www.empireblue.com

SMALL GROUP APPLICATION/CHANGE FORM
(2–50 eligible employees)

Thank you for choosing Empire. Please fill out **all** items below and **print clearly in black or blue ink** in order for us to quickly and accurately process your group's application. Once you've completed this form, please sign in the space provided in **Section 11**.

Current Group Number (if applicable)

1. REASON FOR APPLICATION/CHANGE

(fill in one only)

○ New — Requested Effective Date (MMDDYY)

○ Change Existing Benefits — Revision or Renewal Date (MMDDYY)

Sales Representative Last Name

First Name

2. GROUP INFORMATION

Group Name (as it appears on documents attached)

Doing Business As

Group Mailing Address

City

State

ZIP (5+4)

County

Phone

Fax

Authorized Group Contacts

Primary Group Contact Last Name

Primary Group Contact First Name

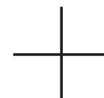
Title

E-mail Address (Benefit Administrator) — mandatory

Secondary Group Contact Last Name

Secondary Group Contact First Name

Title



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2. GROUP INFORMATION (continued)

Tertiary Group Contact Last Name

Tertiary Group Contact First Name

Title

Billing Contact

Billing Phone

Billing Address (if different)

City

State

ZIP (5+4)

Federal Employer Identification Number

County

Type of Industry

Is your group a subsidiary/division affiliated with another company? ◯ Yes ◯ No

If yes, Name

Number of Employees

3. OTHER COVERAGE

Has health insurance been purchased for the group from any carrier, including Empire, during the last twelve (12) months?
If more than one carrier in 12 months, please attach a separate page.

◯ Yes ◯ No

If yes, Insurance Carrier

Coverage Type (ex: HMO, POS, PPO)

Coverage start date (MMDDYY)

Coverage end date (MMDDYY)

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4. GROUP ELIGIBILITY

Note: Eligible persons are defined as employees (on the group's payroll, K1, etc.) whose regular work schedule is at least 20 hours per week under this group contract.

Number of Employees

(a) Number of employees at all locations (include owners and partners, exclude COBRA)*

(b) Number of retirees eligible for coverage

(c) Number of ineligible employees (check reason for ineligibility)

○ Temporary ○ Union ○ Part-Time

○ Other

(d) Number of net eligible employees (a + b – c)

Number of enrolling employees (include retirees and COBRA)

Employer contribution to retiree coverage %

Have you ever employed more than 20 employees?
○ Yes ○ No

If yes, please indicate the last year you had 20 or more employees

*Empire requires proof of employment
(i.e., NYS-45, payroll, etc.)
See small group underwriting guidelines for more info

Eligibility Dates (complete both A & B)

A. Initial Enrollment of Group
All employees' and dependents' coverage will be in effect:

○ On Group Effective Date

○ After new employee eligibility is satisfied (see B)

All enrollment forms must be received no later than thirty (30) days following the new group effective date.

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

○ Date of hire

○ First day following:

○ day(s) following date of hire

○ month(s) following date of hire; or

○ 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 hire

○ Other

Please specify: ____________________

Regions of Residence

If you are choosing HMO, Direct HMO, Empire Total Blue℠ with HSA, Direct POS or DirectShare℠ POS, please check all regions your enrolling employees reside in from the list below.

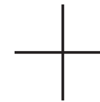
○ **New York:** Bronx, Kings, Queens, New York, Nassau, Rockland, Westchester, Richmond and Suffolk counties.

○ **Mid-Hudson:** Dutchess, Putnam, Orange, Sullivan and Ulster counties.

○ **Albany:** Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

○ **New Jersey Contiguous Counties:** Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex and Union counties.

○ **Connecticut Contiguous Counties:** Fairfield and Litchfield counties.



5. PAYMENT SECTION Group's Contribution, if any.

% Employee only | % 2-Party | % Employee & Spouse | % Parent & Child(ren) | % Family

If your group has multiple locations, do you wish to receive (fill in one):

○ Separate invoices for each location. ○ A summary invoice combining all locations.

If you are requesting quarterly billing, please indicate here; otherwise, group will be billed monthly. ○

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6. MEDICAL BENEFITS SECTION

Please select all of the coverage options you wish to use, and then fill out the details under the coverage sections.

- ◯ HMO*
- ◯ Direct HMO*
- ◯ Direct POS*
- ◯ DirectShare℠ POS
- ◯ PPO
- ◯ EPO
- ◯ Value EPO
- ◯ Comprehensive Hospital/Medical
- ◯ Empire Total Blue℠ with HSA
- ◯ Empire Prism EPO
- ◯ Other ____________________

*HMO benefits provided by Empire HealthChoice HMO, Inc.

HMO / DIRECT HMO

Please select only one product: ◯ HMO ◯ Direct HMO

Co-payment Options (fill in one only)

Co-payment Options	Inpatient Co-pay	PCP/Primary Home/Office Co-pay	Specialist Home/Office Co-pay	ER Co-pay	Ambulatory/ OP Surgery Co-pay
◯ Opt 2	$0	$10	$10	$35	$0
◯ Opt 3	$250/$625*	$10	$10	$35	$0
◯ Opt 4	$500/$1,250*	$15	$15	$35	$0
◯ Opt 5	$0	$20	$20	$35	$0
◯ Opt 6	$500/$1,250*	$20	$20	$35	$0
◯ Opt 7	$0	$25	$25	$75	$0
◯ Opt 8	$0	$25	$40	$75	$0
◯ Opt 9	$500/$1,250*	$25	$40	$75	$75
◯ Opt 10	$0	$30	$50	$100	$0
◯ Opt 11	$500	$30	$50	$100	$100
◯ Opt 12	$1,000	$30	$50	$150	$150

*per admission/family maximum per calendar year

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$5	$20	$40
◯	$10	$20	$40
◯	$10	$25	$50
◯	$10	$35	$70
◯	$10	50%	N/A†
◯	$15	N/A	N/A†

Deductible** (fill in one only)

◯ $0 ◯ $50 ◯ $100 ◯ $150
◯ $250*** ◯ $500***
◯ No prescription drug coverage

*Groups exempt from purchasing contraceptives must attach a signed affidavit.
**Not applicable to mail-order program.
***Available with 10/35/70 co-pay only
† Mandatory $0 deductible

Rating Structure (fill in one only)

◯ 2-Tier ◯ 3-Tier ◯ 4-Tier

Vision Option (fill in one only)

Co-payment (fill in one)

◯ $5 ◯ $10

Benefit cycle (fill in one)

◯ 12-month ◯ 24-month

Plan choice (fill in one)

◯ Low (exam plus discounts)
◯ High (exam plus $10 co-payment on glasses/contacts and $35 allowance on non-plan frames)
◯ No vision coverage

Miscellaneous Options (fill in all of the following options you wish to purchase)

- ◯ Inpatient mental and behavioral health care increases from 30 to 45 days
- ◯ Outpatient mental and behavioral health care increases from 20 to 40 visits
- ◯ Skilled nursing facility increases from 60 to 120 days
- ◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- ◯ Inpatient rehabilitation for alcohol/ substance abuse 30 days in-network
- ◯ Waive waiting period for pre-existing conditions
- ◯ No additional options

HMO / DIRECT HMO

Please select only one product: ◯ HMO ◯ Direct HMO

Co-payment Options (fill in one only)

Co-payment Options	Inpatient Co-pay	PCP/Primary Home/Office Co-pay	Specialist Home/Office Co-pay	ER Co-pay	Ambulatory/ OP Surgery Co-pay
◯ Opt 2	$0	$10	$10	$35	$0
◯ Opt 3	$250/$625*	$10	$10	$35	$0
◯ Opt 4	$500/$1,250*	$15	$15	$35	$0
◯ Opt 5	$0	$20	$20	$35	$0
◯ Opt 6	$500/$1,250*	$20	$20	$35	$0
◯ Opt 7	$0	$25	$25	$75	$0
◯ Opt 8	$0	$25	$40	$75	$0
◯ Opt 9	$500/$1,250*	$25	$40	$75	$75
◯ Opt 10	$0	$30	$50	$100	$0
◯ Opt 11	$500	$30	$50	$100	$100
◯ Opt 12	$1,000	$30	$50	$150	$150

*per admission/family maximum per calendar year

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$5	$20	$40
◯	$10	$20	$40
◯	$10	$25	$50
◯	$10	$35	$70
◯	$10	50%	N/A†
◯	$15	N/A	N/A†

Deductible** (fill in one only)

◯ $0 ◯ $50 ◯ $100 ◯ $150
◯ $250*** ◯ $500***
◯ No prescription drug coverage

*Groups exempt from purchasing contraceptives must attach a signed affidavit.
**Not applicable to mail-order program.
***Available with 10/35/70 co-pay only
† Mandatory $0 deductible

Rating Structure (fill in one only)

◯ 2-Tier ◯ 3-Tier ◯ 4-Tier

Vision Option (fill in one only)

Co-payment (fill in one)

◯ $5 ◯ $10

Benefit cycle (fill in one)

◯ 12-month ◯ 24-month

Plan choice (fill in one)

◯ Low (exam plus discounts)
◯ High (exam plus $10 co-payment on glasses/contacts and $35 allowance on non-plan frames)
◯ No vision coverage

Miscellaneous Options (fill in all of the following options you wish to purchase)

- ◯ **Inpatient mental and behavioral health care increases from 30 to 45 days**
- ◯ Outpatient mental and behavioral health care increases from 20 to 40 visits
- ◯ Skilled nursing facility increases from 60 to 120 days
- ◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- ◯ Inpatient rehabilitation for alcohol/ substance abuse 30 days in-network
- ◯ Waive waiting period for pre-existing conditions
- ◯ No additional options

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6. MEDICAL BENEFITS SECTION (continued)

EMPIRE TOTAL BLUE℠ COVERAGE W/ HSA OPTIONS

Option	In-Network Deductible Individual/Family	In-Network Coinsurance	In-Network Coinsurance Stop Loss Maximum	In-Network Coinsurance Out-of-Pocket Maximum Individual/Family	Out-of-Network Deductible Individual/Family	Out-of-Network Coinsurance	Out-of-Network Coinsurance Stop Loss Individual/Family	Out-of-Network Coinsurance Out-of-Pocket Maximum Individual/Family
◯ 1	$1,250/ $2,500	80/20%	$10,000/ $20,000	$2,000/ $4,000	$5,000/ $10,000	60/40%	$25,000/ $50,000	$10,000/ $20,000
◯ 2	$1,500/ $3,000	80/20%	$17,500/ $35,000	$3,500/ $7,000	$3,000/ $6,000	60/40%	$17,500/ $35,000	$7,000/ $14,000
◯ 3	$2,000/ $4,000	80/20%	$15,000/ $30,000	$3,000/ $6,000	$3,500/ $7,000	60/40%	$17,500/ $35,000	$7,000/ $14,000
◯ 4	$2,000/ $4,000	80/20%	$15,000/ $30,000	$3,000/ $6,000	$10,000/ $20,000	50/50%	$40,000/ $80,000	$20,000/ $40,000
◯ 5	$2,500/ $5,000	80/20%	$12,500/ $25,000	$2,500/ $5,000	$4,500/ $9,000	60/40%	$20,000/ $40,000	$8,000/ $16,000
◯ 6	$3,000/ $6,000	80/20%	$10,000/ $20,000	$2,000/ $4,000	$10,000/ $20,000	50/50%	$40,000/ $80,000	$20,000/ $40,000
◯ 7	$5,000/ $10,000	100%	N/A	N/A	$10,000/ $20,000	70/30%	$66,667/ $133,334	$20,000/ $40,000
◯ 8	$3,000/ $6,000	100%	N/A	N/A	$6,000/ $12,000	60/40%	$30,000/ $60,000	$12,000/ $24,000

Prescription Drug Option

◯ Drug Coverage (Generic $10, Brand $30, Non-Formulary $50 after deductible* and includes contraceptives**) ◯ No Drug Coverage at all

*Rx Co-pays do not apply to Options 7 and 8 but drug option must be selected to receive coverage

**Eligible groups exempt from purchasing contraceptives must submit a signed affidavit for consideration.

Vision Option (fill in one only)

Co-payment (fill in one) ◯ $5 ◯ $10

Benefit cycle (fill in one) ◯ 12-month ◯ 24-month

Plan choice (fill in one)

◯ Low (exam plus discounts)

◯ High (exam plus $10 co-payment on glasses/ contacts and $35 allowance on non-plan frames)

◯ No vision coverage

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

◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)

◯ Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network

◯ Group will establish HSA, butDOES NOT want Empire to facilitate

◯ No additional options

DIRECT POS COVERAGE OPTIONS

Option	In-Network PCP/Primary Home/Office Co-payment	In-Network Specialist Home/Office Co-payment	In-Network Inpatient Co-payment	Out-of-Network Deductible Individual/Family	Out-of-Network Coinsurance	Out-of-Network Coinsurance Stop Loss Individual/Family	Out-of-Network Coinsurance Out-of-Pocket Maximum Individual/Family
◯ Option 1	$15	$15	$0	$500/$1,250	70%/30%	$10,000/$25,000	$3,000/$7,500
◯ Option 2	$15	$15	$250/$625*	$500/$1,250	70%/30%	$10,000/$25,000	$3,000/$7,500
◯ Option 3	$20	$20	$0	$1,000/$2,500	70%/30%	$10,000/$25,000	$3,000/$7,500
◯ Option 4	$20	$20	$250/$625*	$1,000/$2,500	70%/30%	$10,000/$25,000	$3,000/$7,500
◯ Option 5	$20	$20	$500/$1,250*	$1,000/$2,500	70%/30%	$10,000/$25,000	$3,000/$7,500
◯ Option 6	$20	$20	$0	$1,500/$3,750	70%/30%	$15,000/$37,500	$4,500/$11,250
◯ Option 7	$20	$20	$250/$625*	$1,500/$3,750	70%/30%	$15,000/$37,500	$4,500/$11,250
◯ Option 8	$20	$20	$500/$1,250*	$1,500/$3,750	70%/30%	$15,000/$37,500	$4,500/$11,250
◯ Option 9	$15	$15	$0	$2,000/$5,000	60%/40%	$15,000/$37,500	$6,000/$15,000
◯ Option 10	$15	$15	$500/$1,250*	$2,000/$5,000	60%/40%	$15,000/$37,500	$6,000/$15,000
◯ Option 11	$20	$20	$0	$2,000/$5,000	60%/40%	$20,000/$50,000	$8,000/$20,000
◯ Option 12	$20	$20	$500/$1,250*	$2,000/$5,000	60%/40%	$20,000/$50,000	$8,000/$20,000
◯ Option 13	$25	$40	$0	$1,000/$2,500	70%/30%	$10,000/$25,000	$3,000/$7,500
◯ Option 14	$25	$40	$0	$1,500/$3,750	70%/30%	$15,000/$37,500	$4,500/$11,250
◯ Option 15	$25	$40	$0	$2,000/$5,000	60%/40%	$20,000/$50,000	$8,000/$20,000
◯ Option 16	$25	$40	$500/$1,250*	$2,000/$5,000	60%/40%	$15,000/$37,500	$6,000/$15,000

