univera HEALTHCARE an excellus company

New Group Application

Commercial Health and Dental Products

See Instructions for details regarding completion of this form.

Section 1: Group Information - Required for All Submissions

1.	Group/Business name or DBA name (if applicable):										
2.	Legal entity name, if different than group name:										
3.	Most group health plans are governed by ERISA with the exception of some religious organizations and government entities. If your group is NOT governed by ERISA, please check this box: ☐ ERISA Plan Year, if applicable: __ __ / __ __										
4.	EIN/TIN:					SIC Code:					
5.	Requested Effective Date: __ __ / 0 1 / 2 0 __ __										
6.	Company Officer's Name:					Title:					
	Telephone: ( )					Email:					
7.	Group's Health Plan Sponsor (Check one):	☐ Employer	☐ Union	☐ Trustees of Fund	☐ Association	☐ Other: _____					
8.	A. Organization Type (Check one):	☐ Sole Owner	☐ C Corporation	☐ S Corporation	☐ LLC/PLLC	☐ Partnership	☐ Local Government	☐ Trust			
		☐ State Government	☐ Public Entity	☐ Nonprofit	☐ Church Group	☐ Other: _____					
	B.	Is your organization a Professional Employer Organization (PEO)?* ☐ Yes ☐ No									
	C.	Does your group have any employees that are co-employed or leased?* ☐ Yes ☐ No Does your organization intend to cover any of these employees under this policy?* ☐ Yes ☐ No									
		**If any of the responses is "Yes", prior Underwriting review is required.*									

9. List Owners/Partners/Shareholders and Percentage of Ownership:

Name	% owned	Name	% owned	Name	% owned
1.		3.		5.	
2.		4.		6.	

10. Indicate company organization: ☐ Stand Alone ☐ Parent ☐ Subsidiary ☐ Local Plant/Office/Division ☐ Other: _____

11. Do you have any commonly owned businesses or affiliates that qualify as a single employer under subsection (b), (c), (m), or (o) of Internal Revenue Code Section 414? ☐ Yes ☐ No If yes, please complete below.

Legal Name	No. of Employees	EIN/TIN	State

12. Does your group have employees living outside the Univera Healthcare service area who are enrolling in coverage?: ☐ Yes ☐ No
If yes, requires prior review by Underwriting. Please list worksite/physical locations below:

	Physical Location/Worksite Name	Address (City, State, ZIP Code)	# Enrolling
A.			
B.			
C.			

13. Does your company employ any telecommuters or remote employees? ☐ Yes ☐ No *If yes, see instructions.*

14. Other Coverage:

A.	Does your group offer any other health plans in addition to the products offered through Univera Healthcare? ☐ Yes ☐ No
B.	If yes, what carrier issues these health policies?: _____ Are any issued through the New York State of Health? ☐ Yes ☐ No
C.	Number enrolled in other plan(s): _____

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Section 2: Addresses and Contacts – Required for All Submissions

1.	Group Contact:	Name:		Title:	
	Telephone:	Fax:		Email:	
2.	Business Physical Address:	Street:			
	City:	State:	ZIP:	County:	
	Telephone:	Fax:			
3.	Headquarters Address:	If same as physical address, check here: ☐ Otherwise, complete the information below:			
	Street:				
	City:	State:	ZIP:	County:	
	Telephone:	Fax:			
4.	Mailing Address:	Same as: ☐ Physical ☐ Headquarters ☐ Other - Please provide below:			
	Street:				
	City:	State:	ZIP:	County:	
5.	Billing Contact:	Name:		Title:	
	Telephone:	Email:			
	Address: Same as: ☐ Physical ☐ Headquarters ☐ Mailing ☐ Other - Please provide below:				
	Street:				
	City:	State:	ZIP:	County:	

Section 3: Group Size, Other Regulatory Information – Required for Medical Submissions

1.	**Group Size: To Determine Market Segment:**		
	Please include all entities that are combined under IRC 414 (b), (c), (m) or (o). A small group has 100 or fewer full-time Equivalent Employees (FTE's) in the prior calendar year. A large group has 101 or more FTE's in the prior calendar year. See instructions for details regarding the calculation.		All Locations
	Total full-time employees and full-time equivalents in the prior calendar year to determine group size:		
2.	**Group Size: For Medical Loss Ratio Reporting Purposes:**		
	Average number of owners and employees (all Full-Time and Part-Time) at all locations in the prior calendar year:		
3.	**Group Size: For Medicare Secondary Payer Purposes:**		
	A.	Did your group employ 20 or more employees who worked at least 20 weeks in the prior calendar year?	☐ Yes ☐ No
	B.	Did your group employ 20 or more employees who worked at least 20 weeks in the current year?	☐ Yes ☐ No
	C.	Did your group employ 100 or more employees on 50% or more of your business days in the prior calendar year?	☐ Yes ☐ No
	D.	Did your group employ 100 or more employees on 50% or more of your business days in the current year?	☐ Yes ☐ No
4.	**Vermont Regulatory Inquiry:**		
	A.	Does your group employ Vermont residents who work at employer locations in Vermont or telecommute from home?	☐ Yes ☐ No
	B.	If yes, how many work at employer locations in Vermont or telecommute from home?:	Number enrolling:

