EmblemHealth™

LARGE EMPLOYER GROUP APPLICATION

EmblemHealth insurance programs are underwritten by Group Health Incorporated (GHI) and HIP Insurance Company (HIPIC).

PRINT IN INK

SECTION I: GROUP INFORMATION

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. _____ Fax No. _____

Company Officer's Name _____ E-Mail Address _____

Title _____

Group Contact _____ Title _____

E-Mail Address _____ Telephone No. _____

Address ☐ Same as above _____

_____

Additional Office Locations _____

_____

Nature of Business _____ SIC/NAIC Code _____

Taxpayer Identification No. _____

SECTION II: BILLING

Premium invoices should be sent to: _____

Telephone No. _____ E-Mail Address _____

Address _____

_____

Contact Person *(if different than above)* _____

Telephone No. _____ E-Mail Address _____

SECTION III: GROUP ADMINISTRATION

A. Number of Eligible Employees (Employees working at least 20 hours a week) _____

B. Exclusion Class(es) _____

C. Number of Employees Applying _____

D. Number of COBRA Participants _____

EMPLOYEE ELIGIBILTY:

Active Employees: All active, permanent, full-time employees who work at least _____ hours per week (minimum 20 hours/week).

Are any classes excluded? ☐ Yes ☐ No

If yes, indicate classes excluded: _____

Retired Employees: ☐ Yes ☐ No

The definition of a retired employee is:

☐ an employee who is retired on pension by the employer.

☐ an employee who is retired from service by the employer and who immediately prior to the date of his retirement had completed at least _____ years of service with the employer.

☐ an employee who is retired on pension by the employer and who immediately prior to the date of his retirement had completed at least _____ years of service with the employer.

Pre-Existing Condition Limitation: ☐ Yes ☐ No

11 Month exclusion applies to late entrants only. ☐ Yes ☐ No

Other group health or HMO coverage: Indicate below other group health coverage which is still in force or which terminated within the past 3 year.

Please complete the information below for your existing policy.

Name and Address of Insurer	Type of Coverage	Effectve Date of Policy	Termination Date of Policy

SECTION IV: PRODUCT SELECTION

Plan Name _____ Desired Effective Date _____

☐ PPO ☐ EPO ☐ InBalance EPO ☐ InBalance PPO

☐ ConsumerDirect EPO ☐ ConsumerDirect PPO ☐ CompreHealth EPO

☐ Dental ☐ OTHER (Please specify) _____

RATE STRUCTURE ☐ 2-Tier ☐ 3-Tier ☐ 4-Tier

Is this a replacement policy? ☐ Yes ☐ No

Is this an option? ☐ Yes ☐ No

SECTION V: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

☐ **Employee:** _____ % or $ _____ ☐ **Family:** _____ % or $ _____

☐ Other: _____

NEW HIRE ELIGIBLITY POLICY

Desired Effective Date _____

☐ Date of Hire ☐ First of the month following date of hire

PLUS:

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other(please specify): _____

Waived for Rehire? ☐ Yes ☐ No If rehired within _____ days.

TERMINATION POLICY

☐ Date Terminated ☐ End of Month ☐ Other _____

SECTION V-A: ENROLLMENT POLICIES CLASS: _____

The information provided in this application is true to the best of my knowledge. I hereby authorize any person, or other entity to release to GHI, and/or HIP Insurance Company any information requested by GHI, and/or HIP Insurance Company in connection with the processing of this application.

By signing this application, I certify under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business. I hereby authorize any person or other entity to release to GHI, and/or HIP Insurance Company any information requested by GHI, and/or HIP Insurance Company in connection with the processing of this application.

I understand that any person who knowingly and with the 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.

Please sign below, where applicable.

Print Name

Signature of Authorized Officer of the Company

Title of Officer of Company

Print *(Witness/Duly licensed Resident Agent/Broker)*

Broker Code

Signature *(Witness/Duly licensed Resident Agent/Broker)*

Broker Code