Horizon Healthcare

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 entirely 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
SALES DEPARTMENT
1180 AVENUE OF THE AMERICAS, 8TH FLOOR
NEW YORK, NY 10036

Horizon Healthcare

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**

Horizon Healthcare

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type ☐ New Policy ☐ Change in Policy Policy No. _____ Requested Effective Date _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____
   Group Health Plan Name, if any: _____

2. Tax Identification Number: |__|__|__|__|__|__|__|__|__|

3. Email Address _____

4. Main Address: _____
   Street City State Zip Code County

   Mailing Address (Billing): _____
   Street City State Zip Code

   Telephone: |__|__|__|-|__|__|__|-|__|__|__|__| Facsimile: |__|__|__|-|__|__|__|-|__|__|__|__|

5. Name of Correspondent: _____ Title: _____

6. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain): _____

7. Nature of Business (specify): _____ SIC Code: _____

8. Employee Eligibility: All permanent, full-time employees who work at least _____ hours per week (minimum 20 hours/week).

9. Number of eligible employees in your company: _____

10. Number of eligible employees to be insured: _____

11. Insurance request for: ☐ Employees Only ☐ Employees and Dependents

12. Are you subject to the requirements of COBRA? ☐ Yes ☐ No TEFRA Eligible? ☐ Yes ☐ No

13. Waiting period before employees become insured: (May not exceed 6 months) Present: _____ New / Rehire: _____

14. Premium Paid: ☐ Monthly ☐ Quarterly

15. What percentage of the premium will the employer pay: _____ (Minimum of 10% required)

16. Class or classes to be excluded: _____ Number of excluded: _____

Premium will be due as of the effective date.

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

Legal Name & Location	No. of eligible employees in this company	No. of eligible employees to be insured	Type of organization	Nature of Business

Horizon Healthcare Insurance Company of New York
Horizon Healthcare New York, Inc.

SECTION II: SPECIFICATIONS FOR COVERAGE *(Health Benefits Selection)*

1. Plan Design:

HORIZON EPO

	100/0	100/90	90/80
$0			
$10	☐	☐	☐
$15			
$20	☐	☐	☐
$25			
$30	☐	☐	☐

HORIZON PPO

	100/80	100/70	100/90/70	90/80/60
$0			☐	☐
$10	☐	☐		
$15				
$20	☐	☐	☐	☐
$25				
$30	☐	☐	☐	☐

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

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

3. **Per Admission Deductible** ☐ 0 ☐ 500 (applicable to 100/0 EPO)

4. **Stop Loss** ☐ 5K ☐ 10K

5. **Rx Options:**

☐ $5/$12/$25 ☐ $10/$20/$40 ☐ No Rx
☐ $7/$15/$30 ☐ $10/$25/$50

6. **Rx Deductible**: ☐ 0 ☐ 50 ☐ 100 ☐ 150 ☐ 200 ☐ 2500 *Rx Deductible is per person

7. **Tier Options:** ☐ 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

GENERAL AGENT/ PRODUCER INFORMATION (THIS INFORMATION MUST BE ANSWERED COMPLETELY)

VENDOR # GENERAL AGENT	NAME OF AGENCY		TELEPHONE NUMBER
STREET	CITY	STATE	ZIP CODE
VENDOR # SUB-PRODUCER	NAME OF AGENCY		TELEPHONE NUMBER
STREET	CITY	STATE	ZIP CODE

☐ **ONE OPTION BILLING (FOR THOSE GROUPS WITH MORE THAN ONE SUB-GROUP)**

FOR INTERNAL UNDERWRITING USE

☐ Approved for _____ Number of Subscribers _____

☐ Declined

Underwritten By _____ Pre-Ex Applies ☐ Yes ☐ No

FOR INTERNAL UNDERWRITING USE

	HORIZON EPO	HORIZON PPO	HORIZON HMO	Rx	DENTAL
_____					
Coverage Code c/o					
TOTAL APPLICATIONS SUBMITTED					
TRANSFER FROM GROUP # _____					
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)					
EMPLOYER CONTRIBUTION					
EFFECTIVE DATE					
FUTURE RATE RENEWAL DATE					
SALES CREDITS					

APPROVED BY: _____ _____ _____

SALES ADMINISTRATION SIGNATURE | DATE | REP. ITEM NUMBER

_____ _____ _____

CONTRACT DEVELOPMENT SIGNATURE | TITLE | REP. ITEM NUMBER

Horizon Healthcare

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

Horizon Healthcare Insurance Company of New York
Horizon Healthcare of New York, Inc.

Horizon Healthcare

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 _____

Horizon Healthcare Insurance Company of New York
Horizon Healthcare of New York, Inc.

Horizon Healthcare

EMPLOYEE ENROLLMENT CHANGE/DELETION FORM

Horizon Healthcare of New York
Dept. A
P.O. Box 607
Newark, NJ 07101-0607

2. Group Name: _____

1. Group Number: _____ Group Health Plan Name: _____
(IF DIFFERENT THAN GROUP NAME)

I

3. Employee: Last / First / Middle	4. Social Security Number	5. Reason for Transaction	6. Date of Termination	7. Date of Hire	8. Requested* Effective Date	9. Contract Type	10. Product Move	
			Month/Day/Year	Month/Day/Year	Month/Day/Year		Current	New

11. Address: _____

_____

12. Spouse/Dependent Address: (If Different) _____

_____

13. Employee Signature: _____

II

3. Employee: Last / First / Middle	4. Social Security Number	5. Reason for Transaction	6. Date of Termination	7. Date of Hire	8. Requested* Effective Date	9. Contract Type	10. Product Move	
			Month/Day/Year	Month/Day/Year	Month/Day/Year		Current	New

11. Address: _____

_____

12. Spouse/Dependent Address: (If Different) _____

_____

13. Employee Signature: _____

III

3. Employee: Last / First / Middle	4. Social Security Number	5. Reason for Transaction	6. Date of Termination	7. Date of Hire	8. Requested* Effective Date	9. Contract Type	10. Product Move	
			Month/Day/Year	Month/Day/Year	Month/Day/Year		Current	New

11. Address: _____

_____

12. Spouse/Dependent Address: (If Different) _____

_____

13. Employee Signature: _____

See reverse side for codes and instructions.
All fields are mandatory. Form returned if incomplete causing a delay in processing.

I authorize _____ to transmit this enrollment transaction(s) on my behalf.
(Broker Name)

Group Administrator's Signature: _____ Date: _____

** Approval of requested effective date is subject to the Underwriting Rules and Regulations under the contract.*

5447 (W0603)

Horizon Healthcare Insurance Company of New York
Horizon Healthcare of New York, Inc.

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)

EPO	Horizon EPO
PPO	Horizon PPO
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.

Horizon Healthcare

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: _____