

Renewal Requirements

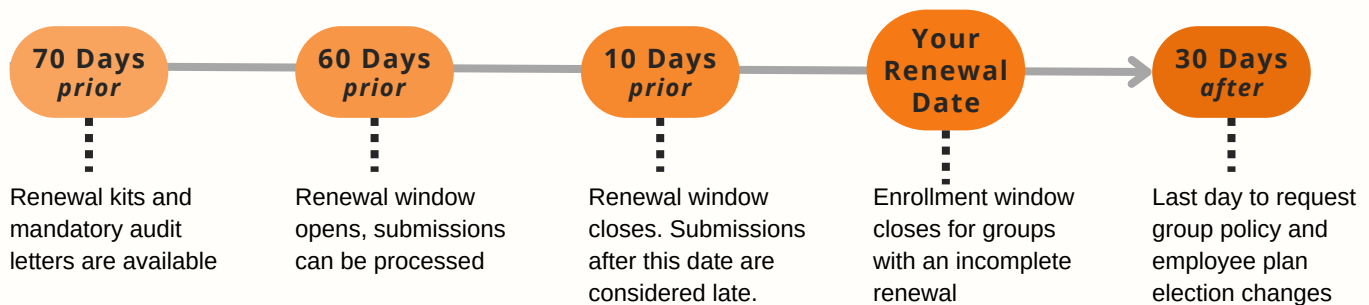


You may be required to submit documentation in order to process your renewal and continue your group policy. This chart indicates what's required for your renewal.

Renewal Type	Types of Changes	Action Required
No Changes	Groups not making changes to their policy or employee plan elections (unless selected for mandatory audit)	No documents required
Employee Plan Changes	Groups making changes to their employee plan elections only	Submit Renewal Attestation Form
Group Level Changes	Groups making changes to: <ul style="list-style-type: none"> Hours worked per week, COBRA Administration participation, and/or Dental/ Vision product offerings that require participation 	*Submit notated tax documents
	All other group changes not listed above	Submit Renewal Attestation Form
Mandatory Audit	Groups selected for mandatory audit. A notice is sent 90 days prior to your renewal date.	*Submit notated tax documents

*Tax documents must be notated with the number of hours worked per week for each employee.

Renewal Timeline



Late/incomplete submissions received after the 20th of the month prior to the renewal date will be subject to delays and enrollees may experience claim issues.

Find Renewal Forms on our website!

<https://healthpass.com/benefits-exchange/forms-and-documents/#renewals>

We're here for you, call us 888-313-7277 | renewals@healthpass.com

Renewing Group Attestation Form

I attest that none of the following changes will be made upon renewal for:

Group Name _____ Group Number _____

- Changing the number of hours worked per week to be eligible for coverage
- Enrolling in COBRA Administration
- Adding a Vision Package with plan offerings that require participation

I understand that if my business has changes to any of the above group criteria, we will be required to provide proof of continued eligibility. Failure to produce the required proof of continued eligibility may result in termination of group coverage. HealthPass and its partner carriers reserve the right to request documentation to ensure continued eligibility at any time.

Authorized Agent or Employer Signature _____

Print Name _____ Date _____

Please complete and submit this form along with any employee plan changes no later than the 20th of the month to ensure that coverage is activated by your renewal date. Late/incomplete submissions will be subject to delays and enrollees may experience claim issues.

Client Retention Department
888-313-7277
renewals@healthpass.com

EMPLOYER RENEWAL

FASTER, EASIER & MORE SECURE ONLINE



Great news - we made your renewal easier! You can now pick the plans you want to offer and have your employees shop and enroll in their benefits online.

- Compare plan options side by side
- No more paper forms
- Built-in decision support
- Enrollment reports

IT'S QUICK AND EASY TO SET UP

Login to the HealthPass Online Portal (HOP)

1. Enter www.healthpass.bswift.com in your browser
2. Enter your username and password

First time users:

Username: First Initial of First Name, First 3 Letters of Last Name, Last 4 of SSN

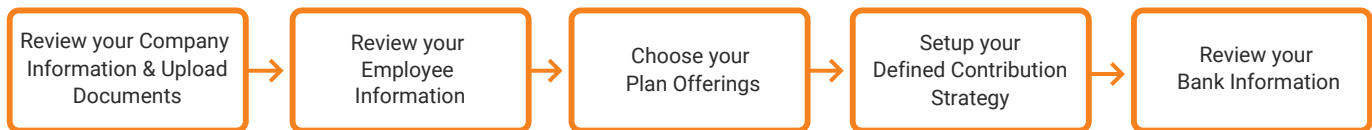
Example: John Smith (SSN: 000-00-1234) = JSMI1234

Password: Date of Birth

Example: John Smith (DOB 1/23/1991) = 01231991

You will be required to change your password after your initial login.

Click "Continue Your Renewal Application"



Start your Open Enrollment

Select "Start an Open Enrollment window for employees", then select "Yes, Send an email notification".

Customize and send your Open Enrollment Email

We recommend including an open enrollment end date to advise employees of the deadline to make plan selections. Select "Include Username", and "Save".

Your employees will receive your email announcing Open Enrollment and can now login to make their plan selections.

Employee Open Enrollment instructions enclosed.

End your Open Enrollment

Once all employees have made their plan selections navigate to Exchange Admin, then Group Manager. Select your group. Click "End Enrollment".

Once enrollment has ended employees cannot make changes to their plan selections. The HealthPass Team will review your submission and contact you if additional information is needed.

We're here for you, call us 888-313-7277 | renewals@healthpass.com

EMPLOYEE OPEN ENROLLMENT SHOP & ENROLL IN YOUR BENEFITS ONLINE



Your employer is giving you a new and easier way to shop, enroll, and manage your healthcare benefits online.

- Compare plan options side by side
- No more paper forms
- Built-in decision support
- Manage your benefits from anywhere

IT'S EASY TO GET STARTED

Login to the HealthPass Online Portal (HOP)

1. Follow the link provided by your employer or enter www.healthpass.bswift.com in your browser, on your desktop or mobile device.
2. Enter your username and password.

First time users:

Username: First Initial of First Name, First 3 Letters of Last Name, Last 4 of SSN

Example: John Smith (SSN: 000-00-1234) = JSMI1234

Password: Date of Birth

Example: John Smith (DOB 1/23/1991) = 01231991

You will be required to change your password after your initial login.

Click "Start Your Enrollment"

Review your information and add family members, if applicable

Review and update your contact information. If you're adding family members for the first time, you'll need their SSN and date of birth.

Review your benefits options

Click "View Plan Options" for each benefit type. You can compare plans side by side, or click "Which Plan is Best for Me?" This gives you a personalized recommendation based on your healthcare spending.

Enroll in benefits

Select the family members you want covered (if any), then select the plan you want. Repeat and continue for each benefit type.

Save your enrollment

View, print, or email your confirmation statement and keep for your records.