Out of Network UCR Option (Usual, Customary and Reasonable Fee Reimbursement) ◯ 70% ◯ 80%

Note: ER co-pay: Options 1–12 — $50 Options 13–16 — $75 Ambulatory/OP Surgery co-pay: Option 16 — $75 *per admission/family maximum per calendar year

Vision Option (fill in one only)

Co-payment (fill in one) ◯ $5 ◯ $10

Benefit cycle (fill in one)

◯ 12-month ◯ 24-month

Plan choice (fill in one)

◯ Low (exam plus discounts)

◯ High (exam plus $10 co-payment on glasses/ contacts and $35 allowance on non-plan frames)

◯ No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$5	$20	$40
◯	$10	$20	$40
◯	$10	$25	$50
◯	$10	$35	$70
◯	$10	50%	N/A†
◯	$15	N/A	N/A†

Deductible** (fill in one only)

◯ $0 ◯ $50 ◯ $100

◯ $150 ◯ $250 ◯ $500

◯ No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

** Not applicable to mail-order program.

† Mandatory $0 deductible

Miscellaneous Options

(check all of the following options you wish to purchase)

◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)

◯ Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network

◯ Waiver for pre-existing conditions

◯ No additional options

DIRECTSHARE℠ POS OPTIONS

Co-payment Options (fill in one only)

	In-Network							Out-of-Network			
	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	In-patient Co-Pay*	Deductible*	Coinsurance*	Coinsurance Stop Loss*	Out-of-Pocket Coinsurance Max*	Deductible*	Coinsurance	Coinsurance Stop Loss*	Out-of-pocket Coinsurance Max
◯ Option 1	$25	$40	Ded + Coins	$ 250	90%/10%	$10,000	$1,000	$1,500	70%/30%	$10,000	$3,000
◯ Option 2	$30	$50	Ded + Coins	$ 500	90%/10%	$10,000	$1,000	$1,000	70%/30%	$10,000	$3,000
◯ Option 3	$30	$50	Ded + Coins	$ 500	80%/20%	$10,000	$2,000	$1,000	60%/40%	$10,000	$4,000
◯ Option 4	$30	$50	Ded + Coins	$ 750	80%/20%	$12,500	$2,500	$1,500	60%/40%	$12,500	$5,000
◯ Option 5	$30	$50	Ded + Coins	$1,000	80%/20%	$15,000	$3,000	$2,000	60%/40%	$15,000	$6,000

Out of Network UCR Option (Usual, Customary and Reasonable Fee Reimbursement) ◯ 70% ◯ 80%

Note: ER co-pay $75 *Family coverage is 2.5 times the individual coverage amount.

Vision Option (fill in one only)

Co-payment (fill in one) ◯ $5 ◯ $10

Benefit cycle (fill in one)

◯ 12-month ◯ 24-month

Plan choice (fill in one)

◯ Low (exam plus discounts)

◯ High (exam plus $10 co-payment on glasses/ contacts and $35 allowance on non-plan frames)

◯ No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$10	$20	$40
◯	$10	$30	$50
◯	$10	$35	$70
◯	$10	50%	N/A†
◯	$15	N/A	N/A†

Deductible** (fill in one only)

◯ $0 ◯ $50 ◯ $100

◯ $150 ◯ $250 ◯ $500

◯ No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

** Not applicable to mail-order program.

† Mandatory $0 deductible

Miscellaneous Options

(check all of the following options you wish to purchase)

◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)

◯ Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network

◯ Waiver for pre-existing conditions

◯ No additional options

6. MEDICAL BENEFITS SECTION (continued)

EPO COVERAGE OPTIONS

In-Network Options (fill in one only) **Office Visit Co-payment** ◯ $12 ◯ $20 ◯ $30

Vision Co-payment (fill in one only)

◯ Low $5 Co-payment (1 exam every 24 months)

◯ High $5 Co-payment (1 exam every 24 months)
$10 Co-payment for frames
$25 Co-payment for contact lenses
$35 Allowance for non-plan frames

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$10	$20	$40
◯	$10	$25	$50

Deductible** (fill in one only)

◯ $0 ◯ $50 ◯ $100

◯ $150 ◯ No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.

