[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):_____
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 for:]
    [☐ 0 month ☐ 1 month ☐ 2 months ☐ exactly 90 days for:]

    [☐Present Employees:_____ ☐New or Rehired Employees:_____]

[☐Present Employees:_____ ☐New Employees:_____ ☐Rehired Employees:____]
Note to Carriers: 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**

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.

If pediatric dental benefits are embedded in the medical plan state the inclusion. If pediatric dental benefits are not included in the medical plan 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.

]

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 (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.)

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.

[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.