

[Carrier name/logo]

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS [POLICY]

Please print or type [Policy] number ([Carrier] Use Only)

New [Policy] Change in [Policy]
Requested Effective Date _____

Note: The Effective Date will be on or after the date [Carrier] approves the application.

SECTION I: [POLICY]HOLDER INFORMATION

1. Policyholder (full legal name of company): _____
2. Tax Identification Number: _____
3. Main Address: _____

Street City State Zip
Mailing Address: _____
Street City State Zip

Telephone: () _____ Facsimile: () _____
E-Mail address _____

Contract information should be provided electronically or hard copy. Check one.
Correspondent: _____

4. Type of organization: Corporation Partnership
 Proprietorship Other (explain): _____
6. Nature of business (specify): _____
SIC Code _____

7. Number of eligible employees in your company: _____

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured: _____
9. Class or classes to be excluded: _____
10. Insurance Requested For: Employees Only Employees & Dependents including Spouse Employees & Dependents excluding Spouse
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? Yes No If yes, should the plan provide coverage for coverage of children of a covered domestic partner? Yes No
11. Is the employer subject to the requirements of COBRA? Yes No
12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? Yes No due to disability? Yes No
13. Orientation Period: Yes No
14. Waiting period before employees become insured: (may not exceed 90 days)
 Present employees: _____ New or Rehired Employees: _____
15. Period for Annual Employee Open Enrollment Period: _____
16. What percentage of the premium will the employer pay? _____
17. Deposit \$ _____

Premium Paid: Monthly [Quarterly] [Automatic checking withdrawal]

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. eligible employees in this company	No eligible employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

[HEALTH BENEFITS

Carriers must include adequate identifying information with respect to at least three standard health benefit plans. Options with riders may also be included.

Carriers may include information regarding pediatric dental benefits. Carriers may request that the employer respond to a question regarding whether the employer has obtained stand-alone pediatric dental benefits.

Carriers may refer to the proposal if there is a means to identify the plan the applicant selected.

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SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:

- now in force and to be continued? Yes No
- currently being applied for? Yes No

If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

2. Name of present or prior group carrier _____

Effective date of prior coverage: _____

Cancellation/termination date: _____

Is the coverage applied for in this application replacing other group insurance?

- Yes No

If "Yes" give reason _____

Plan being replaced: _____

3. Are extended benefits provided in case of termination of health benefits?

- Yes No

4. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?

Yes No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/Extended Benefits	Reason for Termination Disability /Other	Continuation Dates	
				Start	End

If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge:

a) Are any employees or dependents presently incapacitated?

Yes No

b) Are any dependent children incapable of self-support due to a physical or mental disability?

Yes No

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

6. Does the employer participate in an arrangement with a Professional Employer Organization?

Yes No

(Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organizations.)

SECTION IV: AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]

SECTION V: SIGNATURE

[It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of [Carrier] to make or modify any request or application for insurance or to bind [Carrier] by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by [Carrier]. [Final rates will be based on enrollment data as of the Policy effective date.] No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.]

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

[_____
Print name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor]

[_____]
Witness to Signature]

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.