New York
Small Group Employer Enrollment Application
For Groups of 1-100* (Medical/Vision)
For Groups of 1-50 (Dental)

Empire BlueCross BlueShield
An Anthem Company

Consult the Evidence of Coverage for details regarding subscriber eligibility terms and coverage terms.

Please complete in black ink only

Section A: Company Information			
Company name			Employer tax ID no. (required) / /
Doing business as			SIC code – Required
Company street address			
City		State	ZIP code
Billing address- If different from above			
City		State	ZIP code
Company contact name		Title	
Primary phone no.	Fax no.		
Email address			
Additional company contact name		Title	
Primary phone no.	Fax no.		
Email address			

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414?
☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

_____

_____

_____

Open Enrollment

Our standard open enrollment period is 30 days before the Group's renewal date and 30 days after, which is held no more often than once in any 12 consecutive months.

Section B: Application Type	
☐ **New enrollment**	Requested effective date (MM/DD/YYYY)

* A small group must have at least one active full-time equivalent employee that meets the definition of employee in 42 U.S.C 300gg-91(d)(5) but no more than 100 employees. A small group can consist of one non-spouse employee plus the business owner; a group of 100 would consist of the business owner plus 99 employees.

Section C: Type of Coverage

1. Medical Coverage

All medical plans include pediatric dental coverage (up to age 19).

If you want to contribute to your employee's medical premium, indicate the percentage you wish to contribute each month for each category. Employer contributions are voluntary and no minimum is required.

Non-HMO plans must meet participation requirement.

Contribution Option: Contribution Option may be from 0% to 100% and may differ by category:

_____% Employee Only _____% Employee & Spouse/Domestic Partner _____% Employee & Child(ren) _____% Family

For HSA plans:

☐ Group will establish Health Savings Account (HSA) with Empire facilitating with a banking services provider.

☐ Group will establish Health Savings Account (HSA) and does not want Empire to facilitate the creation of the account.

For employers offering a Health Savings Account (HSA) compatible HMO, PPO or EPO plan: We, the employer, understand that the High Deductible plan is designed for Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Exclusive Provider Organization (EPO) usage, and that using non−participating providers will result in significantly higher out−of−pocket costs. Please refer to your Evidence of Coverage for additional benefit details. We understand that having this coverage does not establish an HSA. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. Consultation with a tax advisor is recommended.

Medical contract codes – Indicate the contract codes for the plan(s) selected. The codes can be found on the proposal/quote output.

Contract code	Contract code	Contract code
1.	2.	3.

2. Dental Coverage

Empire Family Dental and Empire Family Dental Enhanced plans include certified pediatric dental essential health benefits. All other plans including Empire Dental Prime and Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits. Please list below the contract code for the dental plan(s) you select.

Dental contract codes – Indicate the contract code(s) for the dental plan(s) chosen. The codes can be found on your Empire proposal/quote output.

Contract code 1:_____ Contract code 2:_____ ☐ No dental coverage

Choose your dental contribution for each month:

_____% per employee _____% per dependent (optional)

Select premium level: (Subject to underwriting approval)

☐ Base premium ☐ Bundled premium

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No

If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, PPO)	Effective Date (MM/DD/YYYY)	Proposed termination date (MM/DD/YYYY)

Voluntary participation

2–50 Eligible Employees: A minimum of two employees must enroll (there is no participation-percentage requirement for our voluntary plans). Dual Option is not available for voluntary plans.

Value, Classic and Enhanced participation

2–4 Eligible Employees: 100% of eligible employees not covered by another dental plan minimum of two must enroll.

5–50 Eligible Employees: A minimum of 50% of employees not covered by another dental plan are required to enroll. A minimum of two must enroll. For orthodontia, a minimum of 10 employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of five employees must enroll in each of the two plans and the two plans offered must have a 20% premium differential.

3. Vision Coverage – Select one plan option.

☐ No vision coverage

☐ Employer-Sponsored Plans (available for groups with 2–100 employees, minimum of two subscribers must enroll).

☐ Voluntary Plans (available for groups with 5–100 employees, minimum of five subscribers must enroll).

Vision contract codes – Indicate the contract code for the vision plan chosen. The codes can be found on your Empire proposal/quote output.

Contract code: _____

Choose your vision contribution for each month.

Employer-Sponsored plans require employers to contribute between 50% and 100%.

For Voluntary plans employers may contribute between 0% and 49%.

We will contribute: _____% per employee _____% per dependent (optional).

Section D: Eligibility[1]

1. Total number of full-time equivalent employees over the previous year (including employed owners/officers, part-time employees, excluding COBRA): _____
2. Number of ELIGIBLE full-time employees as defined in 42 U.S.C. 300gg-91(d)(5). To help with this calculation, see Empire worksheet "Determining Group Size": _____
3. Number of INELIGIBLE employees: (For additional information, please contact your Broker or Empire representative.) _____
4. Total number of employees ENROLLING: _____
5. Probationary period/waiting period for **new employees**:

   ☐ None ☐ First of month after hire date ☐ 1 month
   ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days*
6. Probationary period/waiting period for **rehired employees**:

   ☐ None ☐ First of month after hire date ☐ 1 month
   ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days*
7. New eligible enrollees[2] will become effective on:
   ☐ First of month following completion of waiting period/probationary period
   ☐ Day following completion of waiting period/probationary periods (*required for 90 day waiting period)
8. Do you wish to offer Dependent child coverage from age 26 through age 29 for eligible dependents? ☐ Yes ☐ No
9. Do you wish to offer coverage for domestic partners?
   ☐ Yes ☐ No

The following information is needed to determine TEFRA[3] status. Employers may need to consult a tax expert to determine TEFRA status.

