Section A: Small Business Information

Company Name: ______________________________

Telephone: (____) ______________ Fax: (____) ______________

Street Address of Business: ______________________________

City: ______________ State: ______ Zip: ________ County: ______________

Contact Person: ______________ Title: ______________

Telephone: (____) ______________ Today's Date: ______________

Tax ID #: ____________ SIC Code________ Email address______________

Section B: Employer Size Requirements

To be eligible for Healthy NY coverage, the business must have a total of 50 or fewer FTE (full-time equivalent) employees. The business may offer Healthy NY to a limited class of its employees, but the business cannot have more than 50 FTE employees overall. For more information on how to determine the number of FTE employees your business has, please see the Frequently Asked Questions at http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm

How many total FTE employees does your business employ?

☐ 50 or fewer total FTE employees ☐ More than 50 total FTE employees (not eligible)

Section C: Insurance Information

You may offer Healthy NY to all of your employees or a class of your employees if you have not offered health insurance to them in the last 12 months. Please answer the following questions to assist us in determining your eligibility to purchase Healthy NY.

1. Within the last 12 months, has your business provided health insurance that included both medical and hospital benefits (other than Healthy NY) to the class of employees that you are looking to cover? ☐ Yes ☐ No

2. If the answer to question 1 above is "Yes," did your business contribute more than $50 per employee per month towards the premium (or $75 if the business is located in Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, or Westchester counties)? ☐ Yes ☐ No

If the answers to both questions 1 and 2 above are "Yes," then your business is not eligible for Healthy NY.

Section D: Eligibility Requirements

Eligibility requirements were designed to reach those small businesses most in need. Please answer the following questions about your business. Please note that you must be able to check "Yes" to each question in this section in order to be eligible to purchase Healthy NY.

1. Do at least 30% of the employees who will be offered coverage earn annual wages of $41,250 or less? ☐ Yes ☐ No

2. Will your business contribute at least 50% of the Healthy NY premium on behalf of covered employees? ☐ Yes ☐ No

3. Will your business offer Healthy NY coverage to all employees working 20 hours or more per week who earn annual wages of $41,250 or less? ☐ Yes ☐ No

Section E: Participation Requirements

Please answer these questions about who will be accepting Healthy NY coverage. Please note that you must be able to check "Yes" to each question in this section in order to be eligible to purchase Healthy NY.

1. Will at least 50% of the class of employees who are offered Healthy NY coverage through your business actually accept enrollment or have health insurance through another source? ☐ Yes ☐ No

2. Will at least one employee earning annual wages of $41,250 or less enroll in Healthy NY? ☐ Yes ☐ No

Section F: Employee Information

1. Employers may offer Healthy NY coverage to their employees' dependents, including spouses, domestic partners, and children. Employers are not required to contribute towards the Healthy NY premium for dependents. Will your business be offering Healthy NY coverage to the dependents of your employees? ☐ Yes ☐ No

2. Employers may choose to make Healthy NY available to their part-time workers (those who work less than 20 hours weekly). You do not have to contribute towards the premiums for part-time workers. Will your business be offering Healthy NY coverage to part-time workers? ☐ Yes ☐ No

Section G: Employee Information (continued)

Complete the following information for each employee who is applying for coverage.
Please photocopy and attach additional sheets, if needed

Employee Name (First, MI, Last)	**Is this employee eligible for Medicare? (Yes or No)**

Section H: Certification

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true and accurate to the best of my knowledge. I further certify that I am duly authorized to execute this certification on behalf of the business.

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.

Print name of person completing certification	Signature
Title (must be owner or officer of business)	Date

If a broker assisted you with completing this application, he or she may be eligible for a commission paid by the HMO or insurer. Please complete the information below:

Broker's Name	License #	Company
Michael King	**LA-677677**	**Century Benefits Group**

Address	Phone	E-mail
400 White Spruce Blvd. Rochester, NY 14623	**(585)224-8138**	**mking@aboutcentury.com**

Send your completed application directly to:
Michael King, Century Benefits Group, 400 White Spruce Boulevard, Suite C, Rochester, NY 14623

Eligibility Policy for New Employees

Group Name: ____

Group Number {If Assigned}: ______________________________________

Our Standard new hire waiting period for eligibility for health insurance is:

(Type of employee: salaried, hourly, etc.)

