to access our health plan information, including protected health information, on behalf of our health plan through Empire's EmployerAccess system or any other access points Empire may offer. This information may include, but is not limited to, detail about members, plan selections and bills/invoices. Our Agent is also authorized to make changes to our information on our behalf, including but not limited to adding/deleting plans and members and changing member demographic information. We will be responsible for the activities of our Agent. If our Agent on file changes, these authorizations will apply with respect to our successor Agent. Our Agent is required to maintain all original documentation and will make such documentation available to Empire upon request.

☐ Select this box **ONLY** if the employer DOES NOT want to authorize the agent/producer/broker/general agent to access and change the group's information on behalf of the group. **Do not select this box if you consent.**

Section F: Electronic Billing

Electronic or paperless billing is the Employer's standard option. Monthly bills can be viewed and printed through EmployerAccess.
☐ I will view and print the bill/invoice online through EmployerAccess.
☐ I choose to opt-out of electronic billing, and I wish to receive a monthly paper bill.

Section G: General Terms and Agreements — Please read this section carefully before signing the application.

Standard Open Enrollment for Employees: The standard open enrollment period is at least 30 days before the group's renewal date and 30 days after, no more often than once in any 12 consecutive months. The open enrollment period does not apply to life and/or disability products.

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated on this application. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated on this application.

The undersigned employer and/or authorized representative(s) hereby request(s) that it be approved for insurance coverage issued by Empire. Employer understands and represents, by way of its authorized representatives, that to its best knowledge and belief the entire application for Group Insurance has been reviewed, all answers contained herein are true and complete, and agrees:

1. If the Empire application is not complete, Empire reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Empire, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We further understand and agree that it is recommended that we keep prior coverage in force until notified of acceptance in writing by Empire and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Empire.
2. If we decide to cancel our Empire group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Empire received the written notification of cancellation or such later date as requested, and that no premiums will be refunded for any period between Empire's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums paid after the cancellation date, we understand that Empire will refund these premiums.

   In addition, the agent/producer/broker/general agent named on the next page of this application is hereby authorized to process any enrollment transactions for my company's coverage upon direction from the authorized group representative (including, but not limited to, Member enrollment, 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 I agree that my company will be bound by the actions performed by the herein-named agent/producer/broker/general agent pursuant to my signature. Additionally, I acknowledge that I must notify Empire, in writing, to void this authorization in the event of a change in my company's Broker of Record.

INSURANCE FRAUD STATEMENT FOR INSURANCE COVERAGE: 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.

Sign here	Company officer signature X	Title	
	Printed name		Today's date (MM/DD/YYYY) / /

Employer tax ID no. (Required) _____

Section H: Agent/Producer/Broker Certification — To be completed by the agent/producer/broker.

1. I am not aware of any information not disclosed by the employer in this application that may have bearing on this group's or any member's eligibility.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual employee(s) application. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize the insurer to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage and that coverage shall not be effective until the insurer reviews and approves the application and the employer receives a written notice from the insurer.
5. I am the appointed agent/producer/broker and am receiving commissions for the submission of this employer. No portion of my commission payments from the insurer shall be paid to an agent/producer/broker who is not appointed/approved by the insurer.
6. I have advised the employer not to terminate any existing coverage until receiving written notification from the insurer that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			%	**Second writing payable/sub-agent/producer/broker**			%
Agency name		Agency ID no.		Agency name		Agency ID no.	
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker Tax ID no./SSN				Agent/producer/broker Tax ID no./SSN			
Existing Broker EmployerAccess user name				Existing Broker EmployerAccess user name			
Payable/sub-agent/producer/broker Tax ID no./SSN if different				Payable/sub-agent/producer/broker Tax ID no./SSN if different			
Street address				Street address			
City	State	ZIP code		City	State	ZIP code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature	Today's date (MM/DD/YYYY) / /			Signature	Today's date (MM/DD/YYYY) / /		
For General Agent/Producer/Broker use only							
General agent/producer/broker name				Agent/producer/broker Tax ID no./SSN			
Street address				City	State	ZIP code	
Sales Representative and Account Manager							
Sales representative name				Sales representative ID no.			
Street address				City	State	ZIP code	
Account manager name				Account manager ID no.			

INTERNAL USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY) / /

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾਂiਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf