



SMALL EMPLOYER GROUP APPLICATION

EmblemHealth insurance programs are underwritten by Group Health Incorporated (GHI) and HIP Health Plan of New York (HIP).



SECTION I: GROUP INFORMATION

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. () _____ Fax No. () _____

Company Officer's Name _____ E-Mail Address _____

Title _____

Group Contact _____ Title _____ Telephone No. () _____

E-Mail Address _____

Address Same as above _____

Additional Office Locations _____

Taxpayer ID Number _____

SECTION II: BILLING

Premium invoices should be sent to: _____

Telephone No. () _____ E-Mail Address _____

Address _____

City _____ State _____ ZIP _____ County _____

Contact Person *(if different than above)* _____

Telephone No. () _____ E-Mail Address _____

SECTION III: GROUP ADMINISTRATION

1. Please check all applicable class(es) for the EmblemHealth coverage for which you are applying (note that classes must be based upon conditions pertaining to employment):

- Management Non-Management Union Part-Time Other

If you checked "Other" above, please identify the other class(es): _____

NOTE: Employees must work at least 20 hours per week for applicant in order to be eligible for EmblemHealth coverage. Retirees are not eligible for coverage under EmblemHealth small group programs.

At EmblemHealth's request, employer's quarterly report of wages paid to each employees (NYS-45) must be supplied to EmblemHealth within 15 days after it is filed with New York State.

2. If your Group is an association, chamber of commerce or fund comprised of one or more employees or labor unions, please identify the total number of member groups by the following group size(s):

_____ Total number of member groups with 50 or fewer eligible employees.

_____ Total number of member groups with 51 or more eligible employees.

3. Please specify the current number of COBRA participants: _____

4. Indicate the number of enrollees eligible for EmblemHealth by coverage type:

_____ Individual _____ Employee/Spouse _____ Employee/Child(ren) _____ Family

5. Pre-Existing Condition Limitation:

There will be a waiting period of up to 12 months for benefits for any condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period ending on a member's enrollment date. This waiting period will be reduced to the extent that a member is entitled by law to a credit for prior continuous creditable coverage. The Certificate of Insurance or Certificate of Coverage will contain more information about the pre-existing condition waiting period and the types of coverage that qualify as prior continuous creditable coverage. The CompreHealth program applies a 12-month pre-existing condition limitation. Other EmblemHealth small group products apply an 11-month pre-existing condition limitation.

6. What is the nature of your business or organization? _____

Which of the following describes your company or organization?

Employer/Employee Group Business Association Fraternal/Religious Organization

Sole Proprietor Partnership Non-Profit Organization

Other Group. Please describe _____

Which of the following describes your type of Association?

Trade Association Labor Union or Employer Trust

Professional Association Chamber of Commerce

Credit or Bank Association Special Association (Approved by Department of Insurance)

7. Is your company or organization a subsidiary, division or an affiliate of another company?

Yes No

SECTION IV: OTHER COVERAGE

OTHER GROUP HEALTH OR HMO COVERAGE

Please complete the information below for your other group health coverage which is still in force or which was terminated within the past 12 months.

Name and Address of Insurer	Type of Coverage	Effective Date of Policy	Termination Date of Policy

Was your group health coverage terminated for non-payment of premiums in the last 12 months?

Yes No

SECTION V: PRODUCT SELECTION

EMBLEMHEALTH PRODUCTS

Desired Effective Date: _____

EPO

- Are all eligible employees covered under this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another group health program? Yes No
- Will this program replace another group health coverage program? Yes No

PPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will this program replace another group health coverage program? Yes No

InBalance EPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another group health program? Yes No
- Will this program replace another group health coverage program? Yes No

InBalance PPO

- Are all eligible employees selecting this program? Yes No
- If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
- Will this program replace another group health coverage program? Yes No

- ConsumerDirect EPO**
- Are all eligible employees selecting this program? Yes No
 - If no, are at least 50% of the eligible employees selecting this program or another group health program? Yes No
 - Will this program replace another group health coverage program? Yes No

- ConsumerDirect PPO**
- Are all eligible employees selecting this program? Yes No
 - If no, are at least 50% of the eligible employees selecting this program or another EmblemHealth program? Yes No
 - Will this program replace another group health coverage program? Yes No

- CompreHealth**
- Are all eligible employees selecting this program? Yes No
 - Will this program replace another group health coverage program? Yes No

EmblemHealth Dental Voluntary Contributory

SECTION VI: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth Program premiums for your employees and their dependents.

Employee: _____ % or \$ _____ Family: _____ % or \$ _____

Other: _____

NEW HIRE ELIGIBILITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth program.

Date of hire First of the month following date of hire

PLUS:

30 Days 60 Days 90 Days Other: _____

Waived for rehire? Yes No If rehired within _____ days of rehire.

If more than one class of employees will be covered, please complete **Section (VI-A)** on next page.

SECTION VI-A: ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTIONS

Please specify the percent or amount that your group will contribute towards EmblemHealth Program premiums for your employees and their dependents.

- Employee:** _____ % or \$ _____ **Family:** _____ % or \$ _____
- Other: _____

NEW HIRE ELIGIBILITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the EmblemHealth Program.

- Date of hire First of the month following date of hire

PLUS:

- 30 Days 60 Days 90 Days Other: _____

Waived for rehire? Yes No If rehired within _____ days of rehire.

For additional classes, please continue on a separate piece of paper.

SECTION VII

For employer groups comprised of one or more employees, please check your current employer status below to ensure proper coordination of benefits for your Medicare Eligible Active Employees (*you must check one of the boxes below*):

- A.** Employed fewer than twenty (20) full time or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).
- Employed twenty (20) or more full or part-time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year)

NOTE: All employers that are treated as a single employer under Internal Revenue Code Section 52 must be treated as a single employer for purpose of the Medicare secondary payer rules. According to Internal Revenue Code Section 52, all employees of all corporations that are members of the same controlled group of corporations must be treated as employed by a single employer. This means that if a parent company owns at least fifty percent (50%) of a subsidiary, then the number of employees of the parent and the subsidiary must be combined for purposes of determining the 20-employee threshold. Similarly, brother-sister corporations may be combined in some cases if the parent corporation owns at least fifty percent (50%) of the brother-sister corporations.

- B.** Please check here if your group is a large group health plan. A large group health plan is a plan of, or contributed to by, an employer or employee organization to provide health benefits that cover the employees of at least one (1) employer that normally employed at least one hundred (100) employees on a typical business day during the preceding calendar year.

SECTION VIII

The group agrees to do the following:

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York, or Group Health Incorporated the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify HIP Health Plan of New York, and/or Group Health Incorporated, of the termination or addition of any member(s) covered or to be covered.
- Promptly provide HIP Health Plan of New York, or Group Health Incorporated with any information necessary to properly administer the coverage.
- Ensure compliance with ERISA/TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to your group's coverage, as applicable.

It is understood that:

- If an acceptable employee enrollment form is received prior to the eligibility date, coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt.
- All group applications are subject to approval by HIP Health Plan of New York and/or Group Health Incorporated.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and/or Group Health Incorporated, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the eligibility of the actual enrollees. Any material misrepresentation within this group application or the enrollee transaction and application form, whether intentional or unintentional, may cause termination of this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents, and I will provide an enrollment form or a waiver of coverage form signed by each eligible employee within thirty (30) days of his/her eligibility date.

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. The premium deposit submitted with this application will be refunded if coverage does not become effective.

Subject to applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from the effective date of this Contract.

All statements in this application for coverage under a Contract for insurance shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at: _____

On the _____ Day of _____, 20_____

By: _____ Title: _____

By: _____ Title: _____

Please return this completed application and the following items:

- *Employer's Quarterly Report of Wages Paid to Each Employee (NYS-45)*
- Copy of a 12-month old (or more recent, if necessary) billing statement
- First month's premium

To: **EmblemHealth**
New Business/Sales
55 Water Street
New York, NY 10041

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING

SECTION IX

To be completed by EmblemHealth General Agent or Selling Agent:

Company Name _____ Date _____

Address _____

City _____ State _____ ZIP _____ County _____

Telephone No. () _____ Fax No. () _____

Group Contact _____ E-Mail Address _____

Desired Effective Date _____

Effective date changed since original application? Yes No

Master Agency _____ MA No. _____ Override _____

EmblemHealth Group No. _____ EmblemHealth Marketing Rep _____

Confirmation that the following items are attached:

Deposit Check Yes No Amount: \$ _____

Proof of Employment Yes No

Last Paid Premium Invoice from Current Carrier Yes No

COBRA Letters of Election Yes No

Proof of Medicare Eligibility, Part A and B Yes No

GA Authorized Signature _____

Date _____



TRANSACTION FORM FOR GROUP ACCOUNTS
 MEMBERSHIP/P.O. BOX 2820 • NEW YORK, NY 10116-2820
 (Please read important information on back before completing this form)
 Employers: See back for sections you must complete
PLEASE PRINT CLEARLY

INTERNAL USE ONLY
 CONTROL NUMBER

I. SUBSCRIBER INFORMATION										
LAST NAME		FIRST NAME			M.I.	TELEPHONE NUMBERS HOME WORK		EMAIL ADDRESS		
HOME ADDRESS		APT. NO.	SOCIAL SECURITY NUMBER (REQUIRED)			GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____		
CITY			STATE	ZIP CODE		PRIMARY LANGUAGE SPOKEN				

II. ENROLLMENT INFORMATION											
LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER (REQUIRED)	GENDER	RELATIONSHIP	MAILING ADDRESS (If different from above)	Required for EH CompreHealth		ADD ✓	DELETE ✓
								PRIMARY CARE PHYSICIAN ID Number	OB/GYN SELECTION ID Number		
SUBSCRIBER						SELF					
SPOUSE											
DEPENDENT											
DEPENDENT											
DEPENDENT											

III. OTHER CARRIER INFORMATION Do you or any of your dependents have other health care coverage? <input type="checkbox"/> Yes Please complete this section <input type="checkbox"/> No GO TO SECTION IV										
NAME OF SUBSCRIBER'S OTHER INSURANCE CARRIER		INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.			POLICY ID. NUMBER	EFFECTIVE DATE	
NAME OF SPOUSE'S OTHER INSURANCE CARRIER/MEDICARE		INSURANCE CO. PHONE #	TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Family		NAME OF POLICYHOLDER: LAST NAME