_______Date of Hire ____________________

_______First of the month following date of hire ____________________

_______First of month following 30 days of employment ____________________

_______First of month following 60 days of employment ____________________

_______90 days after date of hire ____________________

_______Other ______________________________________
Must be approved by underwriting prior to submission

Our Standard rehire waiting period for eligibility for health insurance is:

_______Same guidelines as new hire ____________________
_______Date of rehire ____________________
_______First of the month following rehire ____________________
_______Other __ Must be approved by underwriting prior to submission

Minimum hours per week that an employee must work to be eligible:

_______20 hours ____________________
_______25 hours ____________________
_______30 hours ____________________
_______40 hours ____________________

Note:

- Employer can determine full time status as stated above but may not be less than 20 hours.
- Waiting period cannot exceed 90 days

The above policies have been submitted for business indicated above. I understand that these policies are accepted and must remain in effect for at least one full year before they are eligible to be changed.

Authorized Group Signature: ______________________________________

Date Signed:____________________Date Effective: ____________________

Ms. Caitlin Hryzak
Broker Program Manager
Excellus Blue Cross Blue Shield, Rochester Region
265 Court St.
Rochester, New York 14647

Dear Caitlin:

This is to notify you that our company has appointed Century Advisory Group, Inc (Broker no. 265) whose business address is 400 White Spruce Blvd. Suite C, Rochester, New York 14623 as our sole broker of record, with respect to our health insurance coverage provided to this organization by Excellus Blue Cross Blue Shield, Rochester Region, effective immediately.

I understand that if our company elects to purchase coverage from your company that Century Advisory Group, Inc. may be entitled to base and/or bonus compensation for our business.

This designation will remain in effect until we notify Excellus Blue Cross Blue Shield, Rochester region in writing to the contrary.

Sincerely,

165 Court St, Rochester, NY 14647
A nonprofit independent licensee of the BlueCross BlueShield Association

Dear Administrator:

Please complete the following and return it to:

Excellus BlueCross BlueShield
Membership and Billing Department
PO Box 22999
Rochester, New York 14692

1. Billing Election - Please select the option you prefer.

   - ☐ We would like Excellus BlueCross BlueShield to administer the billing for our COBRA or New York State continuation of coverage provisions subscribers. (If you select this option, you must sign the Administrative Agreement on the back of this form.)

   - ☐ We would prefer to collect premiums and remit the payments on our COBRA or New York State continuation of coverage provisions group bill for our subscribers.

2. COBRA and New York State continuation of coverage provisions do not apply to us because:

   - ☐ We are considered a church plan.

3. Group Name: ______________________________

4. Signature: ______________________ Title: ______________

5. Group Number: ___________________ Telephone: ____________

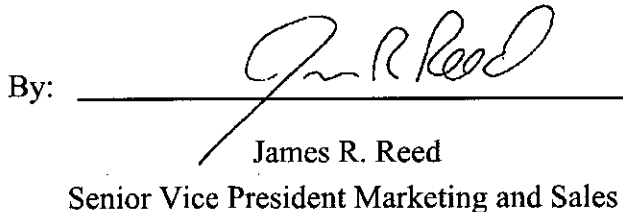
PLEASE SEE REVERSE SIDE FOR ADMINISTRATIVE AGREEMENT

Administrative Agreement for Health Insurance Continuation Coverage

Excellus BlueCross BlueShield and____________________the ("Employer") agree as follows:

1. As agent for the Employer, Excellus BlueCross BlueShield will, on a monthly basis, bill and collect premiums from those employees and other beneficiaries of the Employer's group health insurance plan who qualify for and elect to purchase continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or New York State continuation of coverage provisions. Benefits and premiums will correspond to those otherwise applicable under the plan, provided that Excellus BlueCross BlueShield will add to each bill a charge for its administrative service equal to two percent (2%) of the applicable premium, which service charge the Employer is assigning to Excellus BlueCross BlueShield, as its agent.
2. The employer will have sole responsibility for complying with all notice requirements and election procedures under COBRA or New York State continuation of coverage provisions and for determining who is eligible for continuation coverage under its group health insurance plan. The Employer will notify Excellus BlueCross BlueShield, in writing with respect to the commencement, termination and other terms and conditions of continuation coverage for each eligible individual, and Excellus BlueCross BlueShield, will be entitled to rely upon those instructions.
3. The Employer will indemnify Excellus BlueCross BlueShield from and against any and all claims, liabilities, costs or damages that arise as a result of Employer's failure to comply with the requirements of COBRA or New York State continuation of coverage provisions. The Employer's duty to indemnify will survive the termination of the Agreement."
4. Any party may terminate the Agreement by giving sixty days written notice to the other parties.

Dated: ____________ Excellus BlueCross BlueShield



By: ______________________

James R. Reed
Senior Vice President Marketing and Sales

____
Employer

By: ______________________

National strength.
Local focus.
Individual care.