We're here for you, call us 888-313-7277 | renewals@healthpass.com

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2024, 2/1/2024, 3/1/2024

Dental		
Dental Package 1 - All Carriers (In-Network plans only) Guardian Managed DentalGuard DHMO, Guardian Managed DentalGuard DHMO Plus, Solstice Dental EPO S700B, Solstice Dental EPO S800B and UnitedHealthcare Select Managed Care. There is no minimum participation.		
Guardian Managed DentalGuard DHMO		Four Tier
<ul style="list-style-type: none"> \$5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) No annual maximum on the plan and offers fixed patient charges for basic and major services No deductible Orthodontia benefit 	Employee	\$19.85
	Emp/Spouse	\$37.07
	Emp/Child(ren)	\$38.22
	Family	\$55.32
Guardian Managed DentalGuard DHMO Plus		Four Tier
<ul style="list-style-type: none"> \$5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) No annual maximum, the <i>Plus</i> plan offers a lower fixed patient charges for basic and major services than the standard DHMO plan No deductible Orthodontia benefit 	Employee	\$22.81
	Emp/Spouse	\$42.86
	Emp/Child(ren)	\$46.68
	Family	\$66.74
Solstice Dental EPO S700B		Four Tier
<ul style="list-style-type: none"> \$0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) Open access and no specialist referrals No deductible, no calendar year maximum Cosmetic and orthodontia treatment covered Implant benefit via implant network provider only 	Employee	\$19.37
	Emp/Spouse	\$35.99
	Emp/Child(ren)	\$40.32
	Family	\$55.50
Solstice Dental EPO S800B		Four Tier
<ul style="list-style-type: none"> \$0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) Open access and no specialist referrals No deductible, no calendar year maximum Cosmetic and orthodontia treatment covered Implant benefit via implant network provider only 	Employee	\$15.56
	Emp/Spouse	\$28.36
	Emp/Child(ren)	\$31.65
	Family	\$43.36
UnitedHealthcare Select Managed Care		Four Tier
<ul style="list-style-type: none"> 1 cleaning per consecutive 6 months No deductible, no annual calendar maximum No waiting period Reasonable copayment charges apply for basic and major services Implant benefit 	Employee	\$19.66
	Emp/Spouse	\$32.61
	Emp/Child(ren)	\$39.27
	Family	\$49.52
Dental Package 2 - In order for an employee to enroll in a Guardian PPO plan, there needs to be at least one additional enrollee in any Guardian dental plan.		
Guardian Managed DentalGuard DHMO		Four Tier
<ul style="list-style-type: none"> \$5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) No annual maximum on the plan and offers fixed patient charges for basic and major services No deductible Orthodontia benefit 	Employee	\$19.85
	Emp/Spouse	\$37.07
	Emp/Child(ren)	\$38.22
	Family	\$55.32
Guardian Managed DentalGuard DHMO Plus		Four Tier
<ul style="list-style-type: none"> \$5 copay for each primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) No annual maximum, the <i>Plus</i> plan offers a lower fixed patient charges for basic and major services than the standard DHMO plan No deductible Orthodontia benefit 	Employee	\$22.81
	Emp/Spouse	\$42.86
	Emp/Child(ren)	\$46.68
	Family	\$66.74
Guardian DentalGuard Preferred PPO MAC		Four Tier
<ul style="list-style-type: none"> No referrals needed to see a specialist Out-of-area emergency coverage \$50 deductible for In-Network services/\$75 deductible for Out-of-Network services Annual maximum of \$1,000 In-Network-rollover Implant benefit 	Employee	\$43.66
	Emp/Spouse	\$91.68
	Emp/Child(ren)	\$85.33
	Family	\$133.57
Guardian DentalGuard Preferred PPO 70 UCR		Four Tier
<ul style="list-style-type: none"> No referrals needed to see a specialist Out-of-area emergency coverage \$50 deductible for In-Network services/\$50 deductible for Out-of-Network services Annual maximum of \$1,000 In-Network, \$500 rollover Implant benefit 	Employee	\$52.45
	Emp/Spouse	\$110.44
	Emp/Child(ren)	\$102.46
	Family	\$160.90
Guardian DentalGuard Preferred PPO 90 UCR		Four Tier
<ul style="list-style-type: none"> No referrals needed to see a specialist Out-of-area emergency coverage \$50 deductible for In-Network/\$50 deductible for Out-of-Network, n/a preventive services Annual maximum of \$1,500 In-Network, n/a preventive services Implant benefit Child orthodontia benefit,\$1,500 max 	Employee	\$69.07
	Emp/Spouse	\$145.90
	Emp/Child(ren)	\$147.23
	Family	\$226.88

This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.
The following billing and administrative fees apply to the following products:
• Dental In-Network plans: EE \$3.50, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.00
• Dental PPO plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$18.25, Family \$26.50
• Vision plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
• Guardian Employer Paid Life/AD&D plans: \$3.00 Per Employee Per Month (PEPM)
• Guardian Voluntary Life plans: EE \$2.00, EE/Spouse \$3.00, EE+Child(ren) \$3.00, Family \$4.50
• Guardian EverGuard & EverGuard Plus plans: \$7.50 Per Employee Per Month (PEPM)
• Guardian AccidentGuard Adv plan: EE \$3.50, EE/Spouse \$4.50, EE+Child(ren) \$4.50, Family \$6.50
• ID Theft plans: EE \$3.00, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.50
• Pet Benefit Solutions plan: Single Pet \$2.00, Family Pet (2+) \$4.00