** Not applicable to mail-order program.

Miscellaneous Options

(fill in all of the following options you wish to purchase)

◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)

◯ Inpatient rehabilitation for alcohol/substance abuse — 30 days combined in-network

◯ No additional options

VALUE EPO OPTIONS

Co-payment Options (fill in one only)

In-Network

	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	In-patient Co-Pay*	Deductible*	Coinsurance*	Coinsurance Stop Loss*	Out-of-Pocket Coinsurance Max*
◯ Option 1	$30	$30	Ded + Coins	$1,000	90%/10%	$10,000	$1,000
◯ Option 2	$30	$30	Ded + Coins	$1,500	90%/10%	$10,000	$1,000
◯ Option 3	$30	$30	Ded + Coins	$2,000	80%/20%	$10,000	$2,000
◯ Option 4	$30	$30	Ded + Coins	$500	80%/20%	$20,000	$4,000
◯ Option 5	$30	$30	Ded + Coins	$3,000	80%/20%	$10,000	$2,000

Note: ER co-pay $100 *Family coverage is 2.5 times the individual coverage amount.

Vision Option (fill in one only)

Co-payment (fill in one) ◯ $5 ◯ $10

Benefit cycle (fill in one)

◯ 12-month ◯ 24-month

Plan choice (fill in one)

◯ Low (exam plus discounts)

◯ High (exam plus $10 co-payment on glasses/ contacts and $35 allowance on non-plan frames)

◯ No vision coverage

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$10	$25	$50
◯	$10	$35	$70
◯	$10	50%	N/A†
◯	$10	N/A	N/A†

Deductible** (fill in one only)

◯ $0 ◯ $50 ◯ $100

◯ $150 ◯ $250 ◯ $500

◯ No prescription drug coverage

*Groups exempt from purchasing contraceptives must attach a signed affidavit.

† Mandatory $0 deductible

** Not applicable to mail-order program.

Miscellaneous Options

(check all of the following options you wish to purchase)

◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)

◯ Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network and out-of-network

◯ 4th Quarter Deductible Carry Over

◯ No additional options

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PPO COVERAGE OPTIONS

In-Network Options (fill in one only) **Office Visit Co-payment** ◯ $12 ◯ $20 ◯ $30

Out-of-Network Options (fill in one only)

	Deductible Individual/Family	Coinsurance	Coinsurance Stop Loss Individual/Family	Coinsurance Out-of-Pocket Maximum Individual/Family
◯ 1	$500/$1,250	70%/30%	$5,000/$12,500	$1,500/$3,750
◯ 2	$500/$1,250	70%/30%	$10,000/$25,000	$3,000/$7,500
◯ 3	$750/$1,875	70%/30%	$15,000/$37,500	$4,500/$11,250
◯ 4	$1,000/$2,500	70%/30%	$25,000/$62,500	$7,500/$18,750

Vision Co-payment (fill in one only)

- ◯ Low $5 Co-payment (1 exam every 24 months)
- ◯ High $5 Co-payment (1 exam every 24 months)
  $10 Co-payment for frames
  $25 Co-payment for contact lenses
  $35 Allowance for non-plan frames

Prescription Drug (includes contraceptives*)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$10	$20	$40
◯	$10	$25	$50

Deductible** (fill in one only)

◯ $0 ◯ $50 ◯ $100
◯ $150 ◯ No prescription drug coverage

* Groups exempt from purchasing contraceptives must attach a signed affidavit.
** Not applicable to mail-order program.

Miscellaneous Options

(fill in all of the following options you wish to purchase)

- ◯ Dependent children/student age increases from 19/23 to 23/25 (end of calendar year)
- ◯ Inpatient rehabilitation for alcohol/substance abuse—30 days combined in-network
- ◯ No additional options

COMPREHENSIVE HOSPITAL AND EXTENDED MEDICAL OPTIONS

Deductible and Coinsurance Applies to Hospital and Extended Medical

Deductible, Coinsurance and Stop-Loss Options

Check the deductible you desire in the “Deductible” column below. Then move to the right of your selection and choose the coinsurance and stop-loss level you wish (fill in one only).

Annual Deductible (Individual/Family)	Options: Coinsurance and Stop Loss (Individual/Family)		
◯ $200/$500	◯ 80% Coinsurance to $2,000/$5,000 Stop Loss	◯ 80% Coinsurance to $4,000/$10,000 Stop Loss	◯ 80% Coinsurance with No Stop Loss
◯ $500/$1,000	◯ 80% Coinsurance to $2,000/$5,000 Stop Loss	◯ 80% Coinsurance to $4,000/$10,000 Stop Loss	
◯ $1,000/$2,000	◯ 80% Coinsurance to $4,000/$10,000 Stop Loss		

Rating Structure (fill in one only)

◯ 2-Tier ◯ 4-Tier

Miscellaneous Options (fill in all of the following options you wish to purchase)

- ◯ Alcohol and substance abuse—7 days detox and 30 days inpatient rehab per calendar year
- ◯ Private duty nursing ($10,000 per year maximum; $50,000 per lifetime maximum)
- ◯ Dependent college student age increases to 25 end of calendar year
- ◯ Nonpar hospital paid as par
- ◯ Speech and occupational therapy—unlimited visits
- ◯ Additional outpatient services (7 outpatient visits per person per calendar year for mental and nervous care; 60 additional outpatient visits per person per calendar year for alcohol and substance abuse)

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EMPIRE PRISM EPO OPTIONS

Select the following new Copay Options and prescription drug card choice if applicable.

