

SECTION VII – NEW BUSINESS CHECKLISTS

HIP's Underwriting Guidelines Checklist for Small and Large Business

- The account indicated below qualifies for small business rates and benefits because the group's membership includes TWO (2) TO FIFTY (50) eligible employees.
- For large business 50 plus eligible employee.

Group Name _____

Completed by: Broker signature _____ Date _____

CONTRIBUTION: Will group contribute toward the cost of the coverage? Yes No
If "YES", will the group contribute toward the cost of

- Employee Only Percentage _____ Dollar amount _____
- Family _____

ELIGIBLE MEMBERS: (Check ALL Boxes that apply to this group)

- Owners of the group/corporate officers/partners.
- Members of the board of directors.
- Employees on the group's payroll whose regular work schedule is at least 20 hrs per week (if more than 20 employees, include active employees over 65 and spouse over 65).
- Commissioned employees (no 1099's) with a base salary and commission.
- Eligible dependents of the group employees.
- Retirees & their spouses if the employer pays part or all premium as a retirement benefit.
- Former employee/dependents (COBRA continuation of coverage).
- Eligible union members (members must be employed by the same employer).

WHO MUST BE EXCLUDED FROM GROUP: (Check ALL BOXES that apply to this group)

- Part-time employees who work less than 20 hours a week.
- Seasonal Employees whose employment is six months or less each year.
- Temporary Employees (HIP do not cover temporary workers).
- Employees who do not "work or reside" in the HIP service area.
- Employees in the armed forces of any government other than for duty of 30 days or less.
- Union affiliated employees.
- Hip does not cover babysitters or personal maids.

TYPES OF ORGANIZATIONS: (Check ONE box that applies to this group)

- Sole proprietorship.
- Business establishment.
- Partnership or corporation.
- Not-for-profit organization (employees must work a minimum of 20 hours).
- Government body (state, county, or municipal).
- Union or Union Management Welfare Fund.
(members and/or employees of union and their dependents).
- Association, Chamber of Commerce, Professional Society.
- OTHER (Describe) _____

DOCUMENTS THAT MUST BE SUBMITTED TO ENROLL

- Completed GROUP APPLICATION
- Employee(s) ENROLLMENT APPLICATION(S) with PRE-EXISTING CLAUSE:
See" Election of Coverage and Authorization, paragraph 3.
(Employer must sign bottom of form).
- Requested EFFECTIVE DATE MUST be the **FIRST OF THE MONTH.**
- Waiver Forms (For Groups of 2-24 employees).
(for employees with other coverage of who are excluded or who refuse coverage).
- Copy of the NYS-45. Must indicate NYS Tax ID
- Business check for first month's premium for both large & small business.

ADDITIONAL REQUIRED DOCUMENTS

- For any employee NOT LISTED on the NYS-45, submit a copy of the payroll check showing the company's name and the employee name and SS# and a W-4.
- College/University STUDENT VERIFICATION of active full time status (minimum of 12 credits).
- Owners/Partners of the business NOT reflected on the NYS-45, submit a copy of any other official document substantiating the name of the owners/partners and the company's name.
- NEW BUSINESS: Submit an accountant's letter indicating the date the business started and the number of eligible employees along with a business certificate.
- MEMBERS OF THE BOARD OF DIRECTORS, submit a copy of the annual report indicating the names of the directors.
- COBRA Continuees:
 - Copy of the company's last NYS-45 which includes the former employee.
 - Copy of the individual's COBRA election form. In the absence of the election form, a letter from the former employee/dependent requesting continuation of coverage and the date of the qualifying even may be submitted.

SMALL GROUP ONLY PRE-EXISTING CONDITIONS INFORMATION

- For new Business: Copy of the premium billing statement (or statements if more than one insurance carrier provided coverage) from 12 months preceding the effective date of HIP coverage. For any employee NOT LISTED on that bill a "Certificate of Credible Coverage" must be submitted verifying their previous health insurance.

FOR SECURITY REASONS PLEASE MAKE ALL CHECKS PAYABLE TO:

HIP HEALTH PLAN OF NEW YORK (NOT HIP)

MARKETING REP'S NAME _____
Please print

BROKER'S NAME _____
Please print

PLEASE RETURN A COMPLETED COPY OF THIS FORM PLUS
ALL OTHER REQUIRED DOCUMENTS AS INDICATED ABOVE TO: _____

IMPORTANT DEADLINES

All groups received BEFORE the 15th of the Month ,will be processed
for an Effective Date of the 1st of the following Month.

Other dates will ONLY be considered if HIP is taking over coverage from another POS plan.

HIP SmartStart Subscriber/Member Enrollment Form

Last Name		First Name			M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number		
Street Address		Apt.	City			State	Zip Code		
Are you covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: ___/___/___		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Birth Date Mo. Day Yr.		Tel. #: Home: (___) _____ Work: (___) _____ E-Mail Address: _____			
Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ___/___/___ Coverage End Date ___/___/___		Qualifying Event: <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Hire _____ Qualifying Event Date: Mo. ___ Day ___ Yr. ___				Is your spouse covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: ___/___/___			
		Have you or any of your dependent(s) ever been a member of HIP? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate member ID number(s) or the former employer and your name (if different from shown): _____				SUBSCRIBER <i>Please select a hospital and indicate your choice below</i> Hospital Name: _____ Hospital I.D.: _____ Brookhaven Memorial HospitalBKMH Good Samaritan HospitalGSAM Mercy Medical CenterMERC New Island HospitalNEWI Saint Catherine HospitalSCAT St. Charles-JT MatherSCJM S Nassau CommunitySNAS Winthrop University HospitalWINT Hospital I.D. Selection _____			

*** If you are enrolling for your spouse and/or children, please list each one below - see Election of Coverage for eligibility**

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date Mo. Day Yr.	Check if disabled	Spouse Hospital I.D. Selection
SPOUSE							
		___ - ___ - ____		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/>	_____
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___ Coverage End Date ___/___/___			
ADDITIONAL DEPENDENTS (List oldest first)							
		___ - ___ - ____		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/>	Dependent Hospital I.D. Selection _____
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___ Coverage End Date ___/___/___			
		___ - ___ - ____		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/>	Dependent Hospital I.D. Selection _____
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___ Coverage End Date ___/___/___			
		___ - ___ - ____		<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/>	Dependent Hospital I.D. Selection _____
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___ Coverage End Date ___/___/___			

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form

Applicant must sign here: _____ Date _____

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group		Group Number			Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child		
Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by (Representative of Benefits Administrator)			

Instructions to Benefit Administrators or Group Representatives: For Groups with 50 employees or less, you **MUST** complete Section A on the reverse side of this form. Required documentation **MUST** be attached to this Enrollment Form to be processed.

PROCESSED BY	RECEIVED DATE	PROCESSED DATE
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ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A

(To be completed by
Benefits Administrator)

DOCUMENTATION BASED ON GROUP SIZE

Group Type (Check One)

			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACTION Check (✓)One	Qualifying Event	Documentation Required	Sole Proprietorship or One Subscriber Group	Association of Two or More Employees	Small Group - Less Than 50 Employees
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly provide a recent Copy of NYS45 showing this subscriber as an employee or copy of Payroll documentation reflecting the date, employee's name and Social Security # or the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage	Marriage Certificate			
<input type="checkbox"/> Add Dependent	Birth Adoption	<input type="checkbox"/> Birth Certificate or <input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			

Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.



Group Name

COPAYMENT OPTIONS (Select One from each category)

- PCP Office Visit \$25
- Specialist Office Visit \$25
- Hospital Admission \$250 each day for the first two days; \$100 each day thereafter up to a maximum of \$1,400 per Benefit Period.
- Confinement
- Ambulatory Surgery \$25
- Emergency Room \$50

BENEFIT RIDERS

SKILLED NURSING FACILITY CARE

- 45 days; \$100 each day for the first fifteen (15) days, up to a maximum of \$1,500 per Benefit Period.

