



Employer Notice of Election

HealthPass New York
Phone 888-313-7277

*Required information

A. YOUR COMPANY

Full Name of Company* Doing Business As (DBA) Name*

Federal Tax ID Number* Date Company Founded On (MM/DD/YYYY)*

Organizational Type:* "C" Corp "S" Corp Partnership/LLP Non-Profit Sole Proprietorship Church Limited Liability Corporation

Employer Industry:* Health High Tech Legal Manufacturing Retail Service Tourism Other

Primary Contact Name* Primary Contact Phone Number/Ext.* Primary Contact Email*

Street Address (No P.O. Boxes)* Suite City/State/Zip*

County or Borough* Fax Number

Billing Contact Name* Billing Street Address (if different) Billing Suite City/State/Zip

Billing Contact Phone/Ext. Billing Contact Email

B. ELIGIBILITY AND ENROLLMENT

Total Number of Employees (Full and Part-Time) on Payroll* _____

Total Number of Full-Time Equivalent Employees* _____

Number of Eligible Employees* _____

Are you currently offering group health insurance?* Yes No If yes, name of Current Medical Carrier _____

Waive new hire waiting period at initial open enrollment

Waiting period (Coverage Begins on the 1st of the Month Following)* 0 Months 1 Month 2 Months

How many hours per week must employees work to be eligible for coverage?* _____ (Must be between 20 and 40 hours)

Are any enrollees Age 65+ (currently or within the next 90 days)?* Yes No

Are any former employees currently covered under COBRA?* Yes No If yes, how many?* _____

Are any former employees currently covered under NY State Continuation (NYSC)?* Yes No If yes, how many?* _____

Number of Enrollments with HealthPass* _____

Number of Eligible Employees who have Other Health Coverage* _____

Number of Employees covered by Collective Bargaining Agreement* _____

C. YOUR BENEFITS WITH HEALTHPASS

Tier Structure for: **Medical:*** Four Tier (All Carriers) **Dental:*** Four Tier Not Interested **Vision:*** Four Tier Not Interested

COBRA/NYSC (Included Service):* I would like to participate in COBRA/NYSC service I would like to opt out of COBRA/NYSC service

COBRA (Federal) or NYSC (State):* Federal State

Requested Effective Date* _____ (Must be 1st of the month only)

NYS-45 or applicable tax form from the most recent quarter attached*
Tax docs must be notated with the following only: FT (full-time) PT (part-time) U (union) T (termed) S (seasonal)

D. BROKER AND GA INFORMATION

Broker commission splits must total 100%.

Pay Commission To Broker Name _____ Broker ID# _____ %

Broker Name _____ Broker ID# _____ %

General Agency Name (if applicable) _____ GA ID# _____

General Agency Representative Name _____

E. MEDICAL AND ANCILLARY PLAN OFFERINGS

Participation Requirements

Choose the medical plans you would like to offer to your employees for the upcoming policy year. You may choose to offer all plans or a select number of plans, though it is recommended to allow employees access to the full portfolio. At every policy renewal you must re-establish the medical plans to offer or all plans will be made available.

Carrier Offerings: EmblemHealth, Healthfirst, Oscar, Oxford – Metro

HealthPass Participation Requirements: 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 20% of the total eligible employees must enroll with a HealthPass medical plan.

To include Oxford – Liberty

Liberty Participation Requirements: 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 60% of the total eligible employees, after valid waivers, must enroll in Oxford – Liberty and/or Oxford – Metro plans.

Select one: I would like to offer all plans I have selected the plans I would like to offer below

