univera HEALTHCARE

Community Rated Subgroup Application

Complete this section if adding Subgroup to an existing Group.
If New Business with new subgroup, please skip to Section 1.

Primary Group Name: _____

Group Number: _____

Subgroup #: _____ **(Example: Subgroup # -0002, -0003, etc.)**

Section 1: General Information

1. Group/Business name: _____

2. Requested Effective Date: _ _ / _ _ / 20_ _

Section 2: Ownership and Address Information

1. Subgroup Contact Name: _____ Title: _____ Telephone: (___) ___ - _____

2. Tax Identification Number (EIN/TIN): _____ 3. SIC Code: _____

4. List of Main Groups Owners/Partners/Shareholders and Percentage of Ownership

1. Name: _____ % Owned _____ 4. Name: _____ % Owned _____
2. Name: _____ % Owned _____ 5. Name: _____ % Owned _____
3. Name: _____ % Owned _____ 6. Name: _____ % Owned _____

5. List of Subgroups Owners/Partners/Shareholders and Percentage of Ownership (Same as Main Group ☐ otherwise, please provide below)

1. Name: _____ % Owned _____ 4. Name: _____ % Owned _____
2. Name: _____ % Owned _____ 5. Name: _____ % Owned _____
3. Name: _____ % Owned _____ 6. Name: _____ % Owned _____

6. Business Physical Address: Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (___) ___ - _____ Fax: _____

7. Headquarters Address: (if same as physical address, check here ☐ Otherwise, please provide below)

Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (___) ___ - _____ Fax: _____

8. Mailing/Billing Address: (Same as ☐ Physical ☐ Headquarters Otherwise, complete the information below)

Street: _____ City: _____

State: _____ Zip: _____ County: _____ Telephone: (___) ___ - _____ Fax: _____

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Section 3: Group Size Regulatory Information

1. Total number of full-time employees and full-time equivalents at all locations, including subsidiaries and businesses under common control within the United States, in the prior calendar year: _____

2. Average number of employees and owners (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: _____

Section 4: Employer Attestation

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: _____ Date: _ _ / _ _ / _ _ _ _

Print Name: _____ Email Address: _____

Section 5: Checklist of Required Information

- ☐ Most recent NYS-45 or equivalent, or payroll/w-4 if enrolling member is not listed on NYS-45
- ☐ Business Tax filings and/or Purchase agreement
- ☐ Signed Rate Sheets and Benefit Summaries
- ☐ Subscriber applications or Administrative Electronic and Web Enrollment Agreement
- ☐ Member Roster or Group Census showing new enrollment and/or member movement (if applicable)
- ☐ 1094-C if the group is part of an applicable large employer with 50 or More full-time equivalent employees
- ☐ Eligibility Policy (if Applicable)

Univera Healthcare will submit reports with respect to the benefit plan, in the time and manner required under Section 20 of the Transparency Provisions of the CAA and/or related regulations and/or other authoritative guidance issued under the CAA, on behalf of the group relating to pharmacy benefits and drug costs.