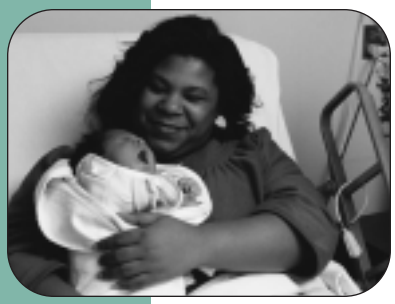
SMALL EMPLOYER GROUP

Group Application



Group Administration
441 Ninth Avenue
Second Floor
New York, NY 10001-1681

GHI HMO
25 Barbarosa Lane
Kingston, NY 12401-0118

www.ghi.com

PRINT IN INK

SECTION I GROUP INFORMATION

Company Name _____ Date _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone No. ( ) _____ Fax No. ( ) _____

Company Officer's Name _____ E-Mail Address _____

Title _____

Group Contact _____ Title _____ Telephone No. ( ) _____

E-Mail Address _____

Address ❒ Same as above _____

Additional Office Locations

SECTION II BILLING

Premium invoices should be sent to: _____ Telephone No. ( ) _____ E-Mail Address _____

Address _____

Contact Person *(if different than above)* _____ Telephone No. ( ) _____ E-Mail Address _____

SECTION III GROUP ADMINISTRATION

A. Number of Eligible Employees _____
(Employees working at least 20 hrs a week)

B. Exclusion Class _____

C. Number of Employees Applying _____

D. Number of COBRA Participants _____

Indicate number of enrollees by type:

_____ Individual _____ Employee/Spouse _____ Employee/Child(ren) _____ Family

Was your Group Policy Terminated for Non-Payment in the last 12 months? ❒ Yes ❒ No

Pre-Existing Condition Limitation: ❒ Yes ❒ No 11 Month exclusion applies to late entrants only. ❒ Yes ❒ No

Other group health or HMO coverage: Indicate below other group health coverage which is still in force or which terminated within the past year.

Please complete the information below for your existing policy.

Name and Address of Insurer	Type of Coverage	Effective Date of Policy	Termination Date of Policy

SECTION IV PRODUCT SELECTION

Plan Name _____ Desired Effective Date _____

❒ PPO ❒ EPO ❒ High Deductible Plan (HDP) ❒ DENTAL ❒ POS

❒ OTHER (Please specify) _____ ❒ PPO/HMO ❒ POS/HMO

Is this a replacement policy? ❒ Yes ❒ No Is this an option? ❒ Yes ❒ No

SECTION V ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTION

❒ Employee:_____ % or $_____

❒ Family: _____ % or $_____

❒ Other

NEW HIRE ELIGIBILITY POLICY

❒ Date of Hire

❒ First of the month following date of hire

Plus: ❒ 30 Days ❒ 60 Days ❒ 90 Days ❒ Other *(please specify)*

_____

Waived for Rehire? ❒ Yes ❒ No

If rehired within _____ months

Desired Effective Date: _____

TERMINATION POLICY

❒ Date Terminated

_____

❒ End of Month

_____

❒ Other

_____

If more than one class will be covered, please complete Section (V-A) below

SECTION V-A ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTION

❒ Employee:_____ % or $_____

❒ Family: _____ % or $_____

❒ Other

NEW HIRE ELIGIBILITY POLICY

❒ Date of Hire

❒ First of the month following date of hire

Plus: ❒ 30 Days ❒ 60 Days ❒ 90 Days ❒ Other *(please specify)*

_____

Waived for Rehire? ❒ Yes ❒ No

If rehired within _____ months

Desired Effective Date: _____

TERMINATION POLICY

❒ Date Terminated

_____

❒ End of Month

_____

❒ Other

_____

SECTION VI

The information provided in this application is true to the best of my knowledge. I hereby authorize any person, or other entity to release to GHI any information requested by GHI in connection with the processing of this application.

By signing this application, I certify under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business. I hereby authorize any person or other entity to release to GHI any information requested by GHI in connection with the processing of this application.

I understand that any person who knowingly and with the 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Name

Signature

Title

Date

Please check current employer status below to ensure proper reimbursement for your Medicare Eligible Active Employees *(you must check one of the boxes below)*:

❒ Employed fewer than twenty (20) full time or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).

❒ Employed twenty (20) or more full or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).

NOTE: All employers that are treated as a single employer under Internal Revenue Code Section 52 must be treated as a single employer for purpose of the Medicare secondary payer rules. According to Internal Revenue Code Section 52, all employees of all corporations that are members of the same controlled group of corporations must be treated as employed by a single employer. This means that if a parent company owns at least fifty percent (50%) of a subsidiary, then the number of employees of the parent and the subsidiary must be combined for purposes of determining the 20-employee threshold. Similary, brother-sister corporations may be combined in some cases if the parent corporation owns at least fifty percent (50%) of the brother-sister corporations.

SECTION VII

GHI Group No: Marketing Rep:

Company Name Date

Address

City State Zip County

Telephone No. ( ) Fax No. ( )

Group Contact E-Mail Address

Desired Effective Date Effective Date Changed Since Original Application? ❒ Yes ❒ No

Master Agency MA No. Override

General Agency ❒ To be Credentialed

GA No. Override:

Contact

Address

Telephone No. E-Mail

Fax

Split Commission _____%

Selling Agent ❒ To be Credentialed

SA No. Commission:

Name/Agency Name

Address

Telephone No. E-Mail

Fax

Split Commission _____%

Selling Agent ❒ To be Credentialed

SA No. Commission:

Name/Agency Name

Address

Telephone No. E-Mail

Fax

Split Commission _____%

Selling Agent ❒ To be Credentialed

SA No. Commission:

Name/Agency Name

Address

Telephone No. E-Mail

Fax

Split Commission _____%

Deposit Check Attached	❒ Yes	❒ NO
Proof of Employment	❒ Yes	❒ NO
Last Paid Premium Invoice from Current Carrier	❒ Yes	❒ NO
COBRA Letters of election	❒ Yes	❒ NO
Proof of Medicare eligibility, Part A and B	❒ Yes	❒ NO

Amount: $_____

GA Authorized Signature _____ Date _____

Group Administration
441 Ninth Avenue, Second Floor
New York, NY 10001

www.ghi.com

Form #7080

UNION 8 5M 11/01