Employer Notice of Election

*Required information

HealthPass New York
80 Pine Street, 29th FL
New York, NY 10005
Phone 888-313-7277
Fax 212-252-7448
Email forms@healthpassny.com

A. YOUR COMPANY

Full Name of Company*

Doing Business As (DBA) Name*

Federal Tax ID Number*

Date Company Founded On (MM/DD/YYYY)*

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

Employer Industry:* ❒Health ❒High Tech ❒Legal ❒Manufacturing ❒Retail ❒Service ❒Tourism ❒Other

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

Billing Contact Phone/Ext. | Billing Contact Email

Indicate designated user(s) with HR access to perform administrative functions within the HealthPass Online Portal (HOP)*
Grant HR Access #1 | Grant HR Access #2

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)
Are any enrollees Age 65+ (currently or within the next 90 days)?* ❒Yes ❒ No
Are any former employees currently covered under COBRA?* ❒Yes ❒No If yes, how many?*_____
Are any former employees currently covered under NY State Continuation (NYSC)?* ❒Yes ❒No If yes, how many?*_____
Number of Enrollments with HealthPass*_____
Number of Eligible Employees who have Other Health Coverage*_____
Number of Employees covered by Collective Bargaining Agreement* _____

C. YOUR BENEFITS WITH HEALTHPASS

Tier Structure for Medical:* ☒Four Tier (All Carriers)
Tier Structure for Dental:* ❒Four Tier ❒Not Interested
Tier Structure for Vision:* ❒Four Tier ❒Not Interested
COBRA/NYSC (Included Service):* ❒ I would like to participate in COBRA/NYSC service ❒ I would like to opt out of COBRA/NYSC service
COBRA (Federal) or NYSC (State):* ❒ Federal ❒State
Requested Effective Date* _____(Must be 1st of the month only)
❒ **NYS-45 or applicable tax form from the most recent quarter attached***
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. 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. 20% of the total eligible employees must enroll with a HealthPass medical plan. 75% of eligible employees must enroll in HealthPass medical or have another credible health insurance plan. At every policy renewal you must reestablish the medical plans to offer or all plans will be made available.

Select one: ❑I would like to offer all plans ❑I have selected the plans I would like to offer below

EmblemHealth Plans			
❒Prime Platinum POS ❒Prime Platinum Premier ❒Select Care Platinum Premier	❒Prime Gold POS ❒Prime Gold Premier ❒Select Care Gold Premier	❒Prime Silver Premier ❒Select Care Silver Premier ❒Select Care Silver Value ❒Millennium Silver Value G ❒Prime Silver HSA	❒Prime Bronze HSA ❒Select Care Bronze Premier ❒Select Care Bronze Value ❒Millennium Bronze Premier G ❒Millennium Bronze Value G
Healthfirst Plans			
❒Platinum Pro EPO	❒Gold Pro EPO ❒Gold 25/50/0 Pro EPO	❒Silver Pro EPO ❒Silver 40/75/4700 Pro EPO	❒Bronze Pro EPO HSA ❒Bronze 6650 Pro EPO HSA ❒Bronze 8150 Pro EPO
Oscar Plans			
❒Circle Platinum 2 ❒Circle Plus Platinum 2 ❒Circle Platinum 1 ❒Circle Plus Platinum 1	❒Circle Gold ❒Circle Plus Gold ❒Circle Gold 1000 ❒Circle Plus Gold 1000 ❒Circle Gold 1250 ❒Circle Plus Gold 1250 ❒Circle Gold 2000 ❒Circle Plus Gold 2000	❒Circle Silver ❒Circle Plus Silver ❒Circle Silver 3000 ❒Circle Plus Silver 3000 ❒Circle Silver 4500 ❒Circle Plus Silver 4500 ❒Circle Silver HSA 3000 ❒Circle Plus Silver HSA 3000	❒Circle Bronze 4500 ❒Circle Plus Bronze 4500 ❒Circle Bronze 8150 ❒Circle Plus Bronze 8150 ❒Circle Bronze HSA 6750 ❒Circle Plus Bronze HSA 6750
Oxford Plans			
❒Liberty Platinum EPO 40/80 411	❒Liberty Gold EPO 25/50 ZD ❒Liberty Gold EPO 30/60 G ❒Liberty Gold EPO 30/60 ❒Metro Gold EPO 25/40 ❒Metro Gold EPO 25/40 G	❒Metro Silver EPO 50/100 ZD ❒Liberty Silver EPO 40/70 ❒Liberty Silver EPO 25/50 G ❒Metro Silver EPO 30/80 G	❒Liberty Bronze EPO HSA 4000 ❒Metro Bronze EPO HSA 6750 G

Dental Plans

Choose one dental package you would like to offer to your employees for the upcoming policy year. 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 reestablish the plans to offer.

Dental Options	❒ 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
	❒ Dental Package 2^ - Guardian Managed DentalGuard DHMO and Guardian DentalGuard Preferred PPO MAC
	❒ Dental Package 3^ - Guardian Managed DentalGuard DHMO *Plus* and Guardian DentalGuard Preferred PPO *Plus* MAC
	❒ Dental Package 4 - Solstice Dental EPO S700B, Solstice Dental EPO S800B, Solstice Dental PPO and Solstice Dental Value PPO MAC
	❒ Dental Package 5^ - UnitedHealthcare Select Managed Care, UnitedHealthcare Low PPO MAC and UnitedHealthcare High PPO MAC
	❒ Dental Package 6^ - UnitedHealthcare INO 100/50/50 and UnitedHealthcare High PPO MAC
	❒ Dental Package 7 - Not Interested

^Participation requirements apply.