EmblemHealth Plans			
<input type="checkbox"/> Prime Platinum PPO <input type="checkbox"/> Prime Platinum Premier <input type="checkbox"/> Select Care Platinum Premier	<input type="checkbox"/> Prime Gold PPO <input type="checkbox"/> Prime Gold Premier <input type="checkbox"/> Prime Gold Virtual <input type="checkbox"/> Select Care Gold Premier <input type="checkbox"/> Select Care Gold Value <input type="checkbox"/> Millennium Gold Virtual	<input type="checkbox"/> Prime Silver Premier <input type="checkbox"/> Select Care Silver Premier <input type="checkbox"/> Select Care Silver Value <input type="checkbox"/> Millennium Silver Value G <input type="checkbox"/> Prime Silver HSA	<input type="checkbox"/> Prime Bronze HSA <input type="checkbox"/> Select Care Bronze Premier <input type="checkbox"/> Select Care Bronze Value <input type="checkbox"/> Millennium Bronze Premier G <input type="checkbox"/> Millennium Bronze Value G
Healthfirst Plans			
<input type="checkbox"/> Platinum Pro EPO	<input type="checkbox"/> Gold Pro EPO <input type="checkbox"/> Gold 25/50/0 Pro EPO	<input type="checkbox"/> Silver Pro EPO <input type="checkbox"/> Silver 40/75/4700 Pro EPO	<input type="checkbox"/> Bronze Pro EPO HSA <input type="checkbox"/> Bronze 6850 Pro EPO HSA <input type="checkbox"/> Bronze 8150 Pro EPO
Oscar Plans			
N/A	<input type="checkbox"/> Circle Gold 2000	<input type="checkbox"/> Circle Silver 5000	<input type="checkbox"/> Circle Bronze 4500
Oxford Metro Plans			
N/A	<input type="checkbox"/> Metro Gold EPO 25/40 G <input type="checkbox"/> Metro Gold EPO 25/40	<input type="checkbox"/> Metro Silver EPO 30/80 G <input type="checkbox"/> Metro Silver EPO 50/100 ZD	<input type="checkbox"/> Metro Bronze HSA 7000 G
Oxford Liberty Plans			
To include Oxford – Liberty Plans, see above Liberty Participation Requirements. If the group does not meet the Oxford – Liberty Participation Requirements at open enrollment; the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Oxford – Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Oxford – Liberty enrollees will be mapped into Oxford – Metro plans within the same selected metal tier.			
<input type="checkbox"/> Liberty Platinum EPO	<input type="checkbox"/> Liberty Gold EPO 30/60 <input type="checkbox"/> Liberty Gold EPO 30/60 G <input type="checkbox"/> Liberty Gold EPO 25/50 ZD <input type="checkbox"/> Liberty Gold HSA 1500 Motion	<input type="checkbox"/> Liberty Silver EPO 25/50 G <input type="checkbox"/> Liberty Silver EPO 40/70 <input type="checkbox"/> Liberty Silver EPO 50/100 ZD <input type="checkbox"/> Liberty Silver HSA 4000 Motion	<input type="checkbox"/> Liberty Bronze HSA 5750

Dental Plans

Choose one dental package you would like to offer to your employees for the upcoming policy year. If you choose not to offer dental at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able to re-establish the plans to offer.

Dental Options	<input type="checkbox"/> Dental Package 1 - All Carriers (In-Network plans only) Guardian Managed DentalGuard DHMO, Guardian Managed DentalGuard DHMO <i>Plus</i> , Solstice Dental EPO S700B, Solstice Dental EPO S800B and UnitedHealthcare Select Managed Care
	<input type="checkbox"/> Dental Package 2 [^] - Guardian Managed DentalGuard DHMO and Guardian DentalGuard Preferred PPO MAC
	<input type="checkbox"/> Dental Package 3 [^] - Guardian Managed DentalGuard DHMO <i>Plus</i> and Guardian DentalGuard Preferred PPO <i>Plus</i> MAC
	<input type="checkbox"/> Dental Package 4 - Solstice Dental EPO S700B, Solstice Dental EPO S800B, Solstice Dental PPO and Solstice Dental Value PPO MAC
	<input type="checkbox"/> Dental Package 5 [^] - UnitedHealthcare Select Managed Care, UnitedHealthcare Low PPO MAC and UnitedHealthcare High PPO MAC
	<input type="checkbox"/> Dental Package 6 [^] - UnitedHealthcare INO 100/50/50 and UnitedHealthcare High PPO MAC
	<input type="checkbox"/> Dental Package 7 - Not Interested

[^]Participation requirements apply.

Vision Plans

Choose one vision package you would like to offer your employees for the upcoming policy year. If you choose not to offer vision at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able to re-establish the plans to offer.

Vision Options	<input type="checkbox"/> Vision Package 1 [^] - Guardian VisionGuard [^] , Solstice Vision PPO and UnitedHealthcare Vision PPO
	<input type="checkbox"/> Vision Package 2 - Solstice Vision PPO and UnitedHealthcare Vision PPO
	<input type="checkbox"/> Vision Package 3 [^] - Guardian VisionGuard
	<input type="checkbox"/> Vision Package 4 - Solstice Vision PPO
	<input type="checkbox"/> Vision Package 5 - UnitedHealthcare Vision PPO
	<input type="checkbox"/> Vision Package 6 - Not Interested

[^]Participation requirements apply.