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2024, 2/1/2024, 3/1/2024

Dental continued...		
Dental Package 3 - Solstice Dental EPO S700B, Solstice Dental EPO S800B, Solstice Dental PPO and Solstice Dental Value PPO MAC. There is no minimum participation.		
Solstice Dental EPO S700B		Four Tier
<ul style="list-style-type: none"> ● \$0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) ● Open access and no specialist referrals ● No deductible, no calendar year maximum ● Cosmetic and orthodontia treatment covered ● Implant benefit via implant network provider only 	Employee	\$19.37
	Emp/Spouse	\$35.99
	Emp/Child(ren)	\$40.32
	Family	\$55.50
Solstice Dental EPO S800B		Four Tier
<ul style="list-style-type: none"> ● \$0 copay for primary care office visit (includes a cleaning, 1 set of x-rays, checkup and 2nd visit includes cleaning only) ● Open access and no specialist referrals ● No deductible, no calendar year maximum ● Cosmetic and orthodontia treatment covered ● Implant benefit via implant network provider only 	Employee	\$15.56
	Emp/Spouse	\$28.36
	Emp/Child(ren)	\$31.65
	Family	\$43.36
Solstice Dental PPO		Four Tier
<ul style="list-style-type: none"> ● Includes 4 cleanings in any 12 consecutive months ● No referrals needed to see a specialist ● \$50 deductible for In-Network services/\$50 deductible for Out-of-Network services ● Annual maximum of \$2,000 ● Implant benefit 	Employee	\$58.90
	Emp/Spouse	\$105.14
	Emp/Child(ren)	\$125.82
	Family	\$163.04
Solstice Dental Value PPO MAC		Four Tier
<ul style="list-style-type: none"> ● Includes 2 cleanings in any 12 consecutive months ● No referrals needed to see a specialist ● Out-of-Network reimbursement is MAC (Maximum Allowable Charge) ● \$50 deductible for In-Network services/\$50 deductible for Out-of-Network services ● Annual maximum of \$1,000 	Employee	\$34.25
	Emp/Spouse	\$68.24
	Emp/Child(ren)	\$75.06
	Family	\$106.03
Dental Package 4 - UnitedHealthcare Select Managed Care, UnitedHealthcare Low PPO MAC and UnitedHealthcare High PPO MAC. There is a two enrolled minimum participation.		
UnitedHealthcare Select Managed Care		Four Tier
<ul style="list-style-type: none"> ● 1 cleaning per consecutive 6 months ● No deductible, no annual calendar maximum ● No waiting period ● Reasonable copayment charges apply for basic and major services ● Implant benefit 	Employee	\$19.66
	Emp/Spouse	\$32.61
	Emp/Child(ren)	\$39.27
	Family	\$49.52
UnitedHealthcare Low PPO MAC		Four Tier
<ul style="list-style-type: none"> ● No referrals to see a specialist ● \$50 deductible /\$75 deductible family (calendar year) ● \$1,000 both In and Out-of-Network annual maximum ● Out-of-Network reimbursement is MAC (Maximum Allowable Charge) which is based on participating provider contracted fees ● Implant and orthodontic benefits ● Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum 	Employee	\$45.35
	Emp/Spouse	\$90.46
	Emp/Child(ren)	\$92.88
	Family	\$142.37
UnitedHealthcare High PPO MAC		Four Tier
<ul style="list-style-type: none"> ● No referrals to see a specialist ● Preventive and diagnostic care like exams, cleanings and x-rays won't apply to the annual maximum ● \$50 deductible /\$100 deductible family (calendar year) ● \$2,000 both In and Out-of-Network annual maximum ● Out-of-Network reimbursement is MAC (Maximum Allowable Charge) which is based on participating provider contracted fees ● Implant and orthodontic benefits ● Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum 	Employee	\$53.23
	Emp/Spouse	\$106.21
	Emp/Child(ren)	\$106.59
	Family	\$164.73
Dental Package 5 - UnitedHealthcare INO 100/50/50 and UnitedHealthcare High PPO MAC. There is a two enrolled minimum participation.		
UnitedHealthcare INO 100/50/50		Four Tier
<ul style="list-style-type: none"> ● 2 cleanings per consecutive 12 months ● No referrals to see a specialist ● No waiting period ● \$50 deductible /\$150 deductible family (calendar year) ● \$1,000 annual maximum ● Includes Out-of-Network emergency treatment, if necessary ● Implant and orthodontic benefits ● Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum 	Employee	\$28.49
	Emp/Spouse	\$54.23
	Emp/Child(ren)	\$56.90
	Family	\$86.32
UnitedHealthcare High PPO MAC		Four Tier
<ul style="list-style-type: none"> ● No referrals to see a specialist ● Preventive and diagnostic care like exams, cleanings and x-rays won't apply to the annual maximum ● \$50 deductible /\$100 deductible family (calendar year) ● \$2,000 both In and Out-of-Network annual maximum ● Out-of-Network reimbursement is MAC (Maximum Allowable Charge) which is based on participating provider contracted fees ● Implant and orthodontic benefits ● Consumer MaxMultiplier® rewards for dental care by adding dollars to next year's maximum 	Employee	\$53.23
	Emp/Spouse	\$106.21
	Emp/Child(ren)	\$106.59
	Family	\$164.73

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.

This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.

The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE \$3.50, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.00
- Dental PPO plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$18.25, Family \$26.50
- Vision plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
- Guardian Employer Paid Life/AD&D plans: \$3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE \$2.00, EE/Spouse \$3.00, EE+Child(ren) \$3.00, Family \$4.50
- Guardian EverGuard & EverGuardPlus plans: \$7.50 Per Employee Per Month (PEPM)
- Guardian Accident/Guard Adv plan: EE \$3.50, EE/Spouse \$4.50, EE+Child(ren) \$4.50, Family \$6.50
- ID Theft plans: EE \$3.00, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.50
- Pet Benefit Solutions plan: Single Pet \$2.00, Family Pet (2+) \$4.00

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2024, 2/1/2024, 3/1/2024

Vision		
Vision Package 1 – Guardian VisionGuard, Solstice Vision 5 PPO and UnitedHealthcare Vision PPO. There is a 20% participation with Guardian VisionGuard, excluding vision waivers.		
Guardian VisionGuard		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$25 copay for lenses & contact lenses every 24 months ● \$25 copay for frames every 24 months ● Davis Vision In-Network; Out-of-Network access as well 	Employee	\$6.12
	Emp/Spouse	\$10.00
	Emp/Child(ren)	\$10.16
	Family	\$15.52
Solstice Vision 5 PPO		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$10 copay for lenses & contact lenses every 12 months ● \$10 copay for frames every 12 months ● Spectera Vision Network In-Network; Out-of-Network access as well 	Employee	\$6.53
	Emp/Spouse	\$11.80
	Emp/Child(ren)	\$13.45
	Family	\$18.77
UnitedHealthcare Vision PPO		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$25 copay for lenses & contact lenses every 24 months ● \$25 copay for frames every 24 months ● Spectera Vision Network In-Network; Out-of-Network access as well 	Employee	\$6.69
	Emp/Spouse	\$12.09
	Emp/Child(ren)	\$13.79
	Family	\$19.23
Vision Package 2 – Solstice Vision 5 PPO and UnitedHealthcare Vision PPO. There is no minimum participation.		
Solstice Vision 5 PPO		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$10 copay for lenses & contact lenses every 12 months ● \$10 copay for frames every 12 months ● Spectera Vision Network In-Network; Out-of-Network access as well 	Employee	\$6.53
	Emp/Spouse	\$11.80
	Emp/Child(ren)	\$13.45
	Family	\$18.77
UnitedHealthcare Vision PPO		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$25 copay for lenses & contact lenses every 24 months ● \$25 copay for frames every 24 months ● Spectera Vision Network In-Network; Out-of-Network access as well 	Employee	\$6.69
	Emp/Spouse	\$12.09
	Emp/Child(ren)	\$13.79
	Family	\$19.23
Vision Package 3 – Guardian VisionGuard 20% participation, excluding vision waivers		
Guardian VisionGuard		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$25 copay for lenses & contact lenses every 24 months ● \$25 copay for frames every 24 months ● Davis Vision In-Network; Out-of-Network access as well 	Employee	\$6.12
	Emp/Spouse	\$10.00
	Emp/Child(ren)	\$10.16
	Family	\$15.52
Vision Package 4 – Solstice Vision 5 PPO no minimum participation		
Solstice Vision 5 PPO		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$10 copay for lenses & contact lenses every 12 months ● \$10 copay for frames every 12 months ● Spectera Vision Network In-Network; Out-of-Network access as well 	Employee	\$6.53
	Emp/Spouse	\$11.80
	Emp/Child(ren)	\$13.45
	Family	\$18.77
Vision Package 5 - UnitedHealthcare Vision PPO no minimum participation		
UnitedHealthcare Vision PPO		Four Tier
<ul style="list-style-type: none"> ● \$10 copay for an exam every 12 months ● \$25 copay for lenses & contact lenses every 24 months ● \$25 copay for frames every 24 months ● Spectera Vision Network In-Network; Out-of-Network access as well 	Employee	\$6.69
	Emp/Spouse	\$12.09
	Emp/Child(ren)	\$13.79
	Family	\$19.23

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.

This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.

