univera HEALTHCARE

New Group Application

Commercial Health, Dental, and Vision 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: _____

3. Tax Identification Number (EIN/TIN): _____ 4. SIC Code: _____

5. 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: _____

6. Requested Effective Date: _____

7. Company Officer's Name: _____ Title: _____ Telephone: _____

8. Group's Health Plan Sponsor (Check one): ☐ Employer ☐ Union ☐ Trustees of Fund ☐ Association ☐ Other: _____

9. Organization Type (Check one): ☐ Sole Owner ☐ C Corporation ☐ S Corporation ☐ LLC/PLLC ☐ Partnership ☐ Trust
   ☐ Local Government ☐ State Government ☐ Public Entity ☐ Nonprofit ☐ Church Group ☐ Other: _____

10. List of 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 _____

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

    1. Legal Entity Name: _____ Number of Employees: _____ EIN/TIN: _____ State: _____

    2. Legal Entity Name: _____ Number of Employees: _____ EIN/TIN: _____ State: _____

12. Indicate company organization:
    ☐ Standalone ☐ Parent ☐ Subsidiary ☐ Local ☐ Plant/Office/Division ☐ Other: _____

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

    1. Physical Location/Worksite Name: _____ Address: _____ # Enrolling: _____

    2. Physical Location/Worksite Name: _____ Address: _____ # Enrolling: _____

14. Does your group offer any other health plans in addition to the products offered through Univera Healthcare? ☐ Yes ☐ No

    A. If yes, what carrier issues these health policies? _____

    B. 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: _____

2. **Business Physical Address:** Street: _____ City: _____

   State: _____ Zip: _____ County: _____ Telephone: _____ Fax: _____

3. **Headquarters Address:** (if same as physical address, check here ☐ Other, please provide below

   Street: _____ City: _____

   State: _____ Zip: _____ County: _____ Telephone: _____ Fax: _____

4. **Mailing Address:** (Same as: ☐ Physical ☐ Headquarters Otherwise, complete the information below

   Street: _____ City: _____

   State: _____ Zip: _____ County: _____ Telephone: _____ Fax: _____

5. **Billing Address and Contact:** _____ Title: _____

   Email: _____

   Street: _____ City: _____

   State: _____ Zip: _____ County: _____ Telephone: _____ Fax: _____

Section 3: Group Size Regulatory Information- Required for All Submissions

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: Individuals not listed on the NYS-45 ATT or other state equivalent - Required for all 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

univera HEALTHCARE

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Section 5: Employee and Retiree Eligibility- Required for All Submissions

1. Total Individuals Eligible for Group Health Insurance Coverage (see instructions): _____

2a. **Eligibility Policy for New Hires 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:

Commercial Product	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**			
Medical						☐ 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*: _____			
Medical						☐ 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*: _____			
Dental ☐ Same as Medical? Skip to Section 6, if no please complete the following:						☐ 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*: _____			
Dental ☐ Same as Medical? Skip to Section 6, if no please complete the following:						☐ 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*: _____			
Vision ☐ Same as Medical? Skip to Section 6, if no please complete the following:						☐ 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*: _____			
Vision ☐ Same as Medical? Skip to Section 6, if no please complete the following:						☐ 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*: _____			

univera HEALTHCARE

New Group Application

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Retiree Eligibility:	Does your group provide health insurance to retirees? ☐ Yes ☐ No 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):

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

A. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

B. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

C. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

D. Product Name: _____ Subgroup #: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

3b. **HSA/HRA** - Employer Contribution **(Annual Amount):**

A. ☐ HSA Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

B. ☐ HSA Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

3c. **Dental Products - Employer Contribution (Monthly Amount):**

A. Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

3d. **Vision Products - Employer Contribution (Monthly Amount):**

A. Product Name: _____ Class Name: _____

Employee: _____ W/Spouse: _____ W/Children: _____ Family: _____

Section 6: Dental Information- Required for Dental Submissions

1. **Eligible Dental Employees**

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. Either type of group must enroll a minimum of 2 contracts.

Employees Eligible for Univera Healthcare Offering

Total number of eligible employees (including active employees and owners, Retirees, and individuals enrolled in COBRA): _____

univera HEALTHCARE

New Group Application

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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: _____ Date: _____

Print Name: _____ Email Address: _____

Section 9: Checklist of Required Information- All Submissions

- ☐ Signed Rate Sheets and benefit summaries
- ☐ NYS-45 or other state equivalents from the most recently filed report. Annotate the report per the instructions.
- ☐ 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 newly formed businesses.
- ☐ 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)
- ☐ Signed rate sheets and benefit selections
- ☐ Subscriber applications or Administrator Electronic and Web Enrollment Agreement
- ☐ Disabled Dependent Form (when applicable)
- ☐ Administrator Electronic and Web Enrollment Agreement (if applicable).

Univera Healthcare will submit reports with respect to the benefit plan, in the time and manner required under Section 204 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.