HEALTH REPUBLIC
INSURANCE

Group Application

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Health Republic Insurance of New Jersey
570 Broad Street
Suite 1100
Newark, NJ 07102

Please print or type policy number _____
(Health Republic Insurance of New Jersey Use Only)

Contract information will be provided: ☐ Electronically ☐ Hard Copy

☐ New Policy ☐ Change in Policy Requested Effective Date: _____

Note: The Effective Date will be on or after the date Health Republic Insurance of New Jersey (HRINJ) approves the application.

Section I: Policy holder information

1. Policyholder (full legal name of Company): _____

2. Tax ID Number: _____

3. Business Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box # City State Zip

Telephone: ( )
Fax: ( )

Contract information should be provided (Check one): ☐ Electronically ☐ Hard Copy

Correspondent: _____

4. Name of Group Administrator: _____

5. Email Address: _____

6. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain) _____

7. Nature of business: (specify) _____ SIC Code: _____

8. Number of eligible employees in your company: _____
Please Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

9. Number of eligible employees to be insured: _____

10. Class or classes to be excluded: _____

11. Insurance requested for: ☐ Employees & Dependents (with spouse) ☐ Employees & Dependents (without spouse)

☐ Employees Only

Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No

If yes, should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

12. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No

13. Is your employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No

    Is your employer subject to the requirements of Medicare as a Secondary Payor Rules for eligibility due to disability? ☐ Yes ☐ No

14. Orientation Period: ☐ Yes ☐ No

15. Waiting period before employees become insured (May not exceed 90 days):

    Present Employees _____ New or Rehired Employees _____

16. Period for Annual Employee Open Enrollment Period: _____

17. What percentage of the premium will the employer pay? (must be a minimum of 10%):
    _____

18. Deposit: $ _____

    Premium Paid: ☐ Monthly ☐ Quarterly ☐ Automatic checking withdrawal
    Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

19. Affiliates, subsidiaries or branches: (must be included for purpose of participation)

Legal Name	Address	Number of eligible employees in this company	Number of eligible employees to be insured

Section II: Specifications for Coverage

Plan Designs:

□ Full Access Prime

□ Bronze: Deductible – $2,500 (individual) / $5,000 (family), 50% coinsurance, Max Out-of-Pocket – $ 6,600 (individual) / $13,200 (family), PCP – Deductible then 50% coinsurance / SPC – Deductible then 50% coinsurance | Rx – Deductible then 50% coinsurance – All Tiers

□*Silver: Deductible – $2,000 (individual) / $4,000 (family), 40% coinsurance, Max Out-of-Pocket – $4,500 (individual) / $9,000 (family), PCP – *First 4 visits $0 cost share then Deductible 40% coinsurance / SPC – Deductible then 40% coinsurance | Rx – Deductible then 40% coinsurance – All Tiers

□ Gold: Deductible – $1,750 (individual) / $3,500 (family), 30% coinsurance, Max Out-of-Pocket – $2,500 (individual) / $5,000 (family), PCP – $0 cost share plan pays 100% coinsurance / SPC – Deductible then 30% coinsurance | Rx – Deductible then 30% coinsurance – All Tiers

□ Full Access Core

□ Silver: Deductible – $2,000 (individual) / $4,000 (family), 40% coinsurance, Max Out-of-Pocket – $4,500 (individual) / $9,000 (family), PCP – $25 Copay / SPC – $50 Copay | Rx – $25 Copay – Tier 1 / $50 Copay – Tier 2 / Deductible then 40% coinsurance – Tiers 3&4

□ Gold: Deductible – $1,500 (individual) / $3,000 (family), 30% coinsurance, Max Out-of-Pocket – $3,500 (individual) / $7,000 (family), PCP – $10 Copay / SPC – $25 Copay | Rx – $10 Copay – Tier 1 / $25 Copay – Tier 2 / Deductible then 30% coinsurance – Tiers 3&4

□ Platinum: Deductible – $750 (individual) / $1,500 (family), 20% coinsurance, Max Out-of-Pocket – $1,500 (individual) / $3,000 (family) PCP – $5 Copay / SPC – $10 Copay | Rx – $5 Copay – Tier 1 / $10 Copay – Tier 2 / Deductible then 20% coinsurance – Tiers 3&4

□ Full Access Solid

□ Bronze: Deductible – $2,500 (individual) / $5,000 (family), 50% coinsurance, Max Out-of-Pocket – $6,450 (individual) / $12,900 (family), PCP – Deductible then 50% coinsurance / SPC – Deductible then 50% coinsurance | Rx – Deductible then 50% coinsurance – All Tiers

□ Silver: Deductible – $2,000 (individual) / $4,000 (family), 40% coinsurance, Max Out-of-Pocket – $4,000 (individual) / $8,000 (family), PCP – Deductible then 40% coinsurance / SPC – Deductible then 40% coinsurance | Rx – Deductible then 40% coinsurance – All Tiers

□ Gold: Deductible – $1,500 (individual) / $3,000 (family), 30% coinsurance, Max Out-of-Pocket – $2,500 (individual) / $5,000 (family), PCP – Deductible then 30% coinsurance / SPC – Deductible then 30% coinsurance | Rx – Deductible then 30% coinsurance – All Tiers

□ Full Access Pure

□ Bronze: Deductible – $2,500 (individual) / $5,000 (family), 50% coinsurance, Max Out-of-Pocket – $6,450 (individual) / $12,900 (family), PCP – Deductible then $50 Copay / SPC – Deductible then $75 Copay | Rx – Deduct then 50% coinsurance up to $100 max – Tier 1 / Deduct then 50% coinsurance up to $250 max – Tier 2 / Deductible then 50% coinsurance up to $500 max – Tier 3 / Deductible then 50% coinsurance – Tier 4

□ Silver: Deductible – $2,000 (individual) / $4,000 (family), 40% coinsurance, Max Out-of-Pocket – $5,000 (individual) / $10,000 (family), PCP – $25 Copay / SPC – $75 Copay | Rx – Deductible then 40% Coinsurance up to $100 max – Tier 1 / Deductible then 40% Coinsurance up to $250 max – Tier 2 / Deductible then 40% Coinsurance up to $500 max – Tier 3 / Deductible then 40% coinsurance – Tier 4

□ Gold: Deductible – $1,800 (individual) / $3,600 (family), 30% coinsurance, Max Out-of-Pocket –$3,000 (individual) / $6,000 (family), PCP – $15 Copay / SPC – $50 Copay | Rx – $10 Copay – Tier 1 / $25 Copay – Tier 2 / $50 Copay – Tier 3 / Deductible then 30% coinsurance – Tier 4

□Platinum: Deductible – $0 (individual) / $0 (family), 20% coinsurance, Max Out-of-Pocket – $2,000 (individual) / $4,000 (family), PCP – $10 Copay / SPC – $25 Copay | Rx – $5 Copay – Tier 1 / $10 Copay – Tier 2 / $25 Copay – Tier 3 / 20% coinsurance – Tier 4

□ Active Access Spotlight

□ Bronze: Deductible – $2,500 (individual) / $5,000 (family), 50% coinsurance, Max Out-of-Pocket – $6,600 (individual) / $13,200 (family), Tier 1 PCP – $10 Copay then Deductible / Tier 2 PCP - 50% coinsurance / SPC – Deductible then $75 Copay | Rx – $10 Copay – Tier 1 / Deductible then 50% coinsurance – Tiers 2-4

□ Silver: Deductible – $2,000 (individual) / $4,000 (family), 40% coinsurance, Max Out-of-Pocket – $6,000 (individual) / $12,000 (family), Tier 1 PCP – $10 Copay / Tier 2 PCP – 40% coinsurance / SPC – $50 Copay | Rx – $25 Copay – Tier 1 / $50 Copay – Tier 2 / $75 Copay – Tier 3 / Deductible then 40% coinsurance – Tier 4

□ Gold: Deductible – $1,500 (individual) / $3,000 (family), 30% coinsurance, Max Out-of-Pocket – $3,000 (individual) / $6,000 (family), Tier 1 PCP – $10 Copay / Tier 2 PCP – 30% coinsurance / SPC – $25 Copay | Rx – $10 Copay – Tier 1 / $25 Copay – Tier 2 / $50 Copay – Tier 3 / 30% coinsurance – Tier 4

□ Platinum: Deductible – $0 (individual) / $0 (family), 20% coinsurance, Max Out-of-Pocket – $1,250 (individual) / $2,500 (family), Tier 1 PCP – $10 Copay / Tier 2 PCP – 20% coinsurance / SPC – $10 Copay | Rx – $5 Copay – Tier 1 / $10 Copay – Tier 2 / $15 Copay – Tier 3 / 20% coinsurance – Tier 4

□ Monmouth County Community Plan

□ Bronze:

Tier 1: Deductible – $1,500 (individual) / $3,000 (family), 50% coinsurance, Max Out-of-Pocket – $6,450 (individual) / $13,200 (family), PCP – Deductible then $50 Copay / SPC – Deductible then $75 Copay | Rx – Deductible then $25 Copay – Tier 1 / Deductible then 50% coinsurance – Tiers 2-4

Tier 2: Deductible – $2,500 (individual) / $5,000 (family), 50% coinsurance, Max Out-of-Pocket – $6,600 (individual) / $13,200 (family), PCP – Deductible then 50% coinsurance / SPC – Deductible then 50% coinsurance | Rx – Deductible then $25 Copay – Tier 1 / Deductible then 50% coinsurance – Tiers 2-4

□ Silver:

Tier 1: Deductible – $0 (individual) / $0 (family), 40% coinsurance, Max Out-of-Pocket – $5,000 (individual) / $10,000 (family), PCP – Deductible then $25 Copay / SPC – Deductible then $50 Copay | Rx – $25 Copay – Tier 1 / $50 Copay – Tier 2 / $75 Copay – Tier 3 / Deductible then 40% coinsurance – Tier 4

Tier 2: Deductible – $2,500 (individual) / $5,000 (family), 40% coinsurance, Max Out-of-Pocket – $6,600 (individual) / $13,200 (family), PCP – Deductible then 40% coinsurance / SPC – Deductible then 40% coinsurance | coinsurance | Rx – $25 Copay – Tier 1 / $50 Copay – Tier 2 / $75 Copay – Tier 3 / Deductible then 40% coinsurance – Tier 4

□ Gold:

Tier 1: Deductible – $0 (individual) / $0 (family), 30% coinsurance, Max Out-of-Pocket – $3,000 (individual) / $6,000 (family), PCP – Deductible then $10 Copay / SPC – Deductible then $20 Copay | Rx – $0 Copay – Tier 1 / $50 Copay – Tier 2 / $75 Copay – Tier 3 / 30% coinsurance – Tier 4

Tier 2: Deductible – $2,500 (individual) / $5,000 (family), 30% coinsurance, Max Out-of-Pocket – $6,600 (individual) / $13,200 (family), PCP – Deductible then 30% coinsurance / SPC – Deductible then 30% coinsurance | Rx – $0 Copay – Tier 1 / $50 Copay – Tier 2 / $75 Copay – Tier 3 / 30% coinsurance – Tier 4

□ Platinum:

Tier 1: Deductible – $0 (individual) / $0 (family), 20% coinsurance, Max Out-of-Pocket – $1,000 (individual) / $2,000 (family), PCP – Deductible then $10 Copay / SPC – Deductible then $20 Copay | Rx – $0 Copay – Tier 1 / $25 Copay – Tier 2 / $50 Copay – Tier 3 / 20% coinsurance – Tier 4

Tier 2: Deductible – $1,500 (individual) / $3,000 (family), 20% coinsurance, Max Out-of-Pocket – $2,000 (individual) / $4,000 (family), PCP – Deductible then 0% coinsurance / SPC – Deductible then 0% coinsurance | Rx – $0 Copay – Tier 1 / $25 Copay – Tier 2 / $50 Copay – Tier 3 / 20% coinsurance – Tier 4

Have you purchased a separate Pediatric Dental Plan?

Yes ☐ No ☐

If No, please note that purchasing a Pediatric Dental Plan is required.

Stand Alone Pediatric Dental Options:

The Patient Protection and Affordable Care Act (PPACA) permits plans outside of the Health Insurance Marketplace and the Small Employer Business Health Options (SHOP) Program to issue coverage without pediatric dental benefits only if reasonably assured that the applicant has purchased an exchange-certified stand-alone dental plan (SAPD) covering the pediatric dental benefits as required by PPACA. In order to receive reasonable assurance from you, we require the following information if you did not select one of the Stand Alone Pediatric Dental Plans listed above:

If Yes, include Insurer and Plan: _____

☐ Proof of Coverage or other documentation reasonably acceptable to the Health Insurance Issuers evidencing your enrollment in an exchange certified SAPD. Proof of acceptable coverage may be a copy of enrollment confirmation from SAPD issuers or a copy of your coverage document (for example, a certificate of coverage).

☐ The contact information of your SAPD issuer that we may verify your enrollment with, which you expressly grant our ability to verify your enrollment:

Name of SAPD Issuer: _____

Policy Number: _____

Name of Contract Holder: _____

Contact Information of SAPD Issuer: _____

Section III:

1. Is there any Group Health Plan now in force and to be continued? ☐ Yes ☐ No If yes, identify:
   a. Name of the Group Health Plan(s):
   b. Description of the plan(s):
   c. Name of insurance carrier(s):
2. Is there any Group Health Plan currently being applied for through another carrier? ☐ Yes ☐ No If yes, identify:
   a. Name of the Group Health Plan(s):
   b. Description of the plan(s):
   c. Name of insurance carrier(s):
3. Is the coverage being applied for in this application replacing other group insurance? ☐ Yes ☐ No
   a. If yes, explain reason:
   b. Name of present or prior group carrier:
   c. Plan being replaced:
   d. Effective date:
   e. Cancellation/Termination date:
4. Has your firm been uninsured for 3 or more months prior to this application? ☐ Yes ☐ No
5. What forms of insurance are now, or were in force? Please attach copies of Booklet/Certificate and most recent Billing Statement.

   ☐ Health Benefits

   ☐ Prescription Drug Benefits

   ☐ Dental Benefits

   ☐ Vision Benefits
6. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

7. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued?

☐ Yes ☐ No

If yes, please provide the following information for each current/former employee or dependent on health continuations:

Name of Employee / Dependent	Date of Birth	Type of Continuation State/ Federal Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

If additional space is needed, please attach a separate sheet, signed and dated.

8. To the best of your knowledge are any employees or dependents presently incapacitated? ☐ Yes ☐ No
9. To the best of your knowledge are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No
10. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
(Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organizations.)

Section IV: Agent/ Producer Information

Agent/Broker Name: _____

Section V: Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Health Republic Insurance of New Jersey (HRINJ) to make or modify any request or application for insurance or to bind Health Republic Insurance of New Jersey (HRINJ) by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Health Republic Insurance of New Jersey (HRINJ). 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 the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

_____ _____

Print name of Officer, Partner, or Proprietor Signature of Officer, Partner, or Proprietor

Witness to Signature _____

Note: If there are any modifications to the statement and answers given in this application (i.e. crossed out, whited-out, erased, etc.), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.