Small Group Application/Change Form
2–50 Eligible Employees

Reset Form | Save and Print

Empire BlueCross BlueShield

Thank you for choosing Empire. Please fill out all items in order for us to quickly and accurately process your application. Once you've completed this form, please sign in the space provided in Section 12.

SECTION 1: REASON FOR APPLICATION/CHANGE (FILL IN ONE ONLY)

☐ New policy	Requested effective date (MMDDYY)	☐ Change existing benefits	Revision or renewal date (MMDDYY)
Empire Sales Representative last name	First name		Current group no. (if applicable)

SECTION 2: GROUP INFORMATION

Group name (as it appears on documents attached)			
Doing business as			
Group mailing street address			
City		State	ZIP code (5+4)
County	Phone		Fax

AUTHORIZED GROUP CONTACTS

Primary group contact last name	First name	Title
Email address (Benefit administrator) – mandatory		
Secondary group contact last name	First name	Title
Tertiary group contact last name	First name	Title
Billing contact		Billing phone
Billing mailing street address (if different)		
City	State	ZIP code (5+4)
County	Federal employer identification no.	
Type of industry		
Is your group a subsidiary/division affiliated with another company? ☐ Yes ☐ No		
If yes, name		No. of employees

SECTION 3: OTHER COVERAGE

Has health insurance been purchased for the group from any carrier, including Empire, during the last twelve (12) months? ☐ Yes ☐ No
(If more than one carrier in 12 months, list all and attach a separate page with details.)

If yes, insurance carrier

Coverage type (ex: HMO, POS, PPO)	Coverage start date (MMDDYY)	Coverage end date (MMDDYY)

SECTION 4: GROUP ELIGIBILITY

NO. OF EMPLOYEES

A. No. of employees at all locations (include owners, partners, officers and paid Board members you wish to enroll, exclude COBRA)*

B. No. of retirees eligible for coverage

C. No. of ineligible employees (check reason for ineligibility)

☐ Part-time ☐ Temporary ☐ Union ☐ Other

D. Employee Eligibility**
All full-time, permanent employees who work at least ___ hours per week (minimum 20 hours/week) are eligible.

E. No. of net eligible employees (A + B - C)

No. of enrolling employees (include retirees and COBRA)

Employer contribution to retiree coverage (%)

The following information is needed to determine TEFRA* status. Employers may need to consult a tax expert to determine TEFRA status.**

1. Is your group TEFRA eligible? ☐ Yes ☐ No

2. Will (or did) your group have at least 20 full-time and part-time employees for at least 20 weeks:

In the current calendar year? ☐ Yes ☐ No If yes, list no. of employees:

In the last calendar year? ☐ Yes ☐ No If yes, list no. of employees: (Include owners and partners. Count all locations.)

3. Is your group subject to Federal COBRA or NY State Continuation of Coverage (fewer than 20 employees?
(check one box to the right) (See this site for additional COBRA information: www.dol.gov/ebsa/cobra)
☐ Federal COBRA
☐ NY State Continuation of Coverage

*Empire requires certain forms of proof to establish eligibility. See small group eligibility guidelines for more details regarding eligibility categories and required forms of proof. At least two eligible, active, full-time employees must be enrolled for non-HMO products.

**Empire reserves the right to request a current payroll register to confirm number of hours worked when verifying group size/eligibility participation.

*** TEFRA stands for the Tax Equity and Fiscal Responsibility Act of 1982. Under TEFRA, when an employer has 20 or more full-time and/or part-time employees on its payroll for 20 weeks in a calendar year, the group becomes the primary payer and Medicare becomes the secondary payer for the remainder of the calendar year and the following calendar year for claims of working-aged employees and their spouses age 65+ even if they go below the 20/20 threshold. The 20 weeks in a calendar year do not have to be consecutive to reach the 20/20 threshold.

Also, under OBRA, when an employer has 100 or more full-time and/or part-time employees on its payroll for 26 weeks in a calendar year, the group becomes the primary payer and Medicare becomes the secondary payer for the remainder of the calendar year and the following calendar year for claims of actively working employees and their dependents under the age of 65 that are Medicare eligible because of a disability.

ELIGIBILITY DATES (COMPLETE BOTH A & B)

A. Initial Enrollment of Group – All employees' and dependents' coverage will be in effect:
All enrollment forms must be received no later than thirty (30) days following the new group effective date.
☐ On group effective date
☐ After new employee eligibility is satisfied (see B)

B. New Employees (after initial enrollment of group) will be eligible for coverage:

☐ Date of hire
☐ First day following:
_____ day(s) following date of hire
_____ month(s) following date of hire
☐ First of the month following:
_____ day(s) following date of hire
_____ month(s) following date of hire

All enrollment forms must be received no later than sixty (60) days following the member's eligibility date.

