



## State of New Jersey

DEPARTMENT OF BANKING AND INSURANCE  
SMALL EMPLOYER HEALTH BENEFITS PROGRAM

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### ADVISORY BULLETIN 21-SEH-01

February 24, 2021

To: SEH Program Member Carriers that Issue Coverage  
SEH Program Interested Parties

From: Ellen DeRosa  
Executive Director

**Re: Application for a Small Group Health Benefits Policy**

As required by N.J.A.C. 11:21-6, carriers offering small employer health benefits plans must use the standard Application for a Small Group Health Benefits Policy and the New Jersey Employer Certification form. The Application form has been updated with new variable text that carriers may begin to include to any time following issuance of this Advisory Bulletin.

The Application has been revised to include variable text that would be included by carriers that elect to give employers the opportunity to choose to receive monthly invoices either electronically or by mail. If the electronic invoices will be available on a group portal, the text may so state.

Carriers that do not intend to make invoices available electronically should continue to use the group application released with Advisory Bulletin 17-SEH-03.

The updated application form is attached to this Advisory Bulletin and is available on the SEH Board's website at [www.state.nj.us/dobi/division\\_insurance/ihcseh/sehforms.html](http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html).

If you have any questions please send them by email to [ellen.derosa@dobi.nj.gov](mailto:ellen.derosa@dobi.nj.gov).

[Carrier name/logo]

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**APPLICATION FOR A SMALL GROUP HEALTH BENEFITS [POLICY][THROUGH THE  
SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)]**

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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.

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**SECTION I: [POLICY]HOLDER INFORMATION**

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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.

[Monthly invoices should be provided  electronically [through the Group Portal] or

hard copy. Check one.]

Correspondent: \_\_\_\_\_

4. Type of organization:  Corporation  Partnership  
 Proprietorship  Other (explain): \_\_\_\_\_

5 Nature of business (specify): \_\_\_\_\_

SIC Code \_\_\_\_\_

6. Number of full-time employees in your company: \_\_\_\_\_

**Refer to the New Jersey Small Employer Certification for the definition of a full time employee**

7. Number of full-time employees to be insured: \_\_\_\_\_
8. Class or classes to be excluded: \_\_\_\_\_
9. 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

10. Is the employer subject to the requirements of COBRA?  Yes  No
11. 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
12. Orientation Period:  Yes  No
13. [Waiting period before employees become insured: (may not exceed 90 days )  
[The  1st or  15th of the month following the waiting period of:]  
[ 0 days  30 days  60 days  exactly 90 days]  
[ 0 month  1 month  2 months  exactly 90 days]

[ Present Employees: \_\_\_\_\_  New or Rehired Employees: \_\_\_\_\_]

[ Present Employees: \_\_\_\_\_  New Employees: \_\_\_\_\_  Rehired Employees: \_\_\_\_\_]

*Note to Carriers: For Non-SHOP applications. Include applicable text.*

[Waiting period before employees become insured: (may not exceed 60 days)

The  1st of the month following the waiting period of:

[ 0 days  15 days  30 days  45 days  60 days]

[ Present Employees: \_\_\_\_\_  New or Rehired Employees: \_\_\_\_\_]

[ Present Employees: \_\_\_\_\_  New Employees: \_\_\_\_\_  Rehired Employees: \_\_\_\_\_]

*Note to Carriers: For SHOP Applications. Include applicable text.*

14. Period for Annual Employee Open Enrollment Period: \_\_\_\_\_

15. What percentage of the total premium will the employer pay? \_\_\_\_\_

16. 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	# full-time employees in this company	# full-time employees to be insured

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**SECTION II: SPECIFICATIONS FOR COVERAGE**

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**[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.*

*If pediatric dental benefits are embedded in the medical plan state the inclusion. If pediatric dental benefits are not included in the medical plan for non-SHOP plans Carriers must include a question regarding whether the employer has obtained stand-alone pediatric dental benefits.*

*If the Carrier offers one or more plans that exclude coverage for services for which Federal funding is prohibited, include information such that the employer may determine which plans exclude coverage of such services.*

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

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**[ANCILLARY BENEFITS**

*Carriers may include information that would allow the employer to apply for a separate policy or policies providing ancillary benefits such as dental or vision benefits provided those benefits are issued by the same carrier.]*

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**SECTION III: ALL QUESTIONS MUST BE ANSWERED**

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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.

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

Yes  No

[If yes, is health coverage available as a client of the PEO?  Yes  No]

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

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#### **SECTION IV: AGENT/PRODUCER INFORMATION**

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

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#### **SECTION V: SIGNATURE**

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[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.

[It is understood that I am responsible to provide Carrier with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.]

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.