10. Is your group TEFRA eligible? ☐ Yes ☐ No
    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 number of employees: _____

    In the last calendar year? ☐ Yes ☐ No

    If yes, list number of employees:
    (Include owners and partners. Count all locations) _____
11. Is your group subject to Federal COBRA or NY State Continuation of Coverage (fewer than 20 employees)? (check one box) See this site for additional COBRA information: www.dol.gov/ebsa/cobra

    ☐ Federal COBRA ☐ NY State Continuation of Coverage
12. Total number of employees waiving coverage for the following reasons (for non-HMO coverage only):

    a. A spouse's health benefit plan: _____
    b. Medicare coverage: _____
    c. Medicaid coverage: _____
    d. Veteran's Administration coverage: _____
    e. A parent's health benefit plan: _____
13. Total number of waivers (for non-HMO coverage only) (sum of a.-e. above): _____
14. Is this employer offering other group health insurance coverage to employees who are eligible for coverage in an Empire product (does not affect eligibility)? Check no if group only offers other HMO coverage:
    ☐ Yes ☐ No

1 Empire requires certain forms of proof to establish eligibility. See the small group guide for more details regarding eligibility categories and required forms of proof. For non-HMO products, 60% of total eligible employees must enroll, except during an annual waiver period pursuant to 45 C.F.R. 147.104. Empire reserves the right to request additional documentation to verify group size/eligibility for participation. Temporary employees; consultants; independent contractors; directors and officers who are not an owner, partner or employee; and union members covered by a union sponsored health plan are not eligible unless they meet the definition of "employee" in NY Ins Law Sect. 4235(d) as amended to have the meaning of "employee" set forth in 42 USC 300gg-91(d)(5).

2 New eligible employees include new employees and rehired employees. Newly eligible employees have 45 days from time of eligibility to enroll in coverage.

3 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 the current or preceding 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. This applies to 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. Employees of affiliated service groups and controlled groups of businesses should also be counted. Employers may need to consult a tax expert to determine TEFRA status.

Also, under OBRA (Omnibus Budget Reconciliation Act), 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.

Section E: General Agreement

Please read this section carefully before signing the application.

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

Or, we, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Empire may rely on this application in deciding whether to provide coverage. If the application is not complete, Empire reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Empire, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We further understand and agree that it is recommended that we keep prior coverage in force until notified of acceptance in writing by Empire and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Empire.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Empire received the written notification of cancellation or such later date as requested, and that no premiums will be refunded for any period between Empire's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums paid after the cancellation date, we understand that Empire will refund these premiums.

In addition, the Broker(s) named on the next page of this application is hereby authorized to process any enrollment transactions for my company's Empire coverage upon direction from the authorized group representative (including, but not limited to, Member enrollment, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations). This authorization shall be effective immediately and I agree that my company will be bound by the actions performed by the herein-named Broker pursuant to my signature. Additionally, I acknowledge that I must notify Empire in writing to void this broker authorization in the event of a change in my company's Broker of Record.

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 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.

Sign here	Company officer signature **X**	Title	
	Printed name		Date (MM/DD/YYYY)

Section F: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this group's or any member's eligibility.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual employee(s) application. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Empire to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage and that coverage shall not be effective until Empire reviews and approves the application and the employer receives a written notice from Empire.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Empire shall be paid to an agent/broker/producer not appointed/approved by Empire.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Empire that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			%	**Second writing payable/sub-agent/producer/broker**			%
Agency name		Agency ID no.		Agency name		Agency ID no.	
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker ID no.				Agent/producer/broker ID no.			
Payable/sub-agent/producer/broker ID no. if different				Payable/sub-agent/producer/broker ID no. if different			
Street address				Street address			
City	State	Zip code		City	State	Zip code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature		Today's Date (MM/DD/YYYY)		Signature		Today's Date (MM/DD/YYYY)	

For General Agent/Producer/Broker use only			
General agent/producer/broker name	Agent/producer/broker ID no.		
Street address	City	State	ZIP code

Sales Representative and Account Manager			
Sales representative name	Sales representative ID no.		
Street address	City	State	ZIP code
Account manager name	Account manager ID no.		

Empire USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)

Get help in your language

Language Assistance Services

Empire BlueCross BlueShield
An Anthem Company

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1806). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1806). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-748-1806). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1806). (TDD/TTY: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1806)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1806)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1806. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-748-1806). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-748-1806). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1806). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1806)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-748-1806). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1806). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1806). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو
جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کرکے اس کی درخواست کرسکتے ہیں
(711:TDD/TTY) (855-748-1806)

Yiddish
אויב איר דארפט הילף צו פארשטיין דעם דאקומענט אין אן אנדערע שפראך, קענט איר עס בעטן אהן קיין
עקסטערע קאסט דורך רופן די מעמבער באדינונגען נומער
(711:TDD/TTY) (855-748-1806)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.