INPATIENT THERAPIES

- \$250 each day for the first two (2) days, and \$100 for days three (3) through sixty (60) up to a maximum of \$1,400 per Benefit Period.

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students

Dependent Children

- 25 End of month

- 19 End of Month

MONTHLY RATES (to be completed by your broker or HIP)

3 TIER

Individual \$ _____

Two Persons \$ _____

Family \$ _____

THE GROUP AGREES TO DO THE FOLLOWING:

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify HIP Health Plan of New York of the termination or addition of any Member(s) covered or to be covered by HIP.
- Promptly provide HIP Health Plan of New York with any information necessary to properly administer the coverage.
- Ensure compliance with TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to group's coverage.

IT IS UNDERSTOOD THAT:

- If an acceptable employee enrollment form is received prior to the eligibility date coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt.
- All group applications are subject to approval by HIP Health Plan of New York.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the census of the actual enrollees. Any material misrepresentation within this group application or the group's census, whether intentional or unintentional, will permit HIP Health Plan of New York to terminate this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents; and I will provide to HIP Health Plan of New York an enrollment form or a waiver of coverage form (applicable to groups with 2-50 eligible employees) signed by each eligible employee within thirty (30) days of his/her eligibility date.

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. HIP Health Plan will refund the premium deposit submitted with this application if coverage does not become effective.

Subject to applicable State and Federal laws pertaining to preexisting conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from the effective date of this Contract.

All statements in this application for coverage under a Contract from HIP Health Plan of New York shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

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 associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at: _____ On the ____ Day of, _____, 20____

By: _____ Title: _____
(Printed name of authorized officer)

By: _____
(Signature of authorized officer)

Please return this completed application and the following items:

- "Employer's Quarterly Report of Wages Paid to Each Employee (NYS — 45)"
- Copy of a 12 month old (or more recent, if necessary) billing statement
- First month's premium

To: The Washwick Agency, Inc.
860 East Main Street
Riverhead, N.Y. 11901

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING



GROUP APPLICATION

Section 1 – APPLICANT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Requested Effective Date:							
Company's Legal Name:						SIC Code:	
Company DBA, if applicable:							
Company's Address (No. and Street):				Billing Address, if different:			
City	State	Zip	County	City	State	Zip	County
Company Officer:				Title:		Telephone:	
Company Contact Person:				Title:		Telephone:	
E-mail Address:				Fax Number:			
How long has your company been at the current address?				Indicate your Company's State Employer Identification Number:			
What is the nature of the Business or Organization?							
Which of the following describes your Company or Organization?							
<input type="checkbox"/> Employer/Employee Group		<input type="checkbox"/> Business Association		<input type="checkbox"/> Fraternal/ Religious Organization			
<input type="checkbox"/> Sole Proprietor		<input type="checkbox"/> Partnership		<input type="checkbox"/> Non-Profit Organization			
<input type="checkbox"/> Other Group, please describe _____							
Which of the following describes your type of Association?							
<input type="checkbox"/> Trade Association		<input type="checkbox"/> Labor Union and Employer Trust		<input type="checkbox"/> Professional Association			
<input type="checkbox"/> Chamber of Commerce		<input type="checkbox"/> Credit or Bank Association					
<input type="checkbox"/> Special Association (Approved by Department of Insurance)							
Is your Company or Organization a Subsidiary, Division or an Affiliate of another Company?							
<input type="checkbox"/> Yes		<input type="checkbox"/> No		If Yes, please complete the following:			

Company Name	Address	Number of Total Employees

Select Product Coverage:

<input type="checkbox"/> PRIME HMO	<input type="checkbox"/> access I	<input type="checkbox"/> HIP PRIME Dental PPO	<input type="checkbox"/> PRIME EPO	<input type="checkbox"/> SMART START EPO
<input type="checkbox"/> PRIME POS	<input type="checkbox"/> access II	<input type="checkbox"/> HIP VIP Medicare	<input type="checkbox"/> PRIME PPO	
<input type="checkbox"/> SELECT EPO	<input type="checkbox"/> SELECT PPO	<input type="checkbox"/> HIP CLASSIC	<input type="checkbox"/> Other: _____	