The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE \$3.50, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.00
- Dental PPO plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$18.25, Family \$26.50
- Vision plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
- Guardian Employer Paid Life/AD&D plans: \$3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE \$2.00, EE/Spouse \$3.00, EE+Child(ren) \$3.00, Family \$4.50
- Guardian EverGuard & EverGuardPlus plans: \$7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE \$3.50, EE/Spouse \$4.50, EE+Child(ren) \$4.50, Family \$6.50
- ID Theft plans: EE \$3.00, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.50
- Pet Benefit Solutions plan: Single Pet \$2.00, Family Pet (2+) \$4.00

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2024, 2/1/2024, 3/1/2024

FSA & Commuter Benefits											
OCA - No minimum participation											
<ul style="list-style-type: none"> ● Flexible Spending Account (FSA) - Employees set aside money to pay for qualified medical, dental & vision expenses on a pre-tax basis ● Dependent Care Account (DCA) - Employees set aside money to pay for qualified dependent care expenses on a pre-tax basis ● Parking & Transit - Employees set aside money to pay for qualified parking & transit expenses on a pre-tax basis 							Per Enrolled Per Month (PEPM)	\$8.00			
Life/AD&D											
Guardian Employer Paid Life/AD&D 50K - Employee non-contributory 100% participation											
<ul style="list-style-type: none"> ● \$50,000 of Term Life Insurance Coverage ● Enhanced AD&D - 100% of life benefit ● Guaranteed Issue - open enrollment ● Accelerated Life Benefit - terminal condition 							Per Enrolled Per Month (PEPM)	\$14.50			
Guardian Employer Paid Life/AD&D 100K - Employee non-contributory 100% participation											
<ul style="list-style-type: none"> ● \$100,000 of Term Life Insurance Coverage ● Enhanced AD&D - 100% of life benefit ● Guaranteed Issue - open enrollment ● Accelerated Life Benefit - terminal condition 							Per Enrolled Per Month (PEPM)	\$26.00			
Life											
Guardian Voluntary Life 25K - 15% participation											
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	
Employee	\$4.13	\$4.33	\$5.10	\$6.33	\$8.90	\$13.35	\$19.53	\$26.38	\$44.60	\$85.40	
EE/Spouse	\$6.40	\$6.72	\$7.96	\$9.92	\$14.04	\$21.16	\$31.04	\$42.00	\$71.16	\$136.44	
EE/Child(ren)	\$6.20	\$6.40	\$7.17	\$8.40	\$10.97	\$15.42	\$21.60	\$28.45	\$46.67	\$87.47	
Family	\$8.97	\$9.29	\$10.53	\$12.49	\$16.61	\$23.73	\$33.61	\$44.57	\$73.73	\$139.01	
Guardian Voluntary Life 50K - 15% participation											
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	
Employee	\$6.25	\$6.65	\$8.20	\$10.65	\$15.80	\$24.70	\$37.05	\$50.75	\$87.20	\$168.80	
EE/Spouse	\$8.53	\$9.05	\$11.06	\$14.25	\$20.94	\$32.51	\$48.57	\$66.38	\$113.76	\$219.84	
EE/Child(ren)	\$8.32	\$8.72	\$10.27	\$12.72	\$17.87	\$26.77	\$39.12	\$52.82	\$89.27	\$170.87	
Family	\$11.10	\$11.62	\$13.63	\$16.82	\$23.51	\$35.08	\$51.14	\$68.95	\$116.33	\$222.41	
Disability/Life/AD&D											
Guardian EverGuard - No minimum participation							Employee Ages		Three Tier		
<ul style="list-style-type: none"> ● \$25,000 of Term Life Insurance ● \$75,000 of Accidental Death & Dismemberment Insurance ● \$1,000 per month of Disability Income ● Guaranteed Issue - open enrollment 							18-39		\$17.50		
							40-54		\$30.00		
							55+		\$52.50		
Guardian EverGuard Plus - No minimum participation							Employee Ages		Three Tier		
<ul style="list-style-type: none"> ● \$50,000 of Term Life Insurance ● \$100,000 of Accidental Death & Dismemberment Insurance ● \$1,500 per month of Disability Income ● Guaranteed Issue - open enrollment 							18-39		\$25.50		
							40-54		\$43.50		
							55+		\$79.50		
Accident											
Guardian AccidentGuard Adv - No minimum participation							Employee		Four Tier		
<ul style="list-style-type: none"> ● X-rays, emergency room and urgent care facility treatment ● Hospital admission and confinement as well as ICU ● Occupational or physical therapy ● Transportation such as ambulance and air ambulance ● Household expenses towards rent, mortgage and/or food ● Injury-related modifications to your home and/or auto 							Employee		\$15.83		
							Emp/Spouse		\$24.63		
							Emp/Child(ren)		\$24.81		
							Family		\$34.61		

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.

This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.

The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE \$3.50, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.00
- Dental PPO plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$18.25, Family \$28.50
- Vision plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
- Guardian Employer Paid Life/AD&D plans: \$3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE \$2.00, EE/Spouse \$3.00, EE+Child(ren) \$3.00, Family \$4.50
- Guardian EverGuard & EverGuard Plus plans: \$7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE \$3.50, EE/Spouse \$4.50, EE+Child(ren) \$4.50, Family \$6.50
- ID Theft plans: EE \$3.00, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.50
- Pet Benefit Solutions plan: Single Pet \$2.00, Family Pet (2+) \$4.00

Ancillary & Additional Products Monthly Rate Sheet

Monthly Rates for Effective Date - 1/1/2024, 2/1/2024, 3/1/2024

All plans listed below have no minimum participation requirements.		
Health, Wellness & Cosmetic		
Beyond Med (discount plan)		
<ul style="list-style-type: none"> Membership program offering up to 20% reduced costs on elective and cosmetic services Services include fertility, dermatology, med spa, plastic surgery, acupuncture, bariatrics and more Exclusive network of board-certified doctors and licensed providers No benefit usage limitations for in-network providers, no claims and no waiting periods 	Employee	\$9.99
	Family	\$19.99
ID Theft		
Allstate Identity Protection Pro		
<ul style="list-style-type: none"> Identity and credit monitoring Financial transaction monitoring Social Media reputation monitoring 24/7 Privacy Advocate remediation \$1 million identity theft insurance policy 	Employee	\$10.95
	Emp/Spouse	n/a
	Emp/Child(ren)	n/a
	Family	\$19.45
Allstate Identity Protection Pro Plus		
<ul style="list-style-type: none"> Includes all the benefits of the Allstate Identity Protection Pro plan with added features Tri-bureau credit alerts and unlimited credit reports from TransUnion In-app Credit Lock IP address Monitoring 401(k) and HSA stolen fund reimbursement Tax fraud refund advances 	Employee	\$12.95
	Emp/Spouse	n/a
	Emp/Child(ren)	n/a
	Family	\$23.45
LifeLock Benefit Elite		
<ul style="list-style-type: none"> LifeLock Identity Alert System Lost Wallet Protection Address Change Verification Black Market Website Surveillance Checking and Savings Account Activity Alerts Stolen Fund Reimbursement: Up to \$1 Million 	Employee	\$10.74
	Emp/Spouse	\$19.73
	Emp/Child(ren)	\$17.80
	Family	\$26.80
LifeLock Ultimate Plus™		
<ul style="list-style-type: none"> Ultimate Plus™ plan includes all of the Benefit Elite plan with added features Checking & Savings Account Application Alerts Bank Account Takeover Alerts Online Annual tri-bureau credit reports & scores Monthly Credit Score Tracking Sex Offender Registry Reports 	Employee	\$26.24
	Emp/Spouse	\$50.73
	Emp/Child(ren)	\$37.18
	Family	\$61.67
Pet Benefit Solutions		
Total Pet Plan (discount plan bundle)		
<ul style="list-style-type: none"> Pet Assure (any type of pet) - 25% discount from participating vets in US and PR, applies to all in-house medical services PetPlus (dogs & cats only) - 40% discount on everyday pet products, Rx and preventatives AskVet (dogs & cats only) - 24/7 Pet Telehealth ThePetTag (dogs & cats only) - 24/7 Lost Pet Recovery Service 	Single Pet	\$13.75
	Family Pet (2+)	\$22.50

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.