FSA & Commuter Benefits

Choose if you would like to offer FSA & Commuter Benefits to your employees for the upcoming policy year. If you choose not to offer FSA & Commuter Benefits at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able to re-establish the plans to offer. Please note: every year your employees will have to re-establish their plans and amounts.

Select any of the plans you wish to offer:

OCA FSA & Commuter Benefits			
<input type="checkbox"/>	Healthcare Flexible Spending Account (FSA) Select Yearly Amount Plan:	<input type="radio"/> FSA \$1000 Max	<input type="radio"/> FSA \$2000 Max <input type="radio"/> FSA \$2750 IRS Max
<input type="checkbox"/>	Dependent Care Account (DCA) FSA Yearly Maximum Amount: \$5000		
<input type="checkbox"/>	Parking Plan Monthly Maximum Amount: \$270		
<input type="checkbox"/>	Transit Plan Monthly Maximum Amount: \$270		
Select your Payroll Cycle: <input type="radio"/> 52 <input type="radio"/> 26 <input type="radio"/> 24 <input type="radio"/> 12 <input type="radio"/> More than 1 cycle			
1st Payroll Processing Date: ____/____/____			
<input type="checkbox"/>	Not Interested		

Life/AD&D/LTD Plans

Choose if you would like to offer Life/AD&D/LTD Plans to your employees for the upcoming policy year. If you choose not to offer Life/AD&D/LTD Plans at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able to re-establish the plans to offer.

Guardian Plans	<input type="checkbox"/> EverGuard	<input type="checkbox"/> EverGuard <i>Plus</i>	<input type="checkbox"/> Dual Option	<input type="checkbox"/> Not Interested
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Accident Plan

Choose if you would like to offer an Accident Plan to your employees for the upcoming policy year. If you choose not to offer an Accident Plan at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able to re-establish the plans to offer.

Guardian Plan	<input type="checkbox"/> AccidentGuard Adv
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ID Theft Plans

Choose if you would like to offer ID Theft Plans to your employees for the upcoming policy year. If you choose not to offer them at this time, current and future employees will be unable to enroll until your next open enrollment. At every policy renewal you will be able re-establish the plans to offer.

Select one option and then select related plan(s)

ID Theft Plans	Options	Plans		
	<input type="checkbox"/> Allstate Identity Protection	<input type="checkbox"/> Allstate Identity Protection Pro	<input type="checkbox"/> Allstate Identity Protection Pro Plus	<input type="checkbox"/> Dual Option
	<input type="checkbox"/> LifeLock	<input type="checkbox"/> Benefit Elite	<input type="checkbox"/> Ultimate Plus	<input type="checkbox"/> Dual Option
<input type="checkbox"/> Not Interested				

Defined Contribution

Determine how to apply your monthly contributions:

- No Contribution**
- Lump Sum \$** _____ Additional funds will rollover into any selected ancillary plans.
- Contribute Per Plan Type (by percent or flat dollar):**
- Medical _____
- Dental _____
- Vision _____
- Contribute by Coverage Tier (by percent or flat dollar):**
- Medical EE Only _____ EE/Sp _____ EE Child(ren) _____ Family _____
- Dental EE Only _____ EE/Sp _____ EE Child(ren) _____ Family _____
- Vision EE Only _____ EE/Sp _____ EE Child(ren) _____ Family _____

F. BANK INFORMATION

An electronic payment or business check, payable to HealthPass, for the full amount due must accompany this application. Applications submitted with less than the full amount due or with personal checks will not be processed.

Initial Payment (Select One)

- Please use electronic funds transfer (EFT) for my initial payment with HealthPass.* (Must attach a voided business check)
- I have remitted a physical check with my application. Are any COBRA members included in the 1st month's premium? Yes No

Ongoing Payments (Select One)

- Please use electronic funds transfer (EFT) for my monthly payment.* (Must attach a voided business check)
- Please bill me monthly.
- I would like to enroll in paperless billing. If enrolling in paperless billing we must have an active email address on file.

If EFT is selected, I hereby authorize HealthPass to initiate electronic funds transfer (EFT) from my account for the payment of my monthly cost of coverage. I understand the debit transaction will occur the 1st of the month or the 1st business day following. In the event that I make changes to my banking arrangements, I understand that I must notify HealthPass to effect the changes for payment collection. All changes must be reported 20 days prior to the effective date of the change by calling HealthPass at 888-313-7277.

