Employer Enrollment Application (Medical, Dental and/or Vision) For 1-100 Small Groups[1]

Consult the Evidence of Coverage for details regarding subscriber eligibility terms and coverage terms.

Please complete in black ink only

Section A: Application Type	
☐ **New enrollment**	Requested effective date (MM/DD/YYYY)
Open Enrollment	
Our standard open enrollment period is 30 days before the Group's renewal date and 30 days after, which is held no more often than once in any 12 consecutive months. The open enrollment does not apply to life and disability products.	

Section B: Company Information		
Legal company name		Employer tax ID no. (required)
Doing Business As (DBA)		SIC code – Required
Company street address		
City	State	ZIP code
Billing address- If different from above		
City	State	ZIP code
Company contact name		Title
Primary phone no.	Fax no.	
Email address		
Additional company contact name		Title
Primary phone no.	Fax no.	
Email address		

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code 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. A small group can consist of one non-spouse employee plus the business owner; a group of 100 would consist of the business owner plus 99 employees.

Section C: Type of Coverage

1. Medical Coverage

All medical plans include pediatric dental coverage (up to age 19).

For HRA plans:
For health reimbursement account (HRA) plans: The annual HRA employer contribution for an individual is $1,000; and for a family is $2,000.The contribution rollover maximum for an individual is up to $2,000; and for a family is up to $4,000.
Please complete and submit the following documents with the Application if you have selected an HRA product:

- Demand Debit Authorization Form
- Agreement for Health Reimbursement Accounts

If you want to contribute to your employee's medical premium, indicate the percentage you wish to contribute each month for each category. Employer contributions are voluntary and no minimum is required.
Non-HMO plans must meet participation requirement.
Contribution Option: Contribution Option may be from 0% to 100% and may differ by category:

_____% Employee Only _____% Employee & Spouse/Domestic Partner _____% Employee & Child(ren) _____% Family

For HSA plans:

☐ Group will establish Health Savings Account (HSA) with Empire facilitating with a banking services provider.
☐ Group will establish Health Savings Account (HSA) and does not want Empire to facilitate the creation of the account.

For employers offering a Health Savings Account (HSA) compatible HMO, PPO or EPO plan: We, the employer, understand that the High Deductible plan is designed for Health Maintenance Organization (HMO), 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 Evidence of Coverage for additional benefit 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 individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. Consultation with a tax advisor is recommended.

Medical contract codes – Indicate the contract codes for the medical plan(s) selected. The codes can be found on the proposal/quote output.

Contract code	Contract code	Contract code
1.	2.	3.

2. Dental Coverage

Empire Dental Family and Empire Dental Family Enhanced plans include certified pediatric dental essential health benefits. All other plans including Empire Dental Prime, EmpireDental Complete, EmpireEssential Care, and Empire Enhanced Care with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Dental contract codes – Indicate the contract code(s) for the dental plan(s) chosen. The codes can be found on the Empire proposal/quote output.
Contract code 1:_____ Contract code 2:_____ ☐ No dental coverage selected

Choose your dental contribution for each month:
_____% per employee _____% per dependent (optional)

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ Bundled premium

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 (DHMO, PPO)	Effective Date (MM/DD/YYYY)	Proposed termination date (MM/DD/YYYY)

3. Vision Coverage – Select one plan option.

☐ No vision coverage.
☐ Employer-Sponsored Plans
☐ Voluntary Plans

Vision contract codes – Indicate the contract code for the vision plan chosen. The codes can be found on your Empire proposal/quote output.
Contract code: _____

Choose your vision contribution for each month.
Employer-Sponsored plans require employers to contribute between 50% and 100%.
For Voluntary plans employers may contribute between 0% and 49%.
We will contribute: _____% per employee _____% per dependent (optional).

4. Life/Accidental Death and Dismemberment (AD&D) and Disability Coverage – Check all that apply. A minimum of two employees must enroll.

Life/AD&D products		Disability products	
Select products and group contribution percentage:		**Select products and group contribution percentage:**	
Product choice	**Percentage**	**Product choice**	**Percentage**
☐ None		☐ None	
☐ Basic Life & AD&D	_____%	☐ Short Term Disability*	_____%
☐ Basic Dependent Life	_____%	☐ Long Term Disability*	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%	☐ Voluntary Short Term Disability*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%	☐ Voluntary Long Term Disability*	_____%
*Available for Groups of 10+		*Available for Groups of 10+	

If disability benefits are selected, indicate whether the employee pays disability premiums on a pre or post tax basis.

Short Term Disability	Voluntary Short Term Disability	Long Term Disability	Voluntary Long Term Disability
☐ Pre Tax	☐ Pre Tax	☐ Pre Tax	☐ Pre Tax
☐ Post Tax	☐ Post Tax	☐ Post Tax	☐ Post Tax

Are more than 50% of eligible employees in the group related by marriage or blood? ☐ No ☐ Yes

Life/AD&D and/or Disability Eligibility Probationary Period/Waiting Period

Is the eligibility probationary period/waiting period for new eligible employees enrolling in Life/AD&D and/or Disability plans after the group's coverage effective date the same as the medical policy eligibility period? ☐ Yes ☐ No
If no, enter the Life/AD&D and Disability eligibility probationary period below.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible employees is 30 hours per week unless otherwise indicated.

