

# SMALL EMPLOYER GROUP APPLICATION

## New York (2-50)



**CIGNA HealthCare**  
of New York, Inc.  
*A Business of Caring.*

### I. COMPANY INFORMATION

Requested Effective Date \_\_\_\_\_ Tax ID # \_\_\_\_\_  
 Full name of company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Nature of business \_\_\_\_\_ How Long in Business \_\_\_\_\_ SIC Code \_\_\_\_\_  
 Contact person \_\_\_\_\_ Title \_\_\_\_\_

#### Billing Information (if different from above)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_

### II. ELIGIBILITY

Number of eligible employees (20 Hrs./Wk.) \_\_\_\_\_ Number of enrollments \_\_\_\_\_  
 Do you have any individuals on COBRA? \_\_\_\_\_ Please list names and extension effective dates on a separate sheet.  
 Class or classes to be excluded \_\_\_\_\_

### III. AFFILIATES, SUBSIDIARIES OR BRANCHES

Legal Name & Location	Number of Eligible Employees in this Company	Number of Eligible Employees to be Insured	Type of Organization	Nature of Business

### IV. CARRIER INFORMATION

Will CIGNA be the only health care insurer?  YES  NO  
 If No, who is/are the other insurer(s)? \_\_\_\_\_  
 What is/are the plan design(s)?  HMO  PPO  POS  Indemnity  
 Who is your current insurer? \_\_\_\_\_ Termination Date if Applicable \_\_\_\_\_  
 What is/are the plan design(s)?  HMO  PPO  POS  Indemnity

### V. PLAN DESIGN (PLEASE REFER TO PROPOSAL FOR PLAN DETAILS)

TYPE	COPAY	DED	CO-INS	OOP	RX	VISION
<input type="checkbox"/> HMO	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> POS	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____	_____	_____
<i>Dual Option</i>						
<input type="checkbox"/> HMO/POS	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> POS/POS	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____	_____	_____

#### NEW HIRE POLICY/WAITING PERIOD

None  30 Days  
 60 Days  90 Days  
 Other (Please Specify) \_\_\_\_\_

#### EMPLOYER CONTRIBUTION: % or \$

Employee: \_\_\_\_\_  
 Dependent: \_\_\_\_\_

**VI. BROKER INFORMATION**

Broker #1	Broker #2 (If applicable)
Broker name _____	Broker name _____
Firm name _____	Firm name _____
Account name _____	Account name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Phone _____	Phone _____
Fax _____	Fax _____
Group # (to be completed by CIGNA) _____	Group # (to be completed by CIGNA) _____
Effective date _____	Effective date _____
% share if other than 100% _____	% share if other than 100% _____

**VII. EMPLOYER CERTIFICATION OF ELIGIBLE EMPLOYEE/DEPENDENT WAIVER**

I, \_\_\_\_\_, representing the organization of \_\_\_\_\_

(NAME OF ADMINISTRATOR)

(COMPANY NAME)

as \_\_\_\_\_, certify that we have offered the CIGNA Healthcare medical plan to all our

(TITLE)

eligible employees and their dependents. I also certify that the enrollment cards for all those eligible employees and dependents which have elected the CIGNA Healthcare medical plan are being included with our submission materials requesting coverage by CIGNA HealthCare. I understand that this certification is made in place of the completion of waiver cards for all of the employees of this organization whom have chosen to waive their and their dependent's right to enroll under this plan. I, also understand that, except in the case of an excused late entrant (defined as a member adding a dependent spouse within 31 days of marriage, dependent child within 31 days of marriage, dependent child within 31 days of birth/adoption or an involuntary loss of coverage), any existing eligible employees and/or dependent that is not enrolled at this time will NOT be able to enroll in the plan until such time as the first open enrollment period occurs, which is defined as the 30 day period preceding the anniversary date, the anniversary date being one year from the coverage effective date.