This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.

The following billing and administrative fees apply to the following products:

- Dental In-Network plans: EE \$3.50, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.00
- Dental PPO plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$18.25, Family \$26.50
- Vision plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
- Guardian Employer Paid Life/AD&D plans: \$3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE \$2.00, EE/Spouse \$3.00, EE+Child(ren) \$3.00, Family \$4.50
- Guardian EverGuard & EverGuardPlus plans: \$7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE \$3.50, EE/Spouse \$4.50, EE+Child(ren) \$4.50, Family \$6.50
- ID Theft plans: EE \$3.00, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.50
- Pet Benefit Solutions plan: Single Pet \$2.00, Family Pet (2+) \$4.00



Renewal Application

*Required information

To make changes to your group policy submit this form to your broker or login to your HealthPass Online Portal (HOP) via www.healthpass.com click "Benefits Exchange" then click "login".

Full Name of Company _____ HealthPass Group # _____ COBRA - Federal or State:

Federal (Greater than 20 Employees)
 State (Less than 20 Employees)

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

SIC Code* _____ SIC lookup here <https://siccocode.com/sic-code-lookup-directory>

A. YOUR COMPANY

Indicate changes to your group policy in the fields below. Your policy will renew as is in the fields where you do not indicate a change.

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 Contact Phone/Ext. _____ Billing Contact Email _____

Billing Street Address (if different) _____ Billing Suite _____ City/State/Zip _____

B. ELIGIBILITY AND ENROLLMENT

Number of Eligible Employees _____
 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)
 Number of Enrollments with HealthPass _____
 Number of Eligible Employees who have Other Health Coverage _____
 Do you have any commonly owned businesses (Single Employer with common ownership - IRS section 414, subsection (b), (c), (m), or (o))*? Yes No

If offering Anthem PPO/EPO and Blue Access Plans my group will have at least 10 employees enrolled in a HealthPass medical plan and I will contribute a minimum of \$750/per month per employee.* I Agree

Are you interested in offering FSA & Commuter Benefits to your employees? (If no, skip to COBRA question.) Yes No
 Select Your Payroll Cycle (FSA & Commuter Benefits) Weekly (52 Contributions) Bi-Weekly (26 Contributions)
 Semi-Monthly (24 Contributions) Monthly (12 Contributions)
 1st FSA Payroll Processing Date (MM/DD/YYYY) ____/____/____

COBRA Administration Services? (included service): I would like to participate in COBRA Administration
 I would like to opt out of COBRA Administration

- NYS 45 or applicable tax documents for the most recent quarter notating the number of hours worked per week for each employee if changing any of the following:
- Number of hours worked per week to be eligible for coverage
 - Enrolling in COBRA Administration
 - Adding a Dental Package and/or a Vision Package with plan offerings that require participation

C. MEDICAL AND ANCILLARY PLAN OFFERINGS

Medical Plans

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.

Core Plans: Anthem (Connection only), EmblemHealth (all) and Oxford (Metro only)

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.

Core Plus Plans (Additional Participation Requirements):

To include Anthem PPO/EPO and Blue Access Plans along with the Core Plans:

PPO/EPO and Blue Access Requirements: available to groups with 10 or more enrolling in any medical plan offered through HealthPass with a \$750 minimum monthly employer contribution per employee.

By offering these plans, the employer attests they are meeting the required monthly contribution per employee stated above.

To include Oxford Liberty Plans along with the Core Plans:

Liberty Participation Requirement: 60% of the total eligible employees, after valid waivers, must enroll in a combination of Liberty and/or Metro plans.

Anthem Connection Plans			
<input type="checkbox"/> Connection Platinum EPO 20/40	<input type="checkbox"/> Connection Gold EPO 25/50 <input type="checkbox"/> Connection Gold 50/55	<input type="checkbox"/> Connection Silver EPO 40/80	N/A
Anthem PPO/EPO and Blue Access Plans			
<p><u>If the group does not meet the PPO/EPO and Blue Access Requirements at open enrollment:</u> employees who selected PPO/EPO and Blue Access plans will need to select alternative plans or they will be mapped into Connection plans within the same selected metal tier. If the member's group is located in a county where Connection plans are not available, enrollment will be pended until an alternative plan is selected by the member.</p>			
<input type="checkbox"/> Platinum EPO 5/25	<input type="checkbox"/> Blue Access Gold EPO 50/55	<input type="checkbox"/> Silver EPO 40/80 <input type="checkbox"/> Silver EPO HSA 4000 <input type="checkbox"/> Blue Access Silver EPO HSA 3250 <input type="checkbox"/> Blue Access Silver EPO 3075	N/A
EmblemHealth Plans			
<input type="checkbox"/> Select Care Platinum Premier	<input type="checkbox"/> Select Care Gold Premier	<input type="checkbox"/> Select Care Silver Premier <input type="checkbox"/> Select Care Silver HSA	<input type="checkbox"/> Select Care Bronze HSA <input type="checkbox"/> Select Care Bronze Premier
Oxford Metro Plans			
N/A	<input type="checkbox"/> Metro Gold EPO 25/40 <input type="checkbox"/> Metro Gold EPO 25/40 G	<input type="checkbox"/> Metro Silver EPO 50/100 ZD <input type="checkbox"/> Metro Silver EPO 30/80 G	<input type="checkbox"/> Metro Bronze HSA 7250 G
Oxford Liberty Plans			
<p><u>If the group does not meet the Liberty Participation Requirement at open enrollment:</u> the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Liberty enrollees will be mapped into Metro plans within the same selected metal tier.</p>			
<input type="checkbox"/> Liberty Platinum EPO	<input type="checkbox"/> Liberty Gold EPO 25/50 ZD <input type="checkbox"/> Liberty Gold EPO 30/60 G <input type="checkbox"/> Liberty Gold HSA 1600 M <input type="checkbox"/> Liberty Gold EPO 30/60	<input type="checkbox"/> Liberty Silver EPO 50/100 ZD <input type="checkbox"/> Liberty Silver EPO 40/80 <input type="checkbox"/> Liberty Silver EPO 30/60 G <input type="checkbox"/> Liberty Silver HSA 4000 M	<input type="checkbox"/> Liberty Bronze HSA 5750

G = Gated, M = Motion, ZD = Zero Deductible

Dental Plans

Indicate a change to your dental offering here. If you do not indicate a change, your offering will renew as is.

