

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type

Policy number: (Carrier Use Only)

New Policy

Change in Policy

Requested Effective Date: _____

SECTION I: POLICYHOLDER INFORMATION:

1. Policyholder (full legal name of company) _____

2. Tax Identification Number: _____

3. Main Address: _____
 Street City State Zip

Mailing Address: _____
 Street City State Zip

Telephone: () _____ Facsimile: () _____

4. Name of Correspondent: _____

5. Type of organization: Corporation Partnership Proprietorship Other (explain) _____

6. Nature of Business (specify) _____ SIC Code _____

7. Number of eligible employees in your company: _____

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured: _____

9. Class or classes to be excluded: _____

10. Insurance Requested For: Employees Only Employees and Dependents

11. Are you subject to the requirements of COBRA? Yes No

12. Waiting period before employees become insured: (May not exceed 6 months)

Present employees: _____ New or Rehired Employees: _____

13. What percentage of the premium will the employer pay? _____

14. Deposit \$ _____

Premium Paid: Monthly Automatic checking withdrawal

Premium will be due as of the effective date: The premium for the first month of coverage must be attached.

Affiliates, subsidiaries, or branches (Must be included for purposes of participation)

Legal Name & Location	No. Eligible Employees in this company	No. Eligible Employees to be insured	Type of Organization	Nature of Business

SECTION II: SPECIFICATIONS FOR COVERAGE

HEALTH BENEFITS:

Indemnity Plan: A B C D E Deductible \$ _____

Remarks: _____

PPO Plan: Please indicate PPO Plan being elected: _____

HMO Plan: Please write in the HMO plan code: _____ (Example 1NJS)

POS: Please write in the POS plan code: _____ (Example 5NJS)

PRESCRIPTION DRUG BENEFITS:

Indemnity Plan: Card - \$5 Copay Generic \$10 Copay Brand \$5 Copay Generic Card/ \$10 Copay Brand Mail Order \$0 Copay Generic Combination \$5 Copay Brand

PPO Plan: Card - \$5 Copay Generic \$10 Copay Brand \$5 Copay Generic Card/ \$10 Copay Brand Mail Order \$0 Copay Generic Combination \$5 Copay Brand

HMO Plan: Base prescription benefit included with medical. \$15 Copay Prescription Card. Optional rider will replace the base prescription benefit.

Card- \$5 Copay Generic \$10 Copay Brand (G1) \$5 Copay Generic Card/ \$10 Copay Brand (G3) Mail Order \$0 Copay Generic Combination \$5 Copay Brand

POS Plan: Base prescription benefit included with medical: Base prescription copay for prescriptions dispensed in-network mirrors base medical copay for office visits in-network, i.e., \$5, \$10, \$15 and \$20 office visit copay plans will have \$5, \$10, \$15 and \$20 prescription copays respectively. Reimbursement for prescriptions dispensed out-of-network, according to plan deductible and coinsurance.

Optional Rider will replace the base prescription benefit:

Card - \$5 Copay Generic \$10 Copay Brand (G7) \$5 Copay Generic Card/ \$10 Copay Brand (G8) Mail Order \$0 Copay Generic Combination \$5 Copay Brand

Card - \$5 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed (H7) out-of-network.

Card - \$10 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed (FN) out-of-network.

Card - \$15 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed (FZ) out-of-network.

Card - \$20 Copay Prescription Card for in-network use and reimbursement to plan deductible and coinsurance when dispensed (H9) out-of-network.

DEPENDENT ELIGIBILITY: PLEASE NOTE: (All medical coverage inforce must carry the same dependent eligibility).

Base Benefit: Dependent children covered to age 19; 23 if full-time student under Indemnity, PPO, HMO, and POS Medical/Prescription Plans.

Optional rider: (86) Dependents covered to age 20; 26 if full-time student. Yes No

OTHER OPTIONAL RIDERS as may become available (Please list): _____ paired with _____ Plan
 _____ paired with _____ Plan
 _____ paired with _____ Plan
 _____ paired with _____ Plan

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1a. Is there any Group Health Plan:

- now in force and to be continued? Yes No
- currently being applied for? Yes No

If yes, give a description of the plan and name of insurance carrier(s) _____

b. Name of present or prior group carrier _____

Effective date of prior coverage _____ Cancellation/termination date _____

Is the coverage applied for in this application replacing other group insurance? Yes No

If yes, give reason _____

Plan being replaced: A B C D E HMO POS PPO Other _____

c. Has your firm been uninsured for 3 or more months prior to application? Yes No

2. What forms of insurance are now or were in force? Health Benefits Prescription Drugs
 (Attach copies of Booklet/Certificate and most recent Billing Statement)

3. Are extended benefits provided in case of termination of health benefits? Yes No

4. 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

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, attach a separate sheet, signed and dated.

5. To the best of your knowledge:

a. Are any employees or dependents presently incapacitated? Yes No

b. Are any dependent children incapable of self-support due to a physical or mental disability? Yes No

Additional space to explain if items 1 a,b,c were answered "yes". Refer to the question number and give details including names, where appropriate.

SECTION IV: AGENT/PRODUCER INFORMATION

1) Agent _____

2) Agent Address _____

3) Phone Number _____ 4) Fax Number _____

5) Agent/Agency Code _____

6) Licensed with The Guardian (?) _____ With PHS (?) _____

SECTION V: SIGNATURE

It is understood that only full-time employees are eligible. It is further understood that no agent has power on behalf of The Guardian or Physicians Health Services of New Jersey, Inc. to make or modify any request or application for insurance or to bind The Guardian or Physicians Health Services of New Jersey, Inc. 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 The Guardian or Physicians Health Services of New Jersey, Inc. 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 statements and answers given in this application (i.e. crossed out, white-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.