HealthPass™ ANCILLARY EXCHANGE

Employer Notice of Election
(Group Application)
*Required information

A. YOUR COMPANY

Full Name of Company*

Doing Business As (DBA) Name

Federal Tax ID Number*

Date Company Founded (MM/DD/YYYY)*

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

SIC Code* _____ SIC lookup here https://siccode.com/sic-code-lookup-directory

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

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)
Number of Enrollments with HealthPass*_____
Pay Frequency* ❒Weekly ❒Bi-Weekly ❒Semi-Monthly ❒Monthly

C. YOUR BENEFITS WITH HEALTHPASS

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

❒ **NYS-45 or applicable Tax Documents for the most recent quarter attached* (Refer to our Eligibility Guidelines, page 2, for list of acceptable tax documents.)**
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. ANCILLARY PLAN OFFERINGS

Dental Packages

Choose either Package 1 - No Participation Requirements Apply or Package 2 - Participation Requirements Apply
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 Package 1 - No Participation Requirements Apply

❒Guardian Managed DentalGuard DHMO
❒Guardian Managed DentalGuard DHMO *Plus*
❒Solstice Dental EPO S700B
❒Solstice Dental EPO S800B
❒Solstice Dental PPO
❒Solstice Dental Value PPO MAC
❒UnitedHealthcare National Exclusive Network

❒Dental Package 2 - Participation Requirements Apply
Participation Requirements – 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. In order for an employee to enroll in either the UnitedHealthcare INO or a UnitedHealthcare PPO plan, there needs to be at least one additional enrollee in any UnitedHealthcare dental plan.

❒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
❒Solstice Dental EPO S700B
❒Solstice Dental EPO S800B
❒Solstice Dental PPO
❒Solstice Dental Value PPO MAC
❒UnitedHealthcare National Exclusive Network
❒UnitedHealthcare INO 100/50/50
❒UnitedHealthcare Low PPO MAC
❒UnitedHealthcare High PPO MAC

❒Not Interested

Vision Plans

Choose if you would like to offer vision plans to 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.

❒Guardian VisionGuard ❒Solstice Vision 5 PPO ❒UnitedHealthcare Vision PPO ❒Not Interested

Life/AD&D Plans

Choose if you would like to offer a Life/AD&D plan to your employees for the upcoming policy year. If you choose not to offer a Life/AD&D 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.
Employee non-contributory and 100% participation requirement.

❒Employer Paid Life/AD&D 50K ❒Employer Paid life/AD&D 100K ❒Not Interested

Life Plans

Choose if you would like to offer Life plans to your employees for the upcoming policy year. If you choose not to offer Life 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.
15% participation requirement

❒Voluntary Life 25K ❒Voluntary life 50K ❒Dual Option ❒Not Interested

Disability/Life/AD&D Plans

Choose if you would like to offer a Disability/Life/AD&D plans to your employees for the upcoming policy year. If you choose not to offer Disability/Life/AD&D 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.

❒EverGuard ❒EverGuard *Plus* ❒Dual Option ❒Not Interested

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 AccidentGuard Adv ❒Not Interested

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.

❒**Allstate Identity Protection**	❒**LifeLock**	❒**Not Interested**
❍Allstate Identity Protection	❍Benefit Elite	
❍Allstate Identity Protection Pro Plus	❍Ultimate Plus	

Pet Plan

Choose if you would like to offer a Pet Plan to your employees for the upcoming policy year. If you choose not to offer a Pet 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.

❒Total Pet Plan ❒Not Interested

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

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):**

Dental _____

Vision _____

❒ **Contribute by Coverage Tier (by percent or flat dollar):**

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.

- Mail your payment to: HealthPass, PO Box 22049, New York, NY 10087-1749
- Payments sent via UPS, FedEx or other courier, please use the following address:
  JP Morgan Chase - Lockbox Processing, HealthPass New York – 22049, 4 Chase Metrotech Center, 7th Floor East, Brooklyn, NY 11245

Recurring 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 premium. I understand the debit transaction will occur the 1st of the month or the 1st business day following. For new business a one-time pament for the total premium is processed at the time of activation. 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 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:

- To access the Ancillary Exchange an employee is required to pay an Exchange Access Fee. Additional participation requirements vary per package or plan.
- 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. In order for an employee to enroll in either the UnitedHealthcare INO or a UnitedHealthcare PPO plan, there needs to be at least one additional enrollee in any UnitedHealthcare dental plan.

❒ 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 additional card possessed.

Please refer to our Eligibility Guidelines for more detailed information.

H. FEE DISCLOSURE

The following billing and administrative fees apply on a per employee per month (PEPM) basis to the products below:

- Exchange Access Fee: $2.00
- 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.

J. 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 and B 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 G and the related fees as enumerated in Section H, and;
- ❒ Agrees to the terms set forth in Section I 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 more valued HealthPass Products & Services, such as Beyond Med, visit https://healthpass.com/extra-products-and-services/ to find out more and enroll.

For FSA, Dependent Care Account and Commuter Benefits through OCA visit: https://oca125.com/healthpass-fsa-application/.