Section 4: Individuals not listed on the NYS-45-ATT or other state equivalent - Required for Small Group Medical and Dental Submissions

Please list persons eligible for coverage who are not on the NYS-45-ATT/other state equivalent. Eligible individuals include: partners or owners actively engaged in the business; COBRA/NYS continuants; new employees; and retirees if the group has a retiree policy in place.
The group attests the individual(s) listed below work at least 20 hours/week at the above-named employer or are otherwise eligible for coverage under group health insurance issued by Univera Healthcare. Include an indicator by each name, per the instructions.

Name	Indicator	DOH or DOR	Name	Indicator	DOH or DOR

Section 5: Employee and Retiree Eligibility – Required for Medical Submissions

A small group employee must work at least 20 hours/week and a large group employee must work at least 17.5 hours/week to be eligible for health insurance.

1. **Eligible Individuals:**

Total Individuals Eligible for Group Health Insurance Coverage (see instructions): ____

2. **Medical Eligibility Policy for New Employees and Rehires**

Please indicate the eligibility policy for both the newly hired and rehired employees by completing the table below.
Below are codes for the most commonly used classes:

A001	A002	A003	A004	A005	A006	A007	A008	A009
All Active Employees	Hourly	Salaried	Management	Non-Management	Union	Non-Union	Full-Time	Part-Time

Employee Class	Number of Hours	New (N), Rehire (R), or Both (B)	Probationary Period
			☐ *Date of hire/rehire* ☐ *First of month following date of hire/rehire* ☐ *First of month following 30 days of employment* ☐ *First of month following 60 days of employment* ☐ *90 days after date of hire* ☐ *Other*:* ________
			☐ *Date of hire/rehire* ☐ *First of month following date of hire/rehire* ☐ *First of month following 30 days of employment* ☐ *First of month following 60 days of employment* ☐ *90 days after date of hire* ☐ *Other*:* ________
			☐ *Date of hire/rehire* ☐ *First of month following date of hire/rehire* ☐ *First of month following 30 days of employment* ☐ *First of month following 60 days of employment* ☐ *90 days after date of hire* ☐ *Other*:* ________
			☐ *Date of hire/rehire* ☐ *First of month following date of hire/rehire* ☐ *First of month following 30 days of employment* ☐ *First of month following 60 days of employment* ☐ *90 days after date of hire* ☐ *Other*:* ________

* "Other" Probationary Period may not extend beyond 90 days.

Retiree Eligibility: Does your group provide health insurance to retirees? ☐ No ☐ Yes *If yes, please complete the following:*

Codes for common retiree classes:	R001	R002
	Retired Non-Medicare Eligible	Retired Medicare Eligible

Class Name:	Minimum Age to Retire (e.g. 55):	Years of Service to Qualify for Retiree Health Insurance (e.g. 10):

3. **Medical Products - Employer Contribution (Monthly Amount) (see instructions for an example):**

Product Name	Subgroup Number	Class Name	Type		Please list percentage or monthly dollar amount contributed by tier:			
			$	%	Employee	w/Spouse	w/Child(ren)	Family
			☐	☐				
			☐	☐				
			☐	☐				
			☐	☐				
			☐	☐				

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4.	HSA/HRA - Employer Contribution (Annual Amount):									
	Does your group contribute to the HSA or HRA? ☐ Yes ☐ No *If yes, please complete the information below.*									
	Check One	Product Name	Subgroup Number	Class Name	Type		*Please list percentage or annual dollar amount contributed by tier:*			
					$	%	Employee	w/Spouse	w/Child(ren)	Family
	☐ HSA ☐ HRA				☐	☐				
	☐ HSA ☐ HRA				☐	☐				

