univera HEALTHCARE

Group Information Form

Failure to respond may result in your policy being canceled.

See instructions for assistance completing this form.

SECTION ONE

GENERAL GROUP INFO

1. Group Number:

2. Group/Business name or DBA name (if applicable):

3. Legal Entity Name, if different than group name:

4. a) Tax Identification Number (EIN/TIN): | b) SIC Code:

5. Most group health plans are governed by ERISA with the exception of *some* religious organizations and governmental entities. If you are **not** governed by ERISA, please check: ☐

6. Business Physical Street Address:

City: | State: | ZIP: | County:

7. Headquarters Street Address[1] (if different than physical):

City: | State: | ZIP: | County:

8. Who sponsors (offers) the group health coverage? (check one): Employer: ☐ Union: ☐ Association: ☐ Trustees of Fund: ☐ Other: _____

9.

A. Organization Type (check one): ☐ Sole Owner ☐ C Corporation ☐ S Corporation ☐ LLC/PLLC ☐ Partnership ☐ Local Government ☐ State Government ☐ Public Entity ☐ Nonprofit ☐ Church Group ☐ Trust ☐ 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 cover any of these employees under this policy? ☐ Yes ☐ No

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

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

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

12. Commonly owned or related businesses (if applicable):

Company Name	EIN/TIN	State

13. a) Is there a group medical plan in place in addition to the products offered through Univera Healthcare?: Yes ☐ No ☐ | b) Plan Type: New York State of Health ☐ Other: _____

14. Number of hours per week an employee must work to be eligible for coverage: _____

15. Total number of individuals eligible for coverage[2]: _____

[1] The main office location for the organization, not an address used solely for billing or mailing purposes

[2] Include owners, employees and retirees not on a plan specifically for the group's Medicare enrollees. Also include individuals enrolled in COBRA, NYS Continuation and the Young Adult Option.

univera HEALTHCARE

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SECTION TWO — GROUP SIZE REGULATORY INFO

1. To Verify Market Segment *–See instructions for details regarding the calculation*:	
Total number of full-time employees and full-time equivalents at all locations in the prior calendar year:	
2. 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. 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

SECTION THREE — EMPLOYER CONTRIBUTION TO HSA/HRA

Annual Employer Contribution to a Health Savings Account (HSA)/Health Reimbursement Account (HRA) (if applicable):

Product Type	Product Name	Subgroup Number	Class Name	Type		Please list percentage or annual dollar amount contributed for *all* tiers			
				$	%	Employee	w/Spouse	w/Child(ren)	Family
HSA ☐ HRA ☐				☐	☐				
HSA ☐ HRA ☐				☐	☐				
HSA ☐ HRA ☐				☐	☐				
HSA ☐ HRA ☐				☐	☐				

Note: Underwriting may require additional documentation during review of the form, such as the most recently filed NYS-45 (or state equivalent).

Signature: *The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.*

_____ __ __ / __ __ / __ __ __ __ (__ __ __) __ __ __ - __ __ __ __

Employer Authorized Representative Signature | Date | Phone Number

_____

Print Name

_____

Email Address

Note: If your company offers a dental and/or Medicare plan through Univera Healthcare please complete the appropriate supplemental form(s).

univera HEALTHCARE

Supplemental Form: Dental

Failure to respond may result in your policy being canceled.

DENTAL GROUP ELIGIBILITY INFO

1. Dental Participation:

	Pooled experience groups have 50 or fewer eligible employees. Experience rated groups have 51 or more eligible employees.	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 (Question A + Question B + Question C):	
E.	Number of eligible employees declining dental coverage due to a valid waiver:	
F.	Net number of eligible employees for dental coverage (Question D – Question E):	
G.	Total number enrolled in the dental plan:	
H.	Participation percentage (Question G ÷ Question F):	

2. Other Coverage:

1. Is there a group dental plan in place in addition to the product(s) offered through Univera Healthcare?: ☐ Yes ☐ No (If No, skip to Contribution Question)
2. What carrier issues the other group dental plan(s)?: _____
3. Number enrolled in the other plan(s): _____

EMPLOYER CONTRIBUTION TO DENTAL

3. Monthly Employer Contribution to Dental Premiums –See Section Three Instructions for assistance:

Product Name	Subgroup Number	Class Name	Type		Please list percentage or monthly dollar amount contributed for *all* tiers			
			$	%	Employee	w/Spouse	w/Child(ren)	Family
			☐	☐				
			☐	☐				

Signature: *The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.*

_____ __ __ / __ __ / __ __ __ __ (__ __ __) __ __ __ - __ __ __ __

Employer Authorized Representative Signature | Date | Phone Number

_____

Print Name

_____

Email Address