\_\_\_\_\_  
(SIGNATURE OF OFFICER, OWNER OR PARTNER)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(WITNESS)

\_\_\_\_\_  
(DATE)

*For the purpose of this application, "you" and "your" and "applicant" and "company" shall be used to refer to the company submitting this application. The completion of this application form does not guarantee acceptance in to the CIGNA HealthCare plan. You also agree to provide CIGNA HealthCare with any additional information requested by CIGNA HealthCare in its processing of this application. Moreover, should CIGNA HealthCare accept your application and offer you coverage, such acceptance and offer of coverage shall be made solely upon information you provided. If it is subsequently determined that such information was inaccurate, you do hereby agree that CIGNA HealthCare shall have the right to terminate with 30 days notice, any coverage(s) offered as a result of this application. This right to terminate shall survive this application and shall be in addition to any provisions set forth in any subsequent agreement entered into by and between you and CIGNA HealthCare.*

*Your signature below constitutes your appointment as "Broker of Record" of the broker(s) identified in section VI of this application and offer you coverage(s) as a result of this application, you do hereby authorize CIGNA HealthCare to communicate to the broker and/or agency identified above, and information relative to your coverage, and you further authorize CIGNA HealthCare to rely upon you. This application must be signed for it to be valid. Any unsigned applications will be discarded. CIGNA HealthCare underwriting department will make reasonable efforts to verify all of the above information.*

**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 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 violation.**

**VIII. SIGNATURE OF INDIVIDUAL AUTHORIZED BY COMPANY TO EXECUTE THIS APPLICATION**

Name \_\_\_\_\_ Title \_\_\_\_\_, Duly Authorized

Signature \_\_\_\_\_ Date \_\_\_\_\_

# CONNECTICUT GENERAL LIFE INSURANCE COMPANY

## The Health Access Insurance Trust Trust Participation Agreement

### PART 1.

#### SECTION 1. REQUEST FOR PARTICIPATION

The undersigned employer/organization, in order to establish a plan or plans of Group Insurance for its employees/members and their dependents, hereby requests participation in the Health Access Insurance Trust (the "Trust" which includes any subtrusts) which provides Insurance benefits under a group insurance policy or policies (the "Policy") issued by Connecticut General Life Insurance Company ("CG") to the Trustee of the Health Access Insurance Trust.

#### SECTION 2. EFFECTIVE DATE OF PARTICIPATION

If the undersigned employer's/organization's request for participation is approved by the Trustee or the Administrator appointed by it (the "Administrator") said employer/organization shall become a Participant (as defined in the Trust Agreement) as of the Effective Date endorsed hereon by the Trustee or the Administrator.

The undersigned employer's/organization's understands and acknowledges that even if it is approved for participation in the Health Access Insurance Trust, its employees/members and their dependents are not automatically insured, but must each satisfy any eligibility requirements of the Policy as well as any evidence of insurability requirements as specified in the Policy. The employer/organization agrees to make the coverage under the policy available to all of its present and future eligible employees/members.

#### SECTION 3. CONDITIONS OF PARTICIPATION

The undersigned employer/organization hereby agrees:

- A. To be bound by all the terms of the Policy (as from time to time amended), a copy of which is available from CG or the Administrator upon request.
- B. To be bound by all the terms of the Trust Agreement (as from time to time amended), a copy of which is available from the Trustee or the Administrator upon request.
- C. To furnish any information requested by the Trustee, CG or the Administrator, which is reasonably required for the proper administration of the Trust and/or the Policy.
- D. To distribute to its eligible employees/members any materials provided by or on behalf of the Trustee or CG describing the Trust or the Policy.
- E. That it has no right, title or interest in or to the Trust Fund created under the Trust.
- F. That it has completed Part II of this Agreement and that all answers contained therein are true and complete to the best of its knowledge.

IN WITNESS WHEREOF, the employer/organization, by its duly authorized officer, has executed this Trust Participation Agreement consisting of Parts I and II on this \_\_\_\_\_ day of \_\_\_\_\_, 2002.

\_\_\_\_\_  
EMPLOYER/ORGANIZATION

By \_\_\_\_\_

(WITNESS)

\_\_\_\_\_  
OFFICIAL TITLE

HEALTH ACCESS INSURANCE TRUST  
Endorsed By:

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
EFFECTIVE DATE

**COMPLETE IF ENROLLING IN A POINT OF SERVICE PLAN.**

**PART 2.**

1. Employer/organization \_\_\_\_\_

2. Address \_\_\_\_\_

(NUMBER AND STREET)

\_\_\_\_\_  
(CITY)

(COUNTRY)

(STATE)

(ZIP CODE)

3. Effective date requested for insurance \_\_\_\_\_

Anniversary date if different from effective date \_\_\_\_\_

4 Total number of eligible employees \_\_\_\_\_

5. (a) Has the employer/organization ever carried any other form of group medical insurance or any other arrangement for employees in a group?  YES  NO

(b) If yes, name of insurer: \_\_\_\_\_

(c) Is coverage still in effect?  YES  NO

(d) If no, when did coverage terminate \_\_\_\_\_