C. Employee Reinstatement Policy: Employees who are re-hired to the company are eligible for coverage:

☐ Date of rehire
☐ First day following:
_____ day(s) following date of rehire
_____ month(s) following date of rehire
☐ First of the month following:
_____ day(s) following date of rehire
_____ month(s) following date of rehire

All enrollment forms must be received no later than sixty (60) days following the member's eligibility date.

DOMESTIC PARTNERSHIP COVERAGE SELECTION (PLEASE SELECT ONE)

☐ Same sex only ☐ Same sex and opposite sex ☐ No domestic partnership coverage

SECTION 5: PAYMENT SECTION (GROUP'S CONTRIBUTION, IF ANY)

% Employee only	% Employee & spouse	% Parent & child(ren)	% Family

If your group has multiple locations, do you wish to receive (select one)**:**
☐ A summary invoice combining all locations. **OR** ☐ Separate invoices for each location.
☐ If you are requesting quarterly billing, please indicate here; otherwise, group will be billed monthly.

SECTION 6: MEDICAL BENEFITS SECTION

Please fill out the details for the coverage options you wish to purchase.

HMO/DIRECT HMO

Is Empire the sole carrier offered by the group? ☐ Yes ☐ No

Please select only one product: ☐ HMO ☐ Direct HMO

Copay Options (select one) Option	Inpatient Copay	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	ER Copay	Ambulatory/ OP Surgery Copay
☐ 12	$1,000/$2,500*	$30	$50	$150	$150

*Per admission/maximum per calendar year

Prescription Drug (includes contraceptives*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
☐	$100	$10	35% Coinsurance	50% Coinsurance
		Generic	Mandated Brand†	
☐	$0	$10	50% Coinsurance	

*Groups exempt from contraceptive coverage must attach a signed affidavit. **Not applicable to Retail Tier 1 generics or drugs ordered through mail-order program.
†Mandated brand-name drugs without a generic equivalent.

Miscellaneous Options (select all of the options you wish to purchase)

☐ Dependent child age increases through age 29 (for eligible dependents)
☐ Inpatient rehabilitation for alcohol/substance abuse increase to 30 days in-network
☐ Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
☐ Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
☐ No additional options

EMPIRE PPO

Is Empire the sole carrier offered by the group? ☐ Yes ☐ No

Cost-sharing and Benefit Maximum Calculation Period (select one) ☐ Calendar Year ☐ Plan Year

Options (select one)	In-Network Deductible*	In-Network Coinsurance	In-Network Total Out-of-Pocket Max*	Out-of-Network Deductible*	Out-of-Network Coinsurance	Out-of-Network Total Out-of-Pocket Max*
☐ 1	$1,000	90%/10%	$3,000	$2,500	70%/30%	$7,500
☐ 2	$1,500	80%/20%	$4,500	$3,000	60%/40%	$9,000

* Individual amount shown. Family coverage is 2.5 times the individual amount.

Prescription Drug (includes contraceptives*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
☐	$50	$10	$35	35% Coinsurance
☐	$100	$10	35% Coinsurance	50% Coinsurance
		Generic	Mandated Brand†	
☐	$0	$10	50% Coinsurance	

*Groups exempt from contraceptive coverage must attach a signed affidavit. **Not applicable to Retail Tier 1 generics or drugs ordered through mail-order program.
†Mandated brand-name drugs without a generic equivalent.

Miscellaneous Options (select all of the options you wish to purchase)

☐ Dependent child age increases through age 29 (for eligible dependents)
☐ Inpatient rehabilitation for alcohol/substance abuse increase to 30 days combined in-network and out-of-network
☐ Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
☐ Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
☐ No additional options

EMPIRE EPO ESSENTIAL

Is Empire the sole carrier offered by the group? ☐ Yes ☐ No

Cost-Sharing and Benefit Maximum Calculation Period (select one) ☐ Calendar Year ☐ Plan Year

In-network Option	PCP/Primary Home/Office Copay	Specialist Home/Office Copay	Deductible*	Coinsurance	Total Out-of-Pocket Max*
☐ 10	$30	$50	$4,000	80%/20%	$10,000

*Individual amount shown. Family coverage is 3 times the individual amount.