Vision Plans

Choose one vision package you would like to offer 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 reestablish the plans to offer.

Vision Options	❒ Vision Package 1^ - Guardian VisionGuard^, Solstice Vision PPO and UnitedHealthcare Vision PPO
	❒ Vision Package 2 - Solstice Vision PPO and UnitedHealthcare Vision PPO
	❒ Vision Package 3^ - Guardian VisionGuard
	❒ Vision Package 4 - Solstice Vision PPO
	❒ Vision Package 5 - UnitedHealthcare Vision PPO
	❒ Vision Package 6 - Not Interested

^Participation requirements apply.

Life/AD&D/LTD Plans

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

Guardian Plans	❒ 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 reestablish the plans to offer.

Guardian Plan	❒ AccidentGuard Adv

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 reestablish the plans to offer.

Select one option and then select related plan(s)

	Options	Plans		
ID Theft Plans	❒ Allstate Identity Protection	❒ Allstate Identity Protection Pro	❒ Allstate Identity Protection Pro Plus	❒ Dual Option
	❒ NortonLifeLock	❒ Benefit Elite	❒ Ultimate Plus	❒ Dual Option
	❒ Not Interested			

Defined Contribution

What dollar amount (if any) are you contributing toward the employee's costs

$_____ Employee $_____ Employee/Spouse $_____ Employee/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.

For the initial payment, how do you prefer to pay for your coverage? (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. Are any COBRA members included in the 1st month's premium? ❒Yes ❒No

After the initial payment, 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.

*Our Merchant ID is 131575 your financial institution may need this ID in order for payments to be processed successfully.

G. EMPLOYER CERTIFICATION

I agree and attest that:

- My business will offer 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 under 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.
- 20% of the total eligible employees must enroll with a HealthPass medical plan. 75% of eligible employees must elect to participate in HealthPass medical coverage or have other credible health insurance coverage.
- The group meets all HealthPass carrier out-of-area coverage requirements:

  - **EmblemHealth**
    Prime - employees must live/work/reside in NY, NJ and CT.
    Select Care - employees must live/work/reside in NY.
    Millennium - employees must live/work/reside in the five boroughs, Nassau, Suffolk and Westchester.

  - **Healthfirst**
    Employees must live/work/reside in the five boroughs, Nassau and Suffolk.

  - **Oscar**
    Circle - employees must live/work/reside in the five boroughs, Nassau, Suffolk, Westchester and Rockland.
    Circle Plus - no more than 20% of eligible employees can live outside of the five boroughs, Nassau, Suffolk, Westchester, Rockland and the Oscar NJ service area.

  - **Oxford**
    Liberty non-gated plans - employees must 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).*
    Metro plans - employees must live/work in NY and NJ.

- 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 addition card possessed.

Please refer to our Eligibility Guidelines for more detailed information.

H. 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 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 fewer 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.

❒ **My 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.healthpassny.com/forms) and return it with this application.

I. PROGRAM BENEFITS

Health Advocate: All members with medical coverage through HealthPass (excluding COBRA enrollees) have access to Health Advocate™ to assist with navigating many healthcare related issues, including support in understanding claims and accessing providers.

Section 125 POP Kit: All groups enrolled with HealthPass have access to a Section 125 Premium Only Plan (POP) Kit which enables employees to make pre-tax contributions to their healthcare rates. Employers must request their POP Kit within 90 days of enrollment by visiting www.healthpassny.com.

HealthPass COBRA Administration Services: All groups have access to COBRA/NYSC Administration Services unless opted out by Employer in Section C. 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 as outlined at www.healthpassny.com. 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 outlined at www.healthpassny.com or; (iii) Employer elects to cease to offer HealthPass COBRA Administration Services by declining such services in Section C 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. Visit www.healthpassny.com for further information on the Program Benefits.

J. FEE DISCLOSURE

Program Fees: All medical rates include $4.95 for HealthPass Program Benefits (non-carrier/agent services) and a 2.9% billing and administrative fee.

- Dental In-Network plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Dental PPO plans: EE $9.25, EE/Spouse $18.25, EE+Child(ren) $16.50, Family $26.50
- Vision plans: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
- Guardian EverGuard & EverGuard *Plus* plans: $3.50 Per Employee Per Month (PEPM)
- Guardian AccidentGuard Adv plan: EE $2.50, EE/Spouse $3.50, EE+Child(ren) $3.50, Family $5.50

K. 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. 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, ts employees and their dependents are not automatically insured, but must each satisfy any eligibility requirements of the Trust and of the applicable Group Contracts. The 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 the premium by the end of the month of the date due. Full payment must be made to keep all group policies active.

L. 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, B and H 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 I and the related fees as enumerated in Section J, and;
- ❒ Agrees to the terms set forth in Section K of this form regarding the Trust Participation Agreement.

Moreover, the Employer, by its duly authorized officer, understands that 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.

Authorized Signature _____ **Title** _____

Print Name _____ **Date** _____