Employer Notice of Election

HealthPass
61 Broadway, Suite 2705
New York, NY 10006
Member Services: (888) 313-7277
Billing: (888) 313-7010
Fax: (212) 252-7448
Email: forms@healthpassny.com

A Company Information

Full Name of Company/DBA

Contact Person (Last, First) Required

Federal Tax I.D. Number

Date Company Founded / /

Street Address (P.O. Box not acceptable)

Suite

City State Zip

County or Borough

Billing Street Address (if different)

City/State/Zip

Business Phone and Ext. ( )

Fax ( )

E-mail Address

Do you currently offer group health insurance? ❒ Yes ❒ No If yes, name of current insurance company.

Organizational Type ❒ "C" Corp ❒ "S" Corp ❒ Partnership ❒ Non-Profit ❒ Sole Proprietorship ❒ Church

Employer Industry ❒ Health ❒ High Tech ❒ Legal ❒ Mfg. ❒ Retail ❒ Service ❒ Tourism ❒ Other

B Eligibility Requirements

Desired Effective Date (Must be 1st or 15th of the month)

To be eligible for coverage employees must work hours per week. (**Must be between 20 and 40 hours and must be uniformly applied to all employees)**

What is your waiting period before employees become eligible for coverage? ❒ 0 days ❒1 Month ❒ 2 Months ❒ 3 Months ❒ 6 Months

Total Number of Employees (full and part-time) Number of Eligible Employees

Must attach NYS-45 or applicable tax form from most recent quarter; 75% of eligible employees must participate in either HealthPass or another health plan

Number of Enrollments with HealthPass Number of employees who have other health coverage

Number of employees covered by collective bargaining agreement

What dollar amount/ if any, are you contributing toward employee-only medical premium? dependent coverage?

Are any former employees covered under COBRA/State Continuation? ❒ Yes ❒ No If yes, how many?

Are any former employees covered under COBRA/Federal Continuation? ❒ Yes ❒ No If yes, how many?

Would you like to offer Domestic Partner Coverage to your company? ❒ Yes ❒ No

C Medical Plan Options

Select tier structure : ❒ Mixed Tier (Two Tier rates for EmblemHealth and HIP ; Four Tier rates for Oxford) ❒ Four Tier (All carriers)

BBMI Rider (applies to Oxford plans only and different rates apply) ❒ Yes ❒ No

D Dental Plan Options

If you enroll on the 15th of the month, your Dental coverage will be effective the subsequent 1st of the month.

Note that if you choose not to offer Dental at this time, current and future employees will be unable to enroll until your next open enrollment.

Would you like to offer Dental coverage? ❒ Yes ❒ No If yes, have you had group dental coverage in place over the last 63 days? ❒ Yes ❒ No

Select tier structure: ❒ Two Tier (Employee Only, Family) ❒ Four Tier (Employee Only, Employee and Spouse, Employee and Child(ren), Family)

Select the desired dental coverage type. If selecting DentalGuard Preferred (Dual Option DMO/PPO), 75% of eligible employees, excluding waivers, must participate and at least one of the eligible employees must enroll in the DMO option.

❒ **Managed DentalGuard** Number of employees enrolling in DMO

❒ **DentalGuard Preferred & Managed DentalGuard** Number of employees enrolling in DMO PPO

❒ **Managed DentalGuard *Plus*** Number of employees enrolling in DMO

❒ **DentalGuard Preferred *Plus* & Managed DentalGuard *Plus*** Number of employees enrolling in DMO PPO

E Vision Plan Option

If you enroll in medical coverage on the 15th of the month, your Vision coverage will be effective the subsequent 1st of the month. Note that if you choose not to offer Vision at this time, current and future employees will be unable to enroll until your next open enrollment.

Would you like to offer Vison coverage? ❒ Yes ❒ No This is a 24 month contract based on your group's effective date. Group and member coverage can only be cancelled at the completion of 2 years or if all HealthPass coverage is cancelled. 20% of eligible employees must participate at inception. If offering, select tier stucture: ❒ Two Tier (Employee Only, Family) ❒ Four Tier (EE Only, EE and Spouse, EE and Child(ren), Family).

F EverGuard Options

If you enroll in medical coverage on the 15th of the month, your EverGuard coverage will be effective the subsequent 1st of the month.
Would you like to offer ❒ EverGuard ❒ EverGuard *Plus* ❒ EverGuard Dual option

G COBRA Administration

As part of the services provided, HealthPass automatically administers COBRA/NY State Continuance (NYSC) for our groups. If you wish to decline this service and administer COBRA/NYSC on your own, please indicate so here: ❒ I would like to OPT OUT of COBRA/NYSC services.

H Broker Information

Broker commission splits must total 100%.

Pay Commission To: Name_____ HealthPass ID#_____ % _____

Pay Commission To: Name_____ HealthPass ID#_____ % _____

General Agency Name (if applicable) _____ GA #_____

General Agency Representative Name_____ Oxford GA_____

I Employer Certification — I attest that:

1. My business maintains an active, bona fide business street address in one of the following coverage areas:
- One of the 5 Boroughs of NYC (Bronx, Brooklyn, Manhattan, Queens, or Staten Island)
- Westchester, Rockland, Orange, Nassau, Suffolk, Putnam, Dutchess, Sullivan and Ulster.

