

SMALL EMPLOYER GROUP APPLICATION INSTRUCTIONS

This form should be completed with the assistance of your authorized Broker or Horizon Healthcare of New York Sales Representative.

Please be sure that all necessary forms are completed in their entirety and printed clearly in ink or typed.

Ensure that all areas requiring a signature and date are completed.

Completed enrollment application forms should be submitted to your authorized Broker or Horizon Healthcare of New York Sales Representative at least fifteen (15) calendar days prior to the requested effective date of coverage.

Attached are the forms that must be completed and submitted with each New York Small Employer Group applying for Standard health insurance coverage:

1. Application for a Small Employer Health Benefits Policy
2. Small Employer Health Benefits Waiver Coverage*
(1 form needed for each employee waiving coverage)
3. Spouses' Business Statement (only for groups where the only employees are husband & wife)
4. Employee Enrollment Change/Deletion Form (to be completed for product conversions)
5. Late Paperwork form for groups received by Horizon Healthcare of New York within 14 days of the requested effective date.

*Additional Forms may be photocopied, if needed, based on number of employees.

In addition to the above forms being completed, the following items must also be attached to this package:

1. Enrollment application/Change Form (1 per each employee enrolling). Your Sales Representative will provide these forms.
2. All new cases must be submitted with a company check for the first month's premium made payable to Horizon Healthcare of New York. If a case is submitted without a premium check, the case will be returned.
3. If replacing group medical coverage submit a copy of the Prior/Current Carrier's most recent billing statement.
4. The rate quote generated for the group must be included with the submission and should match the product selected in Section II of the group application.

The rate quotation is an estimate based on information provided by your authorized Broker or Horizon Healthcare of New York Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon Healthcare of New York.

**HORIZON HEALTHCARE OF NEW YORK
DEPT. A
P.O. BOX 607
NEWARK, NEW JERSEY 07101-0607**

NEW YORK SMALL GROUP SOLD CASE CHECKLIST

This form is required for all new business submission.

Group Name: _____

General Agent: _____

Writing Agent: _____

General Agent Correspondent: _____

General Agent Fax #: _____

Verify Requested Effective Date

Employer Master Group Application

Waiting Period

General Agent ID#

Employer Contribution Level

Federal Tax ID#

Applicable Agent Codes

Complete Company Address

Effective Date

Small Employer/Waiver Form

First Month's Premium Check

(must be company check payable to Horizon Healthcare of New York)

Group's Most Recent Billing Statement From Prior Carrier

NYS45TT (Quarterly Wage & Statement)

Copy of Rate Quote

Employee Enrollment/Application Forms - (dependents not listed will not be covered)

Dates of Hire

Employee's Signature

Employer's Name

Social Security Number

All Listed Data Fields

All Dependent Information

Late paperwork (if Necessary)

Agent Licensing Information

SECTION II: SPECIFICATIONS FOR COVERAGE (Health Benefits Selection)

1. Plan Design:

PPO					VISTA PLUS				EPO	VISTA		
100/80	100/70	100/90/70	90/80/60	100/50	100/80	100/70	100/90/70	90/80/60	100/0	100/0	100/90	90/80
\$0		<input type="checkbox"/>	<input type="checkbox"/>		\$0		<input type="checkbox"/>	<input type="checkbox"/>	\$0			
\$10	<input type="checkbox"/>	<input type="checkbox"/>			\$10	<input type="checkbox"/>	<input type="checkbox"/>		\$10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$15					\$15	<input type="checkbox"/>	<input type="checkbox"/>		\$15	<input type="checkbox"/>		
\$20	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$20	<input type="checkbox"/>	<input type="checkbox"/>		\$20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$25					\$25	<input type="checkbox"/>	<input type="checkbox"/>		\$25	<input type="checkbox"/>		
\$30	<input type="checkbox"/>	<input type="checkbox"/>			\$30	<input type="checkbox"/>	<input type="checkbox"/>		\$30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HORIZON HMO PCP SPECIALIST Co-Pay (Select One) \$10/10 \$15/15 \$10/20 \$20/20

HEALTHY NY Mandated Plan Design \$20 Co-Pay, Rx - \$10/20 (Retail) \$20/40 (Mail Order)
Mandatory Generic Incentive Program, Rx Deductible: \$100

2. **Deductible** 250 500 1000 2000 3000

3. **Per Admission Deductible** 0 500 (applicable to 100/0 EPO and 100/0 VISTA only)

4. **Stop Loss** 5K 10K

5. Rx Options:

- \$5/\$12/\$25 \$10/\$20/\$40
- \$7/\$15/\$30 \$10/\$25/\$50

6. **Rx Deductible:** 0 50 100 150 200 250

7. **Tier Options:** 2 4

SECTION III: PRODUCT/PLAN DESIGN

1. Continuation of Coverage: Are there any former employees who have been paying you for coverage since they stopped working for you. (Either COBRA or State Continuation Provisions) Yes No

If yes, please specify who those individuals are, and attached correspondence (Name, qualifying event and date)

Name of present or prior group carrier: _____ Cancellation Date: _____ Start Date: _____

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

If yes give reason: _____

SECTION IV: APPLICATION AGREEMENT

This application and the premium rates proposed by Horizon Healthcare of New York are subject to Home Office approval in writing by Horizon Healthcare of New York and may change due to difference in selection of benefits as determined by Horizon Healthcare of New York. The Application hereby acknowledges that this application does not constitute any obligation by Horizon Healthcare of New York to offer coverage to the Applicant until such application is accepted in writing by Horizon Healthcare of New York. The Application hereby confirms that it will not cancel any health coverage it may currently have in anticipation that this Application will be accepted by Horizon Healthcare of New York and that Horizon Healthcare of New York shall have no obligation to provide coverage to Applicant unless this Application is formally accepted in writing by Horizon Healthcare of New York. Further, I hereby certify on behalf of the Applicant that the Applicant has not had group health coverage terminated within the past 12 months due to failure to pay premiums.