Co-payment Options (fill in one only)

Co-Payment options	Inpatient Co-Pay	PCP/Primary Home/Office Co-Pay	Specialist Home/Office Co-Pay	ER Co-Pay	Ambulatory/ OP Surgery Co-Pay
◯ Option 1	$200/$500*	$25	$25	$100	$150
◯ Option 2	$500/$1,250*	$35	$35	$100	$300

* per admission/family maximum per calendar year

Prescription Drug (includes contraceptives)

Co-pay Options (fill in one only)

	Generic	Brand	Non-Formulary
◯	$10	$35	$70*
◯	$10	$35	$70 ($2,000 max)
◯	$10	50%	N/A†
◯	$15	N/A	N/A†

Deductible (fill in one only)

◯ $0 ◯ $50

◯ $100 ◯ $250

◯ $500

*$0 Deductible not Allowed

†Mandatory $0 Deductible.

Rating Structure (fill in one only)

◯ 2-Tier (Upstate & Mid-Hudson regions)

◯ 3-Tier (Upstate & Mid-Hudson regions)

◯ 4-Tier (All rating regions)

Vision Option (fill in one only)

Co-payment (fill in one)

◯ $5 ◯ $10

Benefit Cycle (fill in one)

◯ 12-month ◯ 24-month

Plan Choice (fill in one)

◯ Low (exam plus discounts)

◯ High (exam plus $10 co-payment on glasses/contacts and $35 allowance on non-plan frames)

◯ No vision coverage

Miscellaneous Options

(fill in all of the following options you wish to purchase)

◯ Dependent children/student age increase from 19/23 to 23/25 (end of calendar year)

◯ Inpatient rehabilitation for alcohol/substance abuse 30 days in-network

7. DENTAL BENEFITS SECTION

Please select the dental product and coverage options you wish to purchase.

○ No Coverage

○ Premium Care PPO
(fill in one only)

	Coinsurance In-Network	Coinsurance Out-of-Network
○	100%/80%/50%	100%/80%/50%
○	100%/80%/50%	80%/60%/50%

Deductible (fill in one only)

○ $25/$75 ○ $50/$150

Annual Maximum (fill in one only)

○ $1,000 ○ $1,500

○ Orthodontics**

** Contact your Sales representative for availability of this option.

○ Managed Dental Programs* (fill in one only)

○ **Preventive Care**—$10 co-payment on diagnostic and preventive procedures only

○ **Preventive Care Plus**—Adds Basic Restorative coverage

○ **Comprehensive Care**

○ Plan 1 ○ Plan 2 ○ Plan 3

Office visit co-pays

○ $0 ○ $5 ○ $10

Orthodontics**

○ Child only ○ Child and adult

Ortho co-pay max per member

○ $2,000 ○ $2,500 ○ $3,000

Dependent/student age

○ 19/23 ECY ○ 23/25 ECY

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

○ Progressive Dental

○ Age 23/25 Rider

○ Open Access—Voluntary
(fill in one only)

	Coinsurance	Deductible	Orthodontics**
○	100%/50%/50%	$25	○ Child only
○	100%/50%/30%	$50	Not Available
○	100%/50%/0%	$50	Not Available

**Contact your Sales Representative for availability of this option.

Group's Contribution, if any.

% Employee only ☐☐☐ % 2 Party ☐☐☐ % Employee & Spouse ☐☐☐ % Parent & Child(ren) ☐☐☐ % Family ☐☐☐

Other coverage

Does your group currently have dental coverage from any carrier, including Empire? ○ Yes ○ No

If yes, Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Type (ex: DHMO, PPO, Indemnity) ☐☐☐☐☐☐

Coverage start date (MMDDYY) ☐☐☐☐☐☐

Coverage end date (MMDDYY) ☐☐☐☐☐☐

8. PLEASE ATTACH COPY OF RATE PROPOSALS

9. 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 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 Commissions: % of split

Agent or Brokerage of Record Name

Social Security/Tax ID Number

Company Name

E-mail Address

Mailing Address

City

State

ZIP (5+4)

County

Phone

Fax

1st Broker Signature

Date (MMDDYY)

2nd BROKER Commissions: % of split

Agent or Brokerage of Record Name

Social Security/Tax ID Number

Company Name

E-mail Address

Mailing Address

City

State

ZIP (5+4)

County

Phone

Fax

2nd Broker Signature

Date (MMDDYY)

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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, W-2 forms or any additional documentation validating enrollment of employees, owners or partners (i.e., K-1, notarized statements, payroll records) are a completed statement of the total number of our employees, including the reasons why any individuals are not being covered, for which appropriate documentation 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, 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 such contracts, 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 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.