HIP GROUP APPLICATION

Section 2a – EMPLOYEE INFORMATION

(For Small Groups 2-50 employees and Large Groups 51+ employees)

PLEASE TYPE OR PRINT LEGIBLY

Eligible Employees: Employees on your payroll whose regular work schedule is at least [20.0] hours per week.

A - Total Number of Employees _____

C - Number of Employees Enrolling for Coverage _____

B* - Number of Employees Eligible for Coverage _____

D - Number of Employees Waiving Coverage (B-C) _____

Reasons for Waiver(s):

WAITING PERIOD:

PRESENT EMPLOYEES' ELIGIBILITY — Will all current employees be covered as of the effective date of coverage?

Yes No If no, explain: _____

FUTURE EMPLOYEES' ELIGIBILITY — New employees will be eligible for coverage:

Date of Hire

First day of the month following date of hire

_____ Month(s) following the date of hire Other _____

CONTRIBUTIONS: Will the Group contribute 100% of the cost of the coverage? Yes No **If no, complete below:**

Group Contribution

	Dollar Amount	or	Percentage
<input type="checkbox"/> Employee only coverage	\$ _____		_____ %
<input type="checkbox"/> Employee and Spouse	\$ _____		_____ %
<input type="checkbox"/> Employee and Child(ren)	\$ _____		_____ %
<input type="checkbox"/> Family	\$ _____		_____ %

If group contributes 100% of the cost of coverage, all eligible employees must participate.

PREMIUM BILLING/PAYMENT FREQUENCY: Monthly Quarterly Semi- Annually Annually

Section 2b – SOLE PROPRIETOR INFORMATION

A Sole Proprietor purchasing coverage through an association must be a member of the association for at least 60 days prior to the effective date of the insurance coverage.

To be eligible to purchase Sole Proprietor health insurance, please provide the following with the application and on an annual basis:

1. A copy of the New York tax form NYS-45ATT-MN, or other comparable documentation of active employees status such as a copy of a pay stub or estimated tax form;
2. For a business in operation for more than 1 year, the prior year's federal income tax Schedule C for an incorporated business subject to Subscriber S with a Sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or
3. For a business in operation for less than one year, a cancelled business check, a copy of a business bank statement, a certificate of doing business, or appropriate tax documentation; and
4. Such other documentation as may be reasonably required by the insurer and as approved by the Superintendent to verify eligibility of an individual to purchase health insurance pursuant to Chapter 557.

PAYMENT FREQUENCY: Monthly Quarterly Semi- Annually Annually

HIP GROUP APPLICATION

Section 3 - REPLACEMENT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Does this Group Contract replace other coverage? Yes No

If "Yes", please attach a copy of a billing statement from 12 months ago* (or more recent, if necessary) and complete the following:

Effective Date	Termination Date	Prior Carrier	
HMO	_____	_____	_____
POS	_____	_____	_____
Indemnity	_____	_____	_____
PPO/EPO	_____	_____	_____
Dental	_____	_____	_____
Other	_____	_____	_____

* Note: A billing statement from 12 months ago will reduce the probability that employees will need to provide evidence of prior coverage. Eligible employees with less than 12 months of continuous coverage may be required to submit a "Certificate of Creditable Coverage" with their enrollment form.

Section 4 -- GENERAL AGENT/BROKER INFORMATION

General Agent Name: _____

Address: _____

Telephone: _____ Fax _____

Number: _____

E-mail Address: _____

Broker Name: _____

Address: _____

Telephone: _____ Fax _____

Number: _____

E-mail Address: _____

For Office Use Only

HIP Marketing Representative and Code:

Broker/Agent:

Group Number (To Be Completed by Underwriting):