Dated at: _____ this _____ day of _____ Yr _____

(Full Legal Company Name)

The above name company confirms that we employ no more than 50 full-time non-union employees and no fewer than 2 full-time non-union employees. 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 and 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.

X _____
Signature of Authorized Officer of the Company Date

X _____
Print Name Date



SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name: _____

Employee Name: _____
Last First MI

Marital Status: Single Married Widowed Divorced

Date of Employment: _____ Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Healthcare of New York. I *refuse* the following:

- Employee, Spouse, and Child(ren) coverage
- Spouse coverage
- Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

- Other group coverage sponsored by this employer (Must provide carrier & group #)
- Other group coverage sponsored by my spouse's employer (Must provide carrier & group #)
- Other group coverage sponsored by another organization
- Other reasons (please explain) _____

Please provide name of carrier and policy number: _____

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

Signature of Employee

Date

Signature of Witness

Date

SPOUSE'S BUSINESS STATEMENT

WE CERTIFY THAT WE BOTH WORK A MINIMUM OF 20 HOURS PER WEEK IN OUR BUSINESS

(_____)

FOR WHICH WE RECEIVE COMPENSATION.

DATE _____

(HUSBAND) SIGNATURE _____

(WIFE) SIGNATURE _____

INSTRUCTIONS: EMPLOYEE ENROLLMENT CHANGE/DELETION FORM

This form is to be used to notify Horizon Healthcare of New York of the following types of changes to a group policy at the employee level. It should be completed when **ADDING** either a new employee, rehire, or reinstatement; when **CHANGING** an employee's contract type, i.e., from single to family; when **DELETING** an employee from the group; to change to **COBRA** or the Working Aged Provision (**TEFRA, DEFRA**) status of an employee or dependent; or when **MOVING AN EMPLOYEE FROM ONE HEALTH INSURANCE PRODUCT TO ANOTHER**.

ADDING an employee

Complete fields 1, 2, 3, 4, 5 (identify reason for transaction: new hire, rehire, reinstatement), 7, 8, 9 (select appropriate contract code listed below), 11, and 13. **Attach a completed and signed employee application form.**

CHANGING an employee's contract type

Complete fields 1, 2, 3, 4, 5 (identify reason for transaction: marriage, newborn, divorce, overage dependent), 8, 9, (select appropriate contract code listed below), 11, 12, and/or 13. **Attach a completed and signed employee application form.**

DELETING an employee from a group

Complete fields 1, 2, 3, 4, 5 (note appropriate numeric code 388 general, code 387 death), 6, 11, 12, and/or 13.

COBRA/Working Aged Provision (TEFRA, DEFRA)/employee/spouse/dependent status change

Complete fields 1, 2, 3, 4, 5 (identify transaction: COBRA, TEFRA, DEFRA), 8, 9, 11, 12, and/or 13. **Attach completed and signed employee application when appropriate.**

MOVING an employee(s) from one health insurance product to another

Complete fields 1, 2, 3, 4, 5 (indicate Product Move), 8, 9, and 10 (use the product codes listed below to indicate current product and new product). An employee application must be completed whenever the new product is Horizon POS, Horizon HMO.

Transactions (field 5)

Addition: new hire, rehire, reinstatement

Contract Type Change: marriage, newborn, divorce, overage dependent

Deletion: use code 388 for general, code 387 for death

COBRA

TEFRA

DEFRA

Contract Codes (field 9)

1	Single
2	Husband/Wife
3	Family
6	Parent/Child(ren)

Product Codes (field 10)

PPO	Horizon PPO
EPO	Horizon EPO
V	VISTA
VP	VISTA PLUS
HMO	Horizon HMO
HNY	Healthy NY
RX	Prescription
D	Dental

Group Administrator's Signature authorizes the Broker of Record to electronically transmit the information on this form to Horizon Healthcare of New York.

LATE PAPERWORK FORM

Agents: If you are submitting group enrollment paperwork 14 calendar days (or less) prior to the group's requested effective date, this form must be filled out by the group administrator, signed and submitted with their **complete** paperwork.

Group: _____

Address: _____

We the undersigned understand that we are requesting a coverage date that will put our enrollment paperwork in Horizon Healthcare's home office(s) 14 days (or less) prior to our effective date, and that delivery of our I.D. cards and system activation will occur after our effective date.

Upon approval of our request for insurance, we acknowledge that the delivery of our group I.D. cards and system activation may occur after our effective date.

Name (please print): _____

Signature: _____

Date: _____