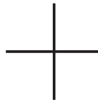
Benefits purchased and established eligibility selected may be changed at renewal only. It is understood that this agreement may be terminated by the group giving 30 days' prior written notice. In the event of termination by the group, the group will be required to pay premiums to a date not less than 60 days subsequent to the written notification by the group to Empire. 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, Direct HMO or Direct POS 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***.

10. SIGNATURE OF AUTHORIZED REPRESENTATIVE — I HAVE READ THIS ENTIRE APPLICATION AND THE CERTIFICATION AND FRAUD STATEMENT.

Group hereby designates the broker(s) listed on this application as the broker(s) of record for the Group (the "BOR"), and agrees that notice to the BOR constitutes notice to the Group. Further, that the Group has agreed that the BOR will be paid the commission specified in #9 above in compliance with Empire's applicable commission schedule. Further the Group agrees that the BOR designation and the commission rate will continue until expressly terminated in writing by the Group.

The commission rate or other compensation that may be received by your broker does not change your premium rate. Small group brokers who provide specific additional administrative services may also receive an additional payment from Empire. You can obtain additional information regarding Empire's standard commission scale applicable to your product and any applicable broker compensation programs by visiting ***www.empireblue.com*** or by contacting your Empire representative.



Authorized Group Signature

Date (MMDDYY)

Print Last Name

Print First Name

Title

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.

Services provided by Empire HealthChoice HMO, Inc., and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

11. OPTIONAL EMPLOYER ONLINE SERVICES DELEGATION FORM

Empire BlueCross BlueShield is offering Group Benefit Administrators an opportunity to delegate the administration of their accounts to their Broker of Record. The Broker of Record will perform the administrative duties assigned to him or her by the Group Benefits Administrator via Empire's secure Broker Online Services web site at ***www.empireblue.com***.

Please complete this form and the Terms and Conditions Letter Agreement (the "Agreement") if you would like to permit your Broker of Record to administer your account for you. Please be sure to discuss this delegation with your broker prior to submission.

Please mail or fax this form to:
Broker Relations
15 MetroTech Center, 4th Fl.
Brooklyn, NY 11201
Fax: 1-718-312- 6006

Please note: By filling out this form and the Agreement and giving your Broker of Record access to manage your account, you are not giving up your right to access your account through Employer Online Services or to administer your account.

Please check if you would like to:

- ○ Delegate administration of your account to your Broker of Record to
  - ○ Manage only existing sub-groups
  - ○ Manage all existing and future sub-groups
- ○ Delegate to your Broker of Record the ability to add/cancel users
- ○ Change your Broker of Record's access level
- ○ Terminate a Broker of Record's administrative rights to manage your account*

Please check all activities that you would like to delegate to your Broker of Record:

- ○ Basic Group Admin
- ○ View Group Forms
- ○ View Claims
- ○ Enroll Employees and Perform Enrollment Changes
- ○ View Roster (2–500)
- ○ Basic Employee Admin
- ○ View Employee Forms
- ○ View Billing
- ○ Request ID Cards
- ○ Perform Demographic/Dependent Changes

Please complete your contact information:

Print Last Name

Print First Name

Company Name

Base Group Number

Renewal Date (MMDDYY)

E-mail Address (optional)

Phone

Please provide your Broker of Record's contact information:

Print Last Name

Print First Name

License Number

E-mail Address (optional)

Date of Birth (MMDDYY)

* You will not be able to assign a new Broker of Record using this form. Please check the box only if you would like to terminate your current Broker of Record's administrative rights.

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11. TERMS AND CONDITIONS LETTER AGREEMENT FOR ACCESS TO THE EMPIRE EMPLOYER ONLINE DELEGATION (continued)

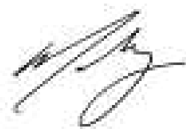
This Terms and Conditions Letter Agreement (the "Agreement") sets forth the understandings and agreement between ____ ("the Group") and Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross BlueShield and Empire HealthChoice HMO, Inc., d/b/a Empire BlueCross BlueShield HMO (together referred to as "Empire"), to permit access to Empire's interactive Employer Online Services web site ("web site") for use by the Broker of Record, or an authorized designee of the Broker of Record (together referred to as "brokers"), designated by the Group, to facilitate the administration of the health benefit plan(s) (the "plan(s)") purchased by the Group from Empire pursuant to a separate Contract (the "Contract").