A nonprofit independent licensee of the Blue Cross Blue Shield Association

For Internal Use Only
HIOS ID#: 78124NY1110009-00
EC: SGL1

Group Health Insurance Application/Change Form

- Please print clearly and complete all sections that apply to you
- Additional instructions are included
- This application cannot be processed without this information and a signature

Section 1: Employer Group Information

This section should be completed by the Group Benefits Administrator

Medical Group Number (8 digits) ______ Medical Subgroup Number (4 digits) ______ Medical Class Number (4 digits) ______

Dental Group Number ______ Dental Subgroup Number ______

Employer Name ______ Association/Chamber Name (if applicable) ______

Group Administrators Signature ______ Date ______

Subscriber Status:

Date of Hire: ___ /___ /____

☐Rehire- Date of Rehire: ___ /___ /____

☐Retired - Effective Date: ___ /___ /____

☐COBRA - Effective Date: ___ /___ /____

☐Cancelled -- Effective Date: ___ /___ /____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Subscriber

☐Dependent Reached Max Age ☐ Other: ______

Section 2: Your Information

This section should be completed by the Subscriber

Last Name ______ First Name ______ MI ______ Social Security # ______

Birthdate ___ /___ /____ Sex: Male ☐ Female ☐

Street Address ______ City ______ State ______ Zip ______

Phone ______

Email ______ Would you like to receive emails about health & wellness? ☐ Yes No☐

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Medicare Number (if applicable) ______ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced/Marital Status Event Date ___/___/______

Section 3: Subscriber Medical Plan Selection

Healthy New York EPO

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren)

☐Self & Spouse/Domestic Partner ☐Family

Effective Date: ___/___/______

Section 4: Subscriber Dental Plan Selection Please select plan if applicable: ☐Dental Blue Classic (DI) ☐Dental Blue Options (DJ) ☐Dental Other (DE)	**If enrolling in a Dental plan, who do you need coverage for?** ☐Self Only ☐Self & Child (ren) ☐Self & Spouse/Domestic Partner ☐Family **Medical & Dental Effective Date: __/___/___**

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

Section 5: Please indicate the reason for this enrollment or change

☐New Hire / Rehire ☐Open Enrollment ☐Retirement ☐Loss of Coverage ☐COBRA
☐Medicare Eligible ☐Change in employment status ☐Change to new employer that does not offer insurance
☐Loss of eligibility through employer or discontinuation of employer coverage

☐Marital Status Change ☐Marriage ☐Divorce ☐Dependent reaches maximum age of coverage
☐Address Change ☐Last Name Change ☐A move in or out of service area
☐Remove Dependent ☐Death

☐Add Dependent: Please indicate reason ☐Newborn ☐Marriage ☐Other ________________

Date of Event ___/___/________

Section 6: If canceling coverage, who are you canceling coverage for?

☐Subscriber
☐Medical Cancellation Date __/__/_____ ☐Dental Cancellation Date __/__/_____
☐Dependent(s) (List each dependent below in section 8)
☐Medical Cancellation Date __/__/_____ ☐Dental Cancellation Date __/__/_____

Why are you canceling coverage?

☐Subscriber's request ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage
☐Coverage through spouse ☐Loss of eligibility through employer or discontinuation of employer coverage
☐Other ________________

Section 7: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child *Separate form required
☐Other_______________

Sex: Male ☐ Female ☐ Birthdate ___/___/_______

Last Name (if different) ______ First Name ______ MI ______ Social Security # ______

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable) ______

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other____________________

Sex: Male ☐ Female ☐ Birthdate ___/___/_______

Last Name (if different) ______ First Name ______ MI ______ Social Security # ______

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable) ______

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_______________

Sex: Male ☐ Female ☐ Birthdate ___/___/______

Last Name (if different) ____ First Name ____ MI ____ Social Security # ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Medicare Number (if applicable) ____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_______________

Sex: M ☐ F ☐ Birthdate ___/___/______

Last Name (if different) ____ First Name ____ MI ____ Social Security # ____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Medicare Number (if applicable) ____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Note: Use an additional application if more than four people need coverage.

Section 8: Other coverage information (Must be completed – you may be contacted for additional information)

Are you or any member of your family enrolled in other coverage? ☐Yes ☐No

If yes, are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage cancel? __/__/__

Policyholder's name ______________________ ID# ______________

Effective Date: ___/___/____

Who did the insurance cover? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family

Section 9: Release – You must sign and date this form to be eligible for health insurance.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)
I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

PREFERRED PROVIDER ORGANIZATION (PPO)
I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.
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 $5,000 and the stated value of the claim for each such violation.

Subscriber Signature______________________________ **Date**______________

Please return to PO Box 22999, Rochester, NY 14692. If you have questions, please contact your Group Administrator.
Or, visit us at: ExcellusBCBS.com