Prior Coverage

Do you have any existing life insurance or annuity contracts with this or any other company? ☐ Yes ☐ No
Do you intend with the purchase of this insurance to replace, terminate or change the value of any existing life insurance or annuity with this or any other company? ☐ Yes ☐ No
If "yes" provide information below for each policy or contract being replaced and attach any applicable replacement forms:

Will this plan replace current	Insurance Company Name - Policy/Contract Number	Termination Date (MM/DD/YYYY)
Life/AD&D coverage ☐ Yes ☐ No		
Disability coverage ☐ Yes ☐ No		

Participation Requirements
Basic Life, Basic Accidental Death & Dismemberment, Short Term Disability: 100% participation required on non-contributory plans and 75% participation required on contributory plans. **Long Term Disability:** 100% participation required on all non-contributory plans. 100% participation required for contributory plans of two or three eligible employees. 75% participation required on contributory plans with four or more eligible employees. **Basic Dependent Life:** 100% participation required on non-contributory plans. **Optional Supplemental/Voluntary Life/Accidental Death & Dismemberment:** The greater of five enrolled employees or 20% participation required. **Voluntary Short Term Disability and Voluntary Long Term Disability:** The greater of 10 enrolled employees or 20% participation 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 ENROLLING: _____
5. Probationary period/waiting period for **new employees**:
   ☐ None ☐ 1 month ☐ 30 days
   ☐ 2 months ☐ 60 days ☐ 90 days*
6. Probationary period/waiting period for **rehired employees**:
   ☐ None ☐ 1 month ☐ 30 days
   ☐ 2 months ☐ 60 days ☐ 90 days*
7. New eligible enrollees[2] will become effective on:
   ☐ First of month following completion of waiting period/probationary period (excluding 90 day choice)
   ☐ Day following completion of waiting period/probationary periods (excluding None choice)
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[3] status. Employers may need to consult a tax expert to determine TEFRA status.

10. Is your group TEFRA eligible? ☐ Yes ☐ No
    Will (or did) your group have at least 20 full-time and part-time employees for at least 20 weeks:
    In the current calendar year? ☐ Yes ☐ No
    If yes, list number of employees: _____
    In the last calendar year? ☐ Yes ☐ No
    If yes, list number of employees:
    (Include owners and partners. Count all locations) _____
11. Is your group subject to Federal COBRA or NY State Continuation of Coverage (fewer than 20 employees)? (check one box) See this site for additional COBRA information: www.dol.gov/ebsa/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 New eligible employees include new employees and rehired employees. Newly eligible employees have 45 days from time of eligibility to enroll in coverage.

3 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.

Section E: General Agreement

Please read this section carefully before signing the application.

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. 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.

Or, 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.

To the best of our knowledge and belief, all information on this application is true and complete, and Empire may rely on this application in deciding whether to provide coverage. If the 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.

If we decide to cancel our 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 Broker(s) named on the next page of this application is hereby authorized to process any enrollment transactions for my company's Empire 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 Broker pursuant to my signature. Additionally, I acknowledge that I must notify Empire in writing to void this broker authorization in the event of a change in my company's Broker of Record.

INSURANCE FRAUD STATEMENT FOR HEALTH 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**	Printed name	Title
Group no.		Tax ID no.	Date (MM/DD/YYYY)

The following subsection is for Life, AD&D and/or Disability Applicants

The undersigned employer and/or authorized representative hereby requests that it be approved for insurance coverage through Anthem Life & Disability Insurance Company (Anthem Life). Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under Anthem Life trust policy(ies), if applicable;
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. To maintain records and furnish to company or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. To provide notice of applicable conversion rights to eligible employees and eligible dependents;
5. That statements of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Company for life and disability insurance;
6. That approval for this insurance may cancel any prior contracts and/or coverage with Company effective immediately preceding the effective date of the employer's coverage;
7. To pay Company by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
8. That claims filed by or on behalf of members may, at Company's option, be suspended if premiums are not received timely;
9. The employer will receive, on behalf of members, all notices delivered by Company, and immediately forward such notices to persons involved, at their last known address;
10. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Company's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these Conditions are met, there shall be no liability on the part of Company, except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
11. That in order for Anthem Life to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Company, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Life may be different than the coverage applied for herein. In that event, Anthem Life shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued. Any change in coverage will not be made without the policyholder's written consent, as contained in the policy or any endorsements or amendments thereon, and signed by the policyholder and the insurer;
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem Life by the employer. Anthem Life reserves the right to review such rates upon receipt of all individual applications for employers' employees and modify the rates in accordance with our underwriting guidelines as approved by the Superintendent of Insurance for the state of New York, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rate as of the effective date of coverage;
13. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief;
14. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Company in writing) and meet any other eligibility requirements for coverage;
15. that an employee not actively at work on the policy effective date or the employee's eligibility date will not be covered until such employee returns to active work.
16. The requested coverage is not in effect unless and until this application is approved by Company, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Company.

Sign here	Company officer signature **X**	Title	
	Printed name		Date (MM/DD/YYYY)
Accepted by Empire BlueCross and BlueShield and/or Anthem Life authorized representative		Printed name	Today's Date (MM/DD/YYYY)

Employer tax ID no. (required): _____

Section F: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
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 applicant. 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 Empire 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 or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Empire reviews and approves the application and the employer receives a written notice from Empire.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Empire shall be paid to an agent/broker/producer not appointed/approved by Empire.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Empire 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 ID no.				Agent/producer/broker ID no.			
Payable/sub-agent/producer/broker ID no. if different				Payable/sub-agent/producer/broker ID no. 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 FNA Insurance Services	Agent/producer/broker ID no.		
Street address 1000 Woodbury Rd, Suite 403	City Woodbury	State NY	ZIP code 11797
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.		

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