2. Only full-time employees are eligible for coverage through HealthPass, and:
- My business has at least two full-time employees. Full-time is defined by the employer (my business). Full-time employees must work between 20 and 40 hours per week, and this standard must be applied uniformly among all of the employees.
- My business will offer HealthPass coverage to every full-time employee and my business cannot use age, sex, health status or occupation to determine employee eligibility.
- I understand that temporary or seasonal employees, consultants, independent contractors, household help, and retirees are not eligible for coverage through HealthPass. Other exclusions may apply.
- I understand that **75% of eligible employees must participate in either HealthPass or another health plan** (through a spouse's plan, Medicare, Medicaid or an alternate plan offered by the employer).
- I understand that if the business chooses to pay the full dollar amount of the premium for employee-only coverage (your employees share none of the cost of premium), then all eligible employees must participate. If the business chooses to pay the full dollar premium for employee + dependent coverage, then all dependents must be covered. Note there is no minimum employer dollar contribution requirement.

3. My business cannot offer HealthPass coverage to any employee who lives outside of the HealthPass coverage area if more than 20% of <u>eligible</u> employees live outside of the coverage area. The HealthPass coverage area is New York, New Jersey, Connecticut, and Bucks County, PA. If 20% or less of the eligible employees live outside of the coverage area, then all out-of-coverage area employees can be covered through HealthPass. "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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

HEALTHPASS INSURANCE TRUST

The undersigned employer, in order to establish a plan or plans of Group Health Insurance for its employees and their dependents, hereby requests participation in the New York Health Purchasing Alliance, Inc. HealthPass Insurance Trust (the "Trust") which provides health insurance benefits under Group Contracts issued by several health insurers and health maintenance organizations to the Trustee of the HealthPass I Insurance Trust.

If the undersigned employer's participation is approved by the Trustee or the Administrator appointed by the Trustee (the "Administrator"), said employer shall become a Participating Employer (as defined in Trust Agreement) as of the effective date endorsed hereon by the Trustee or the Administrator. The undersigned employer understands and acknowledges that even if it is approved as a Participating Employer in the HealthPass Insurance Trust, its employees and their dependents are not automatically insured, but must each satisfy any eligibility requirements of the Trust and of the applicable Group Contracts. The employer agrees to make the coverage under Group Contracts available to all of its current and future eligible employees.

The undersigned employer hereby agrees:

1. To be bound by all the terms of the Trust Agreement and of the Group Contract(s) (as each are from time to time amended), copies of which are available from the Trust or the Administrator upon request.
2. To furnish any information requested by the Trustee, Administrator or any of the Insurers or Health Maintenance Organizations which is reasonably required for the proper administration of the Trust or of the Group Contract.
3. To distribute to its eligible employees any materials provided by or on behalf of the Trustee, Administrator, Health Insurer or Health Maintenance Organization describing Trust or the Group Contract.
4. That it has no right, title or interest in or to the Trust Fund created under Trust.
5. Coverage under any Contract through the Trust shall only apply to the extent provided in the Group Contract held by Trustee, and all claims for and benefits provided will be made payable to the insurance company or HMO issuing the Group Contract.
6. The Trustee does not have any obligation under any of the Group Contracts.

HEALTH ADVOCATE

All Medical plan options available through HealthPass include access to Health Advocate

HEALTHPASS COBRA ADMINISTRATION SERVICES

1. Client must timely and accurately perform all of their responsibilities by providing participant information as outlined in "*The ABC's An Administrative Guide to Your Health Insurance Plan*".
2. HealthPass COBRA Administration Services will terminate if:
- **a**. Client group is mandatory terminated due to non-payment.
- **b**. Client does not comply with "*The ABC's An Administrative Guide to Your Health Insurance Plan*".
- **c**. Client ceases to offer HealthPass COBRA Administration Services.
- **d**. Client ceases to offer medical insurance via HealthPass.

3. Client agrees to indemnify HealthPass and all personnel involved in the provision of COBRA Administration Services.

J Payment Method — A business check, payable to HealthPass, for the full premium due must accompany this application. If a 15th of the month effective date is requested, you must include payment for 1 1/2 months premium. Applications submitted with less than the full premium amount due or with personal checks will not be processed.

After the first payment, how do you prefer to pay for your coverage? _____ Initials

❒ Please bill me monthly. ❒ Please electronical funds transfer (EFT) for monthly payment. **(Must attach a voided business check)**

❒ Please electronically transfer funds (EFT) for my initial payment with HealthPass. **(Must attach a voided business check)**

I hereby authorize HealthPass to initiate electronic funds transfer (EFT) from my account for the payment of my monthly cost of coverage.

I understand the debit transaction will occur the 1st of the month or the first business day following.

In the event that I make changes to my banking arrangements, I understand that I must notify HealthPass to effect the changes for payment collection. All changes must be reported 20 days prior to the effective date of the change. Notify us by calling 888.313.7010

The physical check may be converted to an electronic payment

K Employer Authorization — IN WITNESS hereof, the Employer, by its duly authorized officer, certifies the Employer meets the eligibility requirements and has executed the Trust Participation Agreement under the terms set forth in this form.

Signature_____ Print Name_____