Prescription Drug (includes contraceptives*)

Copay Options (select one)	Deductible**	Tier 1	Tier 2	Tier 3
☐	$50	$10	$35	35% Coinsurance
☐	$100	$10	35% Coinsurance	50% Coinsurance
		Generic	Mandated Brand†	
☐	$0	$10	50% Coinsurance	

*Groups exempt from contraceptive coverage must attach a signed affidavit. **Not applicable to Retail Tier 1 generics or drugs ordered through mail-order program.
†Mandated brand-name drugs without a generic equivalent.

Miscellaneous Options (select all of the options you wish to purchase)

☐ Dependent child age increases through age 29 (for eligible dependents)
☐ Inpatient rehabilitation for alcohol/substance abuse increase to 30 days in-network
☐ Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
☐ Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
☐ No additional options

EMPIRE TOTAL BLUE℠ COVERAGE WITH HSA

Is Empire the sole carrier offered by the group? ☐ Yes ☐ No

Cost-Sharing and Benefit Maximum Calculation Period (select one) ☐ Calendar Year ☐ Plan Year

	In-network			**Out-of-network**		
Option	Deductible*	Coinsurance	Coinsurance Out-of-Pocket Max*	Deductible*	Coinsurance	Coinsurance Out-of-Pocket Max*
☐ 3	$2,000	80%/20%	$3,000	$3,500	60%/40%	$7,000

*Individual amount shown. Family coverage is 2 times the individual amount.

Prescription Drug (includes contraceptives*)

Option	Deductible	Tier 1	Tier 2	Tier 3
☐	Integrated with Medical Plan	$10	$30	$50

*Groups exempt from contraceptive coverage must attach a signed affidavit.

Miscellaneous Options (select all of the options you wish to purchase)

- ☐ Dependent child age increases through age 29 (for eligible dependents)
- ☐ Inpatient rehabilitation for alcohol/substance abuse increase to 30 days combined in-network and out-of-network
- ☐ Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- ☐ Inpatient and Outpatient services for Mental Health Care and Alcohol/Substance Abuse Treatment cost sharing and benefit maximums in parity with similar medical benefits. This option is not available with the following Misc. Options: Inpatient rehab for alcohol/substance abuse 30 days; or Biologically Based Mental Illness and Serious Emotional Disturbances in Children Coverage
- ☐ Group will establish HSA, but DOES NOT want Empire to facilitate
- ☐ No additional options

SECTION 7: DENTAL BENEFITS SECTION (PLEASE SELECT THE DENTAL PRODUCT AND COVERAGE YOU WISH TO PURCHASE)

☐ **No Coverage**

☐ **Managed Dental Programs*** (select one)

- ☐ Preventive Care – $10 Copay on diagnostic and preventive procedures only
- ☐ Preventive Care Plus – Adds Basic Restorative coverage
- ☐ Comprehensive Care

Comprehensive Care Plan	☐ Plan 1	☐ Plan 2	☐ Plan 3
Office visit Copays	☐ $0	☐ $5	☐ $10
Orthodontics**	☐ Child only	☐ Child and adult	
Ortho Copay max per member	☐ $2,000	☐ $2,500	☐ $3,000

*Existing groups can attach member listing with PCD selection. **Contact your Sales Representative for availability of this option.

SECTION 8: VISION BENEFITS SECTION (PLEASE SELECT THE VISION PRODUCT AND COVERAGE OPTIONS YOU WISH TO PURCHASE)

☐ **No Coverage**

☐ **Blue View Vision℠ – Exam Only Benefits** (only available with 50% or more employer contribution)

Exam Frequency	Exam Copay
☐ Every 12 months	☐ $0
☐ Every 24 months	☐ $5
	☐ $10
	☐ $15

☐ **Blue View Vision℠ – Exam and Material Benefits**

Frequency – Exam/Lenses/Frames	Copay – Exam/Lenses	Frame/Contact Lens Allowance
☐ 12/12/12 months	☐ $5/$0	$130/$130
☐ 24/24/24 months	☐ $5/$5	$100/$100
	☐ $5/$5	$80/$80
	☐ $10/$0	$130/$130
	☐ $10/$10	$130/$130
	☐ $10/$20	$130/$130
	☐ $10/$10	$100/$100
	☐ $10/$10	$80/$80
	☐ $20/$20	$130/$130
☐ 12/12/24 months	☐ $5/$0	$130/$130
☐ 12/24/24 months	☐ $10/$0	$130/$130
	☐ $10/$10	$130/$130
	☐ $10/$20	$130/$130
	☐ $20/$20	$130/$130