The Group understands and agrees that access to the web site granted by Group to its designated brokers is subject to the following terms and conditions:

1. Empire shall provide those brokers designated by the Group access to the Employer Online Services web site in accordance with Empire's registration procedures. The Group understands that all designated brokers must agree to the web site Terms and Conditions.
2. The Group understands that the purpose of this web site is to provide an additional medium for the Group, through its designated brokers, to carry out the certain plan administration functions as delegated by the Group, including the ability to: maintain eligibility files, process enrollment and enrollment changes for members and dependents, select and change PCPs on behalf of and at the request of a member, search for participating providers, view certain claims information on behalf of and at the request of a member, request ID cards and print temporary cards, maintain and update COB information, and view statements of account(s), access billing reports, pay and/or adjust bills, and other functions as may be added from time to time by Empire and delegated by the Group.
3. The Group is solely responsible for the accuracy and authenticity of the information submitted on the web site.
4. This agreement relates solely to access by the brokers designated by the Group to the web site and does not add, diminish or otherwise change the obligations of the parties, which remain subject to the Contract, any other agreements executed by the parties, the contracts of health insurance coverage issued by Empire, and Empire policies and procedures. In the event of a conflict between this agreement and any of the aforementioned, the aforementioned shall control.
5. The Group shall advise Empire, in writing, of the names and other information as requested by Empire, of its brokers who shall have web site access, and shall timely notify Empire of brokers who no longer are authorized to access the web site. Notice shall be sent by fax to 1-718-312-6006.
6. Any data accessed and/or provided to the Group or to its brokers on the web site shall remain the property of Empire.
7. Empire is not responsible for the accuracy and completeness of records supplied to Empire by the Group, the brokers or by health care providers.
8. The Group and its representatives shall maintain and preserve the confidential and proprietary nature of all Empire's data to which the Group and its representatives have access. The Group shall not provide either web site access, or other access to Empire's proprietary and confidential information available to the Group on the web site, to any unauthorized party, or in a manner in conflict with this Agreement.
9. The Group will hold Empire, its officers, directors and agents, harmless from any loss, expense, liability, claim, lawsuit or judgement (including reasonable attorneys' fees) arising directly or indirectly out of Empire's disclosure of the Group's enrollment and/or claims information or from the Group's provision to Empire of enrollment information, or resulting from the Group's failure to abide by the terms of this Agreement.
10. The obligations undertaken herein in Paragraphs 8 and 9 above shall survive the expiration or termination of this Agreement.
11. Nothing contained in this Agreement shall be construed as granting or conferring any rights by license, patent, copyright or any other intellectual property right of one party to the other.
12. This Agreement shall terminate:
    a. by Empire or the Group upon five (5) business days written notice by facsimile transmission, or otherwise, or as otherwise agreed to by the parties hereto in writing;
    b. if prohibited by any law or regulation;
    c. six (6) months after the termination of the Contract.
13. If the Group has more than one health benefits plan under the terms of its Contract, the Group's designated brokers shall have access, if such access is delegated to the brokers, to any of its health benefits plans that may terminate during the term of the Contract, for the earlier of twenty-four (24) months after termination of the specific health benefits plan or six (6) months after the termination of the Contract.

Please sign and date this Agreement in the space provided below to confirm your agreement to these terms and conditions, and return the fully executed original at your earliest convenience.

Sincerely,



Mark Wagar
President

Acknowledged and Agreed to

This __________ day of ___________________________, 200_____

Print Name: ____

Signature: ____

Title: Group Benefits Administrator

ENR6000BPB14

NEW RIDER SELECTION WORKSHEET
(2-50 Eligible Employees)

Domestic Partner Rider Selection

New Small Groups are defaulted to Same & Opposite Sex domestic partnership coverage unless otherwise specified. Please make a selection to choose a different form of Coverage.

- ○ Same Sex Only
- ○ No Domestic Partnership Coverage

Product I

Please choose the product for which you request a rider addition:

○ HMO ○ Direct POS ○ PPO ○ Value EPO ○ Empire Total Blue^SM

○ Direct HMO ○ DirectShare^SM POS ○ EPO ○ Empire Prism^SM EPO ○ Other ____________

Rider Selection:

○ Biologically Based Mental Illness and Serious Emotional Disturbances Coverage

○ No Selection

Product II

Please choose the product for which you request a rider addition:

○ HMO ○ Direct POS ○ PPO ○ Value EPO ○ Empire Total Blue^SM

○ Direct HMO ○ DirectShare^SM POS ○ EPO ○ Empire Prism^SM EPO ○ Other ____________

Rider Selection:

○ Biologically Based Mental Illness and Serious Emotional Disturbances Coverage

○ No Selection

Product III

Please choose the product for which you request a rider addition:

○ HMO ○ Direct POS ○ PPO ○ Value EPO ○ Empire Total Blue^SM

○ Direct HMO ○ DirectShare^SM POS ○ EPO ○ Empire Prism^SM EPO ○ Other ____________

Rider Selection:

○ Biologically Based Mental Illness and Serious Emotional Disturbances Coverage

○ No Selection