*The HealthPass Merchant ID is 131575. Check with your financial institution as you may need to provide this ID in order for payments to be processed successfully.

G. EMPLOYER CERTIFICATION

I agree and attest that:

- My business will offer HealthPass medical coverage to every eligible full-time employee and age, sex or health status cannot be used to determine employee eligibility.
- An eligible employee must be defined as one that works no less than 20 hours per week and my business must have at least one (1) such eligible employee.
- Part-time employees (working less than 20 hours per week), temporary employees, employees working outside of the US, household help, and retirees are not eligible for coverage through HealthPass. Other exclusions may apply.
- The group meets HealthPass participation requirements:
- **Carrier offerings:** EmblemHealth, Healthfirst, Oscar, Oxford - Metro
 - **HealthPass Participation Requirements:** 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 20% of the total eligible employees must enroll with a HealthPass medical plan.
 - **To include Oxford – Liberty**
 - **Liberty Participation Requirements:** 75% of the eligible employees must either enroll in HealthPass or submit a valid waiver. 60% of the total eligible employees, after valid waivers, must enroll in Oxford – Liberty and/or Oxford – Metro plans.
- The group meets all HealthPass carrier out-of-area coverage requirements
- **EmblemHealth**
Prime Plans - Employees must live/work/reside in NY, NJ and CT. Prime PPO and Prime Gold Virtual members have access to the First Health National Network and can reside in any of the 50 US states.
Select Care Plans - Employees must live/work/reside in NY.
Millennium Plans - Employees must live/work/reside in the five boroughs, Nassau, Suffolk and Westchester.
 - **Healthfirst**
Pro Plans - Employees must live/work/reside in the five boroughs, Nassau and Suffolk.
 - **Oscar**
Circle Plans - Employees must live/work/reside in the five boroughs, Nassau, Suffolk, Westchester and Rockland.
 - **Oxford**
Metro Plans - Employees must live/work in NY and NJ.
Liberty Non-Gated Plans - Employees can live anywhere in the continental US
Liberty Gated (G) Plans - Employees must live in NY, NJ and CT. These members have access to Choice Plus when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT).

- This application has been completed with accurate information and has in no way has any information been misrepresented, falsely provided, or reinforced by false documentation that has been presented. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or state department of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material here to, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation plus the amount of the claim on individuals who commit fraudulent insurance acts. Additionally, the State has the right to levy a civil fine of up to \$1,000 for possession of a fraudulent health insurance identification card and up to \$5,000 for each addition card possessed.

Please refer to our Eligibility Guidelines for more detailed information.

H. MEDICARE SECONDARY PAYER

The Medicare Secondary Payer (MSP) provisions apply to situations when Medicare is not the primary payer. If your company has employed 19 or fewer, and employees in the current or preceding year, Medicare is almost always primary. If your company has employed 20 or more employees in the current or preceding year, Medicare is almost always secondary. In the case where an employer has 19 or employees and is part of a multi-employer group health plan (e.g. HealthPass) then Medicare is by default the secondary payer to the group health plan (GHP).

Participating employers with HealthPass that certify they have 19 or fewer employees, and have enrolling employees age 65 or older, must file for the MSP Small Employer Exception Certification. The exception means the employer is not held to the MSP rules governing multi-employer group health plans and Medicare will be the primary payer of Medicare Part A claims for any employee that is a working-aged Medicare beneficiary. For purposes of this calculation both full-time and part-time employees are counted toward the 20 employee threshold. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20 or more employee requirement is met. The 20 employee or more requirement is met if the employer employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Note that the 20 weeks do not have to be consecutive. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full and/or part-time employees on its employment rolls each working day of that week.

- My group size per Medicare standards:* _____**

If your answer is 20 or more, no further action needs to be taken. If your answer is 19 or fewer, and you have at least one enrolling employee age 65+, you must complete and sign the MSP Small Employer Exception Certification (www.healthpassny.com) and submit it with this application.

I. PROGRAM BENEFITS

Health Advocacy: All members with medical coverage through HealthPass (excluding COBRA enrollees) have access to Health Advocate™ to assist with navigating many healthcare related issues, including support in understanding claims and accessing providers.

Section 125 POP Kit: All groups enrolled with HealthPass have access to a Section 125 Premium Only Plan (POP) Kit which enables employees to make pre-tax contributions to their healthcare rates. Employers must request their POP Kit within 90 days of initial enrollment by visiting www.healthpassny.com.

HealthPass COBRA Administration Services: All groups have access to COBRA/NYSC Administration Services unless opted out by Employer in Section C. The service includes notification of former employees of their rights upon termination and the collection of payments from employees who elect to continue their coverage with their former employer. Employer understands it is responsible to timely and accurately perform all of their responsibilities by providing participant information. HealthPass COBRA Administration Services will terminate if (i) mandatory termination occurs due to non-payment or Employer otherwise ceases to offer medical insurance via HealthPass; (ii) Employer does not comply with the information or; (iii) Employer elects to cease to offer HealthPass COBRA Administration Services by declining such services in Section C of this form or otherwise in writing at any time. Employer agrees to indemnify HealthPass and all personnel involved in the provision of COBRA Administration Services.

J. FEE DISCLOSURE

Program Fees: All medical rates include \$4.95 for HealthPass Program Benefits (non-carrier/agent services) and a 2.9% billing and administrative fee.

- Dental In-Network plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
- Dental PPO plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$16.50, Family \$26.50
- Vision plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
- Guardian EverGuard & EverGuard *Plus* plans: \$3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE \$2.50, EE/Spouse \$3.50, EE+Child(ren) \$3.50, Family \$5.50

K. HEALTHPASS INSURANCE TRUST

The undersigned employer, in order to establish a plan or plans of Group Health Insurance for its employees and their dependents, hereby requests participation in the New York Health Purchasing Alliance, Inc. and/or HealthPass Insurance Trust (the "Trust") which provides health insurance benefits under Group Contracts issued by several health insurers and health maintenance organizations (HMO) to the Trustee of the HealthPass Insurance Trust. If the undersigned employer's participation is approved by the Trustee or the Administrator appointed by the Trustee (the "Administrator"), said employer shall become a Participating Employer (as defined in Trust Agreement) as of the effective date endorsed herein by the Trustee or the Administrator. The undersigned employer understands and acknowledges that even if it is approved as a Participating Employer in the HealthPass Insurance Trust, employees and their dependents are not automatically insured, as each must satisfy any eligibility requirements of the Trust and of the applicable Group Contracts. The Participating Employer agrees to make the coverage under Group Contracts available to all of its current and future eligible employees.

The undersigned employer hereby agrees:

- To be bound by all the terms of the Trust Agreement and of the Group Contract(s) as each may be from time to time amended, changed or terminated by the Insurer, HMO or Trustee, copies of which are available from the Trust or the Administrator upon request.
- To furnish any information requested by the Trustee, Administrator or any of the Insurers or HMOs, which is reasonably required for the proper administration of the Trust or of the Group Contract.
- To distribute to its eligible employees any materials provided by or on behalf of the Trustee, Administrator, Health Insurer or HMO describing Trust or the Group Contract.
- That it has no right, title or interest in or to the Trust Fund created under Trust.
- Coverage under any Contract through the Trust shall only apply to the extent provided in the Group Contract issued to the Trust by the insurer or HMO. All claims for benefits must be submitted to the insurer or HMO. Benefits are payable only by the insurer or HMO. The Trust's responsibility is solely to pay premiums to the insurer or HMO. The Trust is not liable for any benefit payments.
- The Trustee does not have any obligation under any of the Group Contracts to automatically insure employer groups should HealthPass not be in receipt of payment by the end of the month of the date due. Full payment must be made to keep all group policies active.

L. EMPLOYER AUTHORIZATION

IN WITNESS hereof, the Employer, by its duly authorized officer, certifies the Employer:

- Meets the eligibility requirements including, but not limited to, the criteria specified in Section G,
- Has completed Sections A, B and H with accurate information and have in no way misrepresented, falsely provided, or reinforced any information with false documentation,
- Authorizes any initial and ongoing payments as specified in Section F,
- Understands and agrees to the requirements of the Program Benefits afforded in Section I and the related fees as enumerated in Section J, and;
- Agrees to the terms set forth in Section K of this form regarding the Trust Participation Agreement.

All enrollment documentation must be fully complete and submitted by the 20th of the month prior for effective coverage for the 1st of the following month. Any enrollment documentation received after the 20th of the month will subject the entire group to delays in coverage activation up to 10-12 business days.

Print Name _____

Date _____

Authorized Signature _____

Title _____

For extra HealthPass Products & Services, such as pet insurance and a hearing benefit program, visit <https://healthpass.com/extra-products-and-services> to find out more.