Employer Contribution to Vision Premium: ☐ 50% or more ☐ Less than 50%

Rating Structure (for standalone vision; if sold with medical, vision tier will match medical): ☐ 2 Tier ☐ 3 Tier ☐ 4 Tier

SECTION 9: GROUP DECLARATION

The Personnel Record and the attached complete copy of my New York State Department of Taxation and Finance "Quarterly Combined Withholding and Wage Reporting Return of Wages Paid to each Employee (NYS-4/NYS-45/NYS-45ATT)" as filed, signed by an officer or owner of the group, and any additional documentation validating enrollment of employees, owners, partners, officers or paid Board members (i.e., K-1, notarized statements, payroll records) are a complete statement of the total number of employees for which I am applying for coverage. For any employees for which I am not seeking coverage, appropriate documentation to support their exclusion is submitted.

For eligible retirees, evidence of past employment and continuing financial arrangements is required.

If the enrollment forms submitted meet Empire's credentialing and eligibility requirements, including a minimum of 60% of group members residing within the Empire Service Area*, and are in compliance with New York State law, and we issue coverage, the group agrees to the following:

Remit to Empire the charges payable in accordance with the terms of the contract between Empire and the group, and if employee contributions are required, make necessary payroll deductions; group must also submit payment promptly, not to be received after the expiration of the grace period. (Failure to pay promptly will result in the termination of the group's coverage.) Empire must be allowed to audit and/or make copies of any records or information that relate to the administration of this coverage.

Ensure compliance with HIPAA (45 CFR Parts 160–164) as it relates to health plans. Ensure compliance with TEFRA/DEFRA/COBRA/OBRA legislation as it relates to any active employee or dependent of an active employee who elects the group's benefits as primary. Ensure prompt conversion to Medicare-related/Carveout coverage of Medicare-eligible actively employed group members and dependents not covered by TEFRA/DEFRA/OBRA legislation. Ensure prompt conversion to Medicare-related/Carveout coverage for eligible Medicare retirees.

Promptly submit an employee's enrollment form for eligible members only and promptly remove members who are no longer eligible. Failure to report removals promptly could result in the group being responsible for premiums or claims paid subsequent to the employee's removal date. The group must also ensure all employees enroll in accordance with their marital/domestic partner status.

If an acceptable enrollment form is received prior to or within 60 days after the eligibility date, coverage will begin on the date of eligibility; otherwise, coverage will begin on open enrollment or the next group renewal date.

Benefits purchased and established eligibility selected may be changed at renewal only. It is understood that this agreement may be terminated by the group giving prior written notice in accordance with the group contract. In the event of termination by the group, the group will be required to pay premiums through the date of termination according to the group contract. Empire may terminate this agreement for any of the reasons set forth in the group contract. This group application is a part of the agreement between Empire and the group for health insurance benefits.

New York insurance law requires that your employees who receive health coverage from an HMO or Direct HMO health plan, be given 30 days prior notice when an increase in the group insurance premium rates results in an increase to their premium contributions. Employers offering other types of health coverage are also encouraged to provide this information to their employees. For more information and to download a sample employee notification letter, visit www.empireblue.com.

*Empire's Service Area consists of the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

SECTION 10: INSURANCE FRAUD STATEMENT

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 material fact 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.

SECTION 11: SIGNATURE OF AUTHORIZED REPRESENTATIVE – I HAVE READ THIS ENTIRE APPLICATION AND THE CERTIFICATION AND FRAUD STATEMENT.

Authorized group signature **X**	Date
Printed name	Title

SECTION 12: AGENT/BROKER DECLARATION AND INFORMATION

To the best of my knowledge, all the statements/responses in this application are true and complete. I have no relevant knowledge about the Applicant, his/her employees, the dependents of such employees or an individual who is receiving continuation of coverage under federal or state laws which is not fully stated in this application.

1ST BROKER		COMMISSION % OF SPLIT	
Agent or Brokerage of Record last name	First name	SSN/Tax ID no.	
Company name			
Email address			
Mailing street address			
City	State	ZIP code (5+4)	
County	Phone	Fax	
1st broker signature X		Date	

2ND BROKER		COMMISSION % OF SPLIT	
Agent or Brokerage of Record last name	First name	SSN/Tax ID no.	
Company name			
Email address			
Mailing street address			
City	State	ZIP code (5+4)	
County	Phone	Fax	
2nd broker signature X		Date	

Empire BlueCross BlueShield

This page intentionally left blank.