Section 6: Dental Information – Required for Dental Submissions

1.	Dental Participation Calculation:		
	Pooled experience groups have 50 or fewer eligible employees. Experience rated groups have 51 or more eligible employees. Contributory groups contribute 25% or more of the single rate. Non-contributory groups contribute less than 25% of the single rate. Contributory groups must meet or exceed a minimum participation percent of 50% of net eligible employees. Non-contributory groups must meet or exceed a minimum participation percent of 20% of net eligible employees. Either type of group must enroll a minimum of 2 contracts.		Employees Eligible for Univera Healthcare offering
	A.	Number of eligible active employees and owners:	
	B.	Number of retirees eligible for the employer group plan:	
	C.	Number of individuals enrolled in COBRA:	
	D.	Total individuals eligible for group dental insurance coverage (Line A + Line B + Line C):	
	E.	Number of eligible employees declining dental coverage due to a valid waiver:	
	F.	Net number of eligible employees for dental coverage (Line D - Line E):	
	G.	Total number enrolled in the dental plan:	
	H.	Participation percentage (Line G / Line F):	
	I.	Does your group offer any other dental plans in addition to the products offered through Univera Healthcare? ☐ Yes ☐ No If yes, what carrier issues these dental policies?: ____________ Number enrolled in other plan: ________	

2.	**Dental Eligibility Policy for New Employees and Rehires:** Same as Medical? ☐ Yes, Skip to Question 3 ☐ No, Please complete the following:			
	Please use the employee classifications, as shown in Section 5 to complete the section below. *Indicate the eligibility policy for newly hired or rehired employees by checking the appropriate option:*			
	Employee Class	Number of Hours	New (N), Rehire (R), or Both (B)	Probationary Period
				☐ *Date of hire/rehire* ☐ *First of month following date of hire/rehire* ☐ *First of month following 30 days of employment* ☐ *First of month following 60 days of employment* ☐ *90 days after date of hire* ☐ *Other:* ____________
				☐ *Date of hire/rehire* ☐ *First of month following date of hire/rehire* ☐ *First of month following 30 days of employment* ☐ *First of month following 60 days of employment* ☐ *90 days after date of hire* ☐ *Other:* ____________
				☐ *Date of hire/rehire* ☐ *First of month following date of hire/rehire* ☐ *First of month following 30 days of employment* ☐ *First of month following 60 days of employment* ☐ *90 days after date of hire* ☐ *Other:* ____________
	Retiree Eligibility:	Does your group provide dental insurance to retirees? ☐ No ☐ Yes *If yes, please complete the following table.* *Refer to Section 5 for common retiree classes.*		

Class Name:	Minimum Age to Retire (e.g. 55):	Years of Service to Qualify for Retiree Dental Insurance (e.g. 10):

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3.	Dental Employer Contribution (Monthly Amount):								
	Product Name	Subgroup Number	Class Name	Type		Please list percentage or monthly dollar amount contributed by tier:			
				$	%	Employee	w/Spouse	w/Child(ren)	Family
				☐	☐				
				☐	☐				

Section 7: Broker of Record Information – Required if Group Appoints a Broker

Our company has appointed _____ (name of agent),

_____ (name of agency) whose business address is:

_____ ,

street city state ZIP

as the sole insurance representative for coverage provided to this company by Univera Healthcare effective .

I understand that since our company has elected to purchase coverage from Univera Healthcare the above named agent may be entitled to base and/or bonus compensation for our business.

This designation will remain in effect until we notify Univera Healthcare in writing to the contrary.

Section 8: Employer Attestation – Required for All Submissions

I certify that, to the best of my knowledge and belief and under penalty of perjury, all of the information contained within this application is true and complete.

I understand that 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 a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Employer Authorized Representative Signature:	Title:	Date:

Print Name:	Phone Number:	Email:

Section 9: Checklist of Required Information for All Submissions:

Please review carefully and ensure that all required information is included at the time of submission to ensure prompt processing of your group's application.

Small Group:	Large Group:
☐ Business check for the first month's premium	☐ Signed rate sheets and benefit selections
☐ Signed rate sheets and benefit summaries	☐ Subscriber applications or Administrator Electronic and Web Enrollment Agreement
☐ NYS-45 or other state equivalents from the most recently filed report. Annotate the report per the instructions.	☐ Disabled Dependent Form (when applicable)
☐ For a new employee, a current payroll report and W-4's	
☐ Business Tax Filings –See instructions regarding when tax documentation is required and for documentation needed for a newly formed business	
☐ 1094-C if the group is part of an applicable large employer with 50 or more full-time equivalent employees (see instructions)	
☐ Subscriber applications ☐ Waivers of coverage for employees who decline enrollment (if applicable) ☐ Disabled Dependent Form (when applicable)	
☐ Administrator Electronic and Web Enrollment Agreement (if applicable)	

Note: We reference public sources of information during our review process. If public sources conflict with the information provided on this form, additional information may be required.

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