Dental Options	<input type="checkbox"/> Package 1 (In-Network plans only): Guardian Managed DentalGuard DHMO Guardian Managed DentalGuard DHMO Plus Solstice Dental EPO S700B Solstice Dental EPO S800B UnitedHealthcare Select Managed Care	<input type="checkbox"/> Package 2^: Guardian Managed DentalGuard DHMO Guardian Managed DentalGuard DHMO Plus Guardian DentalGuard Preferred PPO MAC Guardian DentalGuard Preferred PPO 70 UCR Guardian DentalGuard Preferred PPO 90 UCR	<input type="checkbox"/> Package 3: Solstice Dental EPO S700B Solstice Dental EPO S800B Solstice Dental PPO Solstice Dental Value PPO MAC
	<input type="checkbox"/> Package 4^: UnitedHealthcare Select Managed Care UnitedHealthcare Low PPO MAC UnitedHealthcare High PPO MAC	<input type="checkbox"/> Package 5^: UnitedHealthcare INO 100/50/50 UnitedHealthcare High PPO MAC	<input type="checkbox"/> Package 6: Not Interested

^Participation requirements apply:

- Dental Package 2 - In order for an employee to enroll in a Guardian PPO plan, there needs to be at least 1 additional enrollee in any Guardian dental plan.
- Dental Package 4 - In order for an employee to enroll in an UnitedHealthcare PPO plan, there needs to be at least 1 additional enrollee in any UnitedHealthcare dental plan.
- Dental Package 5 - In order for an employee to enroll in either the UnitedHealthcare INO or UnitedHealthcare PPO plan, there needs to be at least 1 additional enrollee in any UnitedHealthcare dental plan.

Vision Plans

Indicate a change to your vision offering here. If you do not indicate a change, your offering will renew as is.

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

^Participation requirements apply.

- Vision Package 1 & 3 - In order for an employee to enroll in the Guardian VisionGuard plan there is a 20% participation requirement excluding vision waivers.

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.

OCA FSA & Commuter Benefits: \$8.00 PEPM (per enrolled per month) is billed directly to the employer by OCA for each enrolled employee. Only (1) fee is charged per employee even if enrolled in multiple plans.

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 \$3,200 IRS Max
<input type="checkbox"/> Dependent Care Account (DCA) FSA Yearly Maximum Amount: \$5,000			
<input type="checkbox"/> Parking Plan Monthly Maximum Amount: \$315			
<input type="checkbox"/> Transit Plan Monthly Maximum Amount: \$315			
<input type="checkbox"/> Not Interested			

An OCA representative will reach out to you directly to complete the enrollment in these plans

Life/AD&D Plans

Indicate a change to your Life/AD&D plan offerings here. If you do not indicate a change, your offering will renew as is.

Guardian Plans	<input type="checkbox"/> Employer Paid Life/AD&D 50K	<input type="checkbox"/> Employer Paid Life/AD&D 100K	<input type="checkbox"/> Not Interested
-----------------------	--	---	---

Life Plans

Indicate a change to your Life plan offerings here. If you do not indicate a change, your offering will renew as is.

Guardian Plans	<input type="checkbox"/> Voluntary Life 25K	<input type="checkbox"/> Voluntary Life 50K	<input type="checkbox"/> Dual Option	<input type="checkbox"/> Not Interested
-----------------------	---	---	--------------------------------------	---

^AParticipation requirements apply.

- In order for an employee to enroll in a Guardian Life plan there is a 15% participation requirement.

Disability/AD&D/LTD Plans

Indicate a change to your Disability/Life/AD&D plans offerings here. If you do not indicate a change, your offering will renew as is.

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

Accident Plan

Indicate a change to your Accident plan offering here. If you do not indicate a change, your offering will renew as is.

Guardian Plan	<input type="checkbox"/> AccidentGuard Adv	<input type="checkbox"/> Not Interested
----------------------	--	---

Beyond Med Plan

Indicate a change to your Beyond Med offering here. If you do not indicate a change, your offering will renew as is.

Beyond Med Plan	<input type="checkbox"/> Beyond Med	<input type="checkbox"/> Not Interested
------------------------	-------------------------------------	---

This is a discount plan (not insurance).

ID Theft Plans

Indicate a change to your ID Theft plan offering here. If you do not indicate a change, your offering will renew as is.

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

Pet Plan

Indicate a change to your Pet Plan offering here. If you do not indicate a change, your offering will renew as is.

Pet Plan	<input type="checkbox"/> Total Pet Plan	<input type="checkbox"/> Not Interested
-----------------	---	---

This is a discount plan bundle from Pet Benefit Solutions and includes Pet Assure, Pet Plus, AskVet and The PetTag (not insurance).

For more valued HealthPass Products & Services visit
<https://healthpass.com/extra-products-and-services/> to find out more and enroll.

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 _____

D. BANK INFORMATION

How do you prefer to pay for your coverage? (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.

E. EMPLOYER CERTIFICATION

I agree and attest that:

- My business offers 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:

- **Core Plans: Anthem (Connection only), EmblemHealth (all) and Oxford (Metro only)**

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.

- **Core Plus Plans (Additional Participation Requirements):**

To include Anthem PPO/EPO and Blue Access Plans along with the Core Plans:

PPO/EPO and Blue Access Requirements: available to groups with 10 or more enrolling in any medical plan offered through HealthPass with a \$750 minimum monthly employer contribution per employee.

If the group does not meet the PPO/EPO and Blue Access Requirements at open enrollment: employees who selected PPO/EPO and Blue Access plans will need to select alternative plans or they will be mapped into Connection plans within the same selected metal tier. If the member's group is located in a county where Connection plans are not available, enrollment will be pended until an alternative plan is selected by the member.

By offering these plans, the employer attests they are meeting the required monthly contribution per employee stated above.

- To include Oxford Liberty Plans along with the Core Plans:

Liberty Participation Requirement: 60% of the total eligible employees, after valid waivers, must enroll in a combination of Liberty and/or Metro plans.

If the group does not meet the Liberty Participation Requirement at open enrollment: the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Liberty enrollees will be mapped into Metro plans within the same selected metal tier.

- The group meets all HealthPass carrier out-of-area coverage requirements

- **Anthem**

PPO/EPO, Blue Access and Connection Plans - Employees can live/work/reside anywhere in the US.

- **EmblemHealth**

Select Care - Employees must live/work/reside in NY.

- **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 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 additional card possessed.

Please refer to our Eligibility Guidelines for more detailed information.

F. 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.

- 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.healthpass.com) and submit it with this application.

G. PROGRAM BENEFITS

Health Advocacy: All members with medical coverage through HealthPass have access to additional support with navigating many healthcare related issues, including understanding claims and accessing providers.

HealthPass COBRA Administration Services: All groups have access to COBRA/NYSC Administration Services unless opted out by Employer in Section B. 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 B 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.

H. FEE DISCLOSURE

Program Fees: All medical rates include \$5.95 for HealthPass Program Benefits (non-carrier/agent services) and a 2.9% billing and administrative fee.

- Dental In-Network plans: EE \$3.50, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.00
- Dental PPO plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$18.25, Family \$26.50
- Vision plans: EE \$1.50, EE/Spouse \$2.25, EE+Child(ren) \$2.25, Family \$3.00
- Guardian Employer Paid Life/AD&D plans: \$3.00 Per Employee Per Month (PEPM)
- Guardian Voluntary Life plans: EE \$2.00, EE/Spouse \$3.00, EE+Child(ren) \$3.00, Family \$4.50
- Guardian EverGuard & EverGuard Plus plans: \$7.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE \$3.50, EE/Spouse \$4.50, EE+Child(ren) \$4.50, Family \$6.50
- ID Theft plans: EE \$3.00, EE/Spouse \$4.25, EE+Child(ren) \$4.25, Family \$5.50
- Pet Benefit Solutions plan: Single Pet \$2.00, Family Pet (2+) \$4.00

I. 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.

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.

Company Name _____ **Group Number** _____

Print Name _____ **Date** _____

Authorized Signature _____ **Title** _____

Happy to help.

For assistance contact the HealthPass Retention Department at 888-313-7277 or email renewals@healthpass.com.

Employee Name:

Group Name/Group #:

A. Enrollments/Additions - Complete A, E, F, T, U and select coverages G -S

Requested Effective Date (Other than birth or adoption, all coverage effective dates are the 1st of the month following the qualifying event):

____/____/____

Reason (Select one):

- | | | |
|--|--|---|
| <input type="checkbox"/> Open Enrollment/Renewal | <input type="checkbox"/> New Hire | <input type="checkbox"/> Involuntary Loss of Coverage |
| <input type="checkbox"/> Add Dependent | <input type="checkbox"/> Rehire | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Date of Birth ____/____/____ | <input type="checkbox"/> Status Change (part-time to full-time) ____/____/____ | |
| <input type="checkbox"/> Date of Marriage ____/____/____ | <input type="checkbox"/> Adoption (requires legal documentation) | |

The following documents are required and must be submitted within 30 days of an associated qualifying event:

HIPAA Certificate or Carrier Termination Letter if enrolling due to loss of coverage; Marriage Certificate if enrolling a spouse due to a qualifying event; Birth Certificate if adding a newborn to the policy outside 30 days of the qualifying event (DOB); Declaration of Cohabitation & Financial Interdependence Form if enrolling a domestic partner due to a qualifying event. Note: Additional documentation may be required.

B. Waive Coverage - Complete B, E, T, U

Requested Effective Date
(1st of the month only)

____/____/____

Waive coverages:

- Medical
 Dental
 Vision

Reason for Waiving:

- Valid Waiver:
 Spousal Coverage
 Medicare
 Medicaid
 Veteran's Administration
 Parental Waiver

Invalid Waiver:

- Employer Sponsored Coverage
 Individual Coverage
 Exchange Coverage

C. Change Requests - Complete C, T, U and list changes in E, F

Requested Effective Date:

____/____/____

Change Type:

- Name Change Address Change Other _____

D. Terminations - Complete D, E, F, T, U. Termination date must be the last day of the month.

Requested Effective Date:

____/____/____

Reason:

- No Longer Employed Cancel Coverage Other _____

<input type="checkbox"/> Medical <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> FSA & Commuter Benefits <input type="checkbox"/> Healthcare Flexible Spending Account (FSA) <input type="checkbox"/> Dependent Care Account (DCA) FSA <input type="checkbox"/> Parking Plan <input type="checkbox"/> Transit Plan
<input type="checkbox"/> Life/AD&D <input type="checkbox"/> Employer Paid Life/AD&D 50K <input type="checkbox"/> Employer Paid Life/AD&D 100K	<input type="checkbox"/> Life <input type="checkbox"/> Voluntary Life 25K <input type="checkbox"/> Voluntary Life 50K
<input type="checkbox"/> Disability/AD&D/LTD <input type="checkbox"/> EverGuard <input type="checkbox"/> EverGuard Plus	<input type="checkbox"/> Accident <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<input type="checkbox"/> Beyond Med <input type="checkbox"/> Employee <input type="checkbox"/> Family	<input type="checkbox"/> ID Theft <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<input type="checkbox"/> Pet Plan <input type="checkbox"/> Single Pet <input type="checkbox"/> Family Pet	

Indicate the coverage(s) and member(s) to terminate above. Select Child(ren) - If terminating coverage for one or more child(ren) on the policy (but not all) then list in Section F those who should have their coverage terminated.

NOTE - If no child(ren) are separately listed in Section F, ALL dependent children on the policy will be terminated.

E. Employee Information

Group Name				Hire Date* (MM/DD/YYYY)	
Prefix	First Name*	Middle Initial	Last Name*	Suffix	Social Security #*
Date of Birth* (MM/DD/YYYY) ____/____/____		Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Address*		Apt	City/State/Zip*		County
Home Phone/Cell Phone			Work Phone*		
Email*					

F. Dependent Demographics

Dependent 1

Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents) <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Relationship*:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child	<input type="checkbox"/> Domestic Partner Child	

Dependent 2






Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents) <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Relationship*:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child	<input type="checkbox"/> Domestic Partner Child	

Dependent 3

Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? (Requires Additional Documents) <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Relationship*:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child	<input type="checkbox"/> Domestic Partner Child	

Employee Name:

Group Name/Group #:

G. Medical (Select one):			
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
 <p>To enroll in Connection plans employees can live/work/reside anywhere in the US.</p>			
<input type="checkbox"/> Connection Platinum EPO 20/40	<input type="checkbox"/> Connection Gold EPO 25/50 <input type="checkbox"/> Connection Gold 50/55	<input type="checkbox"/> Connection Silver EPO 40/80	N/A
 <p>If the group does not meet the PPO/EPO and Blue Access Requirements at open enrollment: employees who selected PPO/EPO and Blue Access plans will need to select alternative plans or they will be mapped into Connection plans within the same selected metal tier. If the member's group is located in a county where Connection plans are not available, enrollment will be pended until an alternative plan is selected by the member.</p> <p>To enroll in PPO/EPO or Blue Access plans employees can live/work/reside anywhere in the US.</p>			
<input type="checkbox"/> Platinum EPO 5/25	<input type="checkbox"/> Blue Access Gold EPO 50/55	<input type="checkbox"/> Silver EPO 40/80 <input type="checkbox"/> Silver EPO HSA 4000 <input type="checkbox"/> Blue Access Silver EPO HSA 3250 <input type="checkbox"/> Blue Access Silver EPO 30/75	N/A
 <p>To enroll in Select Care employees must live/work/reside in NY.</p>			
<input type="checkbox"/> Select Care Platinum Premier	<input type="checkbox"/> Select Care Gold Premier	<input type="checkbox"/> Select Care Silver Premier <input type="checkbox"/> Select Care Silver HSA	<input type="checkbox"/> Select Care Bronze HSA <input type="checkbox"/> Select Care Bronze Premier
 <p>To enroll in Metro plans employees must live/work in NY and NJ.</p>			
N/A	<input type="checkbox"/> Metro Gold EPO 25/40 <input type="checkbox"/> Metro Gold EPO 25/40 G	<input type="checkbox"/> Metro Silver EPO 50/100 ZD <input type="checkbox"/> Metro Silver EPO 30/80 G	<input type="checkbox"/> Metro Bronze HSA 7250 G
 <p>If the group does not meet the Liberty Participation Requirement at open enrollment: the group must either increase their Oxford enrollment to meet the 60% participation OR those enrollees selecting Liberty must select another plan through HealthPass. If an alternative plan is not selected, the Liberty enrollees will be mapped into Metro plans within the same selected metal tier.</p> <p>To enroll in Liberty non-gated plans employees can live anywhere in the continental US.</p> <p>To enroll in Liberty gated (G) plans employees must live in NY, NJ and CT. These members have access to Core Network when they travel or have children attending college outside of the Oxford service area (NY/NJ/CT).</p>			
<input type="checkbox"/> Liberty Platinum EPO	<input type="checkbox"/> Liberty Gold EPO 25/50 ZD <input type="checkbox"/> Liberty Gold EPO 30/60 G <input type="checkbox"/> Liberty Gold HSA 1600 M <input type="checkbox"/> Liberty Gold EPO 30/60	<input type="checkbox"/> Liberty Silver EPO 50/100 ZD <input type="checkbox"/> Liberty Silver EPO 40/80 <input type="checkbox"/> Liberty Silver EPO 30/60 G <input type="checkbox"/> Liberty Silver HSA 4000 M	<input type="checkbox"/> Liberty Bronze HSA 5750

G = Gated, M = Motion, ZD = Zero Deductible

Employee Name:

Group Name/Group #:

H. PCP Selection

NOTE If enrolling in an EmblemHealth or Oxford G (gated) medical plan for the first time, you must select a primary care physician (PCP) by writing the Primary Physician ID # below. IMPORTANT: write the exact PCP # for proper assignment. If you do not have a PCP at the moment, write 4 zeros (0000) in the field. Do NOT write a symbol/letter/space/doctor name/character or less than 4 numeric digits as those will cause enrollment issues. If you do not write a true PCP # one will be assigned to you by the carrier. To change a PCP after initial enrollment, you must contact the carrier directly.

Employee# _____

Dependent 2# _____

Dependent 1# _____

Dependent 3# _____

I. Dental (Select one plan)

Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
Guardian	<input type="checkbox"/> Managed DentalGuard DHMO**	<input type="checkbox"/> Managed DentalGuard DHMO Plus**		
	<input type="checkbox"/> DentalGuard Preferred PPO MAC	<input type="checkbox"/> DentalGuard Preferred PPO 70 UCR	<input type="checkbox"/> DentalGuard Preferred PPO 90 UCR	
Solstice	<input type="checkbox"/> Dental EPO S700B	<input type="checkbox"/> Dental EPO S800B		
	<input type="checkbox"/> Dental PPO	<input type="checkbox"/> Dental Value PPO MAC		
UnitedHealthcare	<input type="checkbox"/> Select Managed Care	<input type="checkbox"/> INO 100/50/50		
	<input type="checkbox"/> Low PPO MAC	<input type="checkbox"/> High PPO MAC		

J. Dental Facility**

NOTE If enrolling in a Guardian DHMO dental plan for the first time, you must select a primary care dentist (PCD) by writing the Primary Dentist ID # below. IMPORTANT: write the exact PCD # for proper assignment. If you do not have a PCD at the moment, write 4 zeros (0000) in the field. Do NOT write a symbol/letter/space/doctor name/character or less than 4 numeric digits as those will cause enrollment issues. If you do not write a true PCD # one will be assigned to you by the carrier. To change a PCD after initial enrollment, you must contact the carrier directly.

Employee _____ Dependent #1 _____ Dependent #2 _____ Dependent #3 _____

K. Vision

Coverage for (Select one):	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(ren)	<input type="checkbox"/> Family
Coverage type (Select one):	<input type="checkbox"/> Guardian VisionGuard	<input type="checkbox"/> Solstice Vision 5 PPO	<input type="checkbox"/> UnitedHealthcare Vision PPO	

L. FSA & Commuter Benefits

Select any of the plans you wish to enroll in and your amount(s):
Please note: every year you will have to re-establish your plans and amounts.

- Healthcare Flexible Spending Account (FSA)** Yearly Amount: \$ _____
(Confirm with your employer which plan your group offers FSA \$1,000 Max, FSA \$2,000 Max, FSA IRS Max)
- Dependent Care Account (DCA) FSA** Yearly Amount: \$ _____ (IRS Max)
- Parking Plan** Monthly Amount: \$ _____ (IRS Max)
- Transit Plan** Monthly Amount: \$ _____ (IRS Max)

Please process any mid-year OCA enrollments, changes and terminations through the HealthPass Online Portal (HOP).

M. Life/AD&D

Coverage type (Select one):	<input type="checkbox"/> Employer Paid Life AD&D 50K	<input type="checkbox"/> Employer Paid Life/AD&D 100K
-----------------------------	--	---

Indicate the percent of life insurance proceeds for each beneficiary below (must total 100%):

Beneficiary Name 1*	Relation*	Percent*
Beneficiary Name 2*	Relation*	Percent*

Employee Name:

Group Name/Group #:

N. Life Plans

Coverage type (Select one): Voluntary Life 25K Voluntary Life 50K

Indicate the percent of life insurance proceeds for each beneficiary below (must total 100%):

Beneficiary Name 1* Relation* Percent*

Beneficiary Name 2* Relation* Percent*

O. Disability/Life/AD&D

Coverage type (Select one): EverGuard EverGuard Plus

Indicate the percent of life insurance proceeds for each beneficiary below (must total 100%):

Beneficiary Name 1* Relation* Percent*

Beneficiary Name 2* Relation* Percent*

P. Accident

Coverage type (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family

Guardian AccidentGuard Adv *To enroll in the Guardian Accident Plan: comprehensive hospital, surgical and medical insurance is required on the effective date of this application for all enrollees.*

Beneficiary Name 1* Relation* Percent*

Beneficiary Name 2* Relation* Percent*

Q. Beyond Med

Coverage type (Select one): Employee Family

R. ID Theft

Allstate Identity Protection Coverage for (Select one): Employee Only Family

Coverage type (Select one): Allstate Identity Protection Pro Allstate Identity Protection Pro Plus

LifeLock Coverage for (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family

Coverage type (Select one): Benefit Elite Ultimate Plus™

A phone number is required when enrolling in either plan.

S. Pet

Total Pet Plan Coverage type (Select one): Single Pet Plan Family Pet Plan (2+)

This is a discount plan bundle from Pet Benefit Solutions and includes Pet Assure, Pet Plus, AskVet and The PetTag (not insurance).

T. Employee Signature

I hereby apply for the health insurance company and benefit plans selected, understanding all benefits and coverage as specified in the enrollment materials and agreeing to abide by all the rules and regulations therein specified. I certify that I am actively at work a minimum of 20 hours per week and will notify HealthPass if my employment status changes. I elect to enroll myself and any family members indicated on this form with the benefit plans and primary care provider as indicated on this form. I certify that all dependents listed on this form are eligible for coverage under the terms of the plan documents. I agree to notify my employer within 30 days when such eligibility ceases. I understand the plans have no liability to provide coverage for ineligible dependents. On behalf of myself and all family members, I hereby authorize all physicians, nurses, hospitals and other providers who or which have at any time, either before or after we became covered by the health insurance company, provided any diagnosis, treatment or any other service to any of us, to furnish the insurance companies or their authorized representative all information and records relating thereto. A photocopy or digital image of this authorization shall be considered as valid as the original. I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the other applicable coverage ends. (See HealthPass' Eligibility Guidelines). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoptions, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If I am required to contribute premium toward my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due to me and remit the same to HealthPass. I understand that the subscriber is responsible for the total cost of care received and/or for drugs purchased which are not authorized by the plan. "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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation". I am aware the NYHPA/dba HealthPass privacy practices is posted for my review and can be found on www.healthpass.com. I have carefully read this section and certify that all information provided on this form is true and complete to the best of my knowledge.

Employee Signature: X _____ Date: X _____

U. Authorized Signature

I certify that the person(s) presented on this form are eligible employees or dependents and the employee works for the employer identified on this form. This form and all other enrollment documentation submitted by the employer, or its duly authorized officer, must be fully complete and transacted by the 20th of the month prior for effective coverage for the 1st of the following month. Any documentation received after the 20th of the month will result in delays in enrollment up to 10-12 business days.

Authorized Signature: X _____ Date: X _____

V. Extra Products & Services

For more valued HealthPass Products & Services visit <https://healthpass.com/extra-products-and-services/> to find out more and enroll.