(1-50) Application
SMALL GROUP EMPLOYER APPLICATION

HEALTH REPUBLIC
INSURANCE OF NEW YORK

❑ Original Check/Money order enclosed

1. GROUP INFORMATION

Full Legal Name of Group _____

DBA (Doing Business As) _____

Tax ID Number _____

Business Address _____
(cannot be a P.O. Box)

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

County _____

2. BILLING INFORMATION

Contact Name _____ Title _____

Address _____
(If different than above)

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

3. GROUP ADMINISTRATION

To be eligible for small group coverage the group must have a business address in New York State.
Groups must have between 1 and 50 eligible employees.

1. Requested Effective Date_____ (Note: Must be 1st of the month)
2. How many total employees in this group? _____ (Note: This includes part-time employees)
3. Total number of employees being offered coverage through this product_____
   Please see our Off Exchange Small Group Underwriting Guide for more information.
4. How many eligible employees in this group are enrolling? _____

   Eligible employees are active employees of the employer and of all subsidiaries or affiliates of a corporate employer who work a minimum of 20 or more hours per week.

   Eligible employees do not include:

   - Any person who is compensated via IRS form 1099
   - Any former employee who is covered through retiree benefits, COBRA or state continuation.

5. Total number of employees and COBRA eligible employees enrolling_____
   Enrolling means the total number of eligible employees and COBRA or state continuation enrollees accepting coverage with any Health Republic product.

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3. GROUP ADMINISTRATION *(continued)*

An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic site 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 Health Republic Group Products. If coverage is limited to specific class(es) of employees, the classes must be specified. **Eligible employee class(es), Waiting period and Termination:** If coverage is being limited to particular class(es) of employees, please specify class definition(s) on reverse side. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic site 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, Health Republic products are not available to employees who work less than 20 hours per week.

Group waiting period _____

1. **Waiting period for new hire:** ❑ 0 days ❑ 30 days ❑ 60 days

New employees will be able to enroll in the plan on the first of the month following the group's waiting period. As such, the waiting period cannot exceed 60 days.

2. **Waiting period for rehires:** ❑ 0 days ❑ 30 days ❑ 60 days

Rehired employees will be able to enroll in the plan on the first of the month following the group's waiting period. As such, the waiting period cannot exceed 60 days.

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

PLAN SELECTION: Please select the plan (s) being offered:

EssentialCare

- ❑ EssentialCare Bronze Plan
- ❑ EssentialCare Silver Plan
- ❑ EssentialCare Gold Plan
- ❑ EssentialCare Platinum Plan
- ❑ EssentialCare Bronze Plan 29
- ❑ EssentialCare Silver Plan 29
- ❑ EssentialCare Gold Plan 29
- ❑ EssentialCare Platinum Plan 29

PrimarySelect

- ❑ PrimarySelect Silver Plan
- ❑ PrimarySelect Gold Plan
- ❑ PrimarySelect Platinum Plan
- ❑ PrimarySelect Silver Plan 29
- ❑ PrimarySelect Gold Plan 29
- ❑ PrimarySelect Platinum Plan 29

PrimarySelect PCMH

- ❑ PrimarySelect PCMH Silver Plan
- ❑ PrimarySelect PCMH Silver Plan 29

TotalFreedom

- ❑ TotalFreedom Platinum Plan
- ❑ TotalFreedom Platinum Plan 29

If additional options are required please list on an separate page.

4. 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:

Single	Couple	Parent/Child(ren)	Family
$	$	$	$

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4. RATE INFORMATION *(continued)*

Plan #3 Rates:

Single	Couple	Parent/Child(ren)	Family
$	$	$	$

5. BROKER/GA INFORMATION

	Broker	Co-Broker	General Agency
Individual Agent/ Brokerage/GA Code			
SSN or Tax ID #			
Commission Split*			
Individual Agent Name			
Brokerage Name			
Phone			

*If more than one broker – Commission must add up to 100%

6. BROKER CONSENT

Authorization for Broker to Act as Benefits Administrator

The undersigned hereby requests Health Republic Insurance of New York 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 Health Republic Insurance of New York's 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 Health Republic Insurance of New York in writing to void this agreement in the event of a change in my company's Broker of Record.

Signature of Authorized Company Representative _____

7. APPLICANT AGREEMENT

This Application and the premium rates proposed by Health Republic Insurance of New York are subject to approval, in writing, by Health Republic Insurance of New York. 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 a 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

7. APPLICANT AGREEMENT *(continued)*

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 we employ no more than 50 eligible active permanent employees and no fewer than 1 eligible active permanent employees. The Applicant understands that 1099-compensated individuals are not eligible for group coverage with Health Republic Insurance of New York.

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 Health Republic Insurance of New York to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by Health Republic Insurance of New York, the 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 Health Republic Insurance of New York. 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. Applicant certifies that the Applicant has not had a group health policy or health maintenance organization contract terminated within the past 12 months due to failure to pay premiums.

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 Health Republic Insurance of New York: 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. 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_____

Signature of Authorized Company Representative _____

Title_____

Witness Duly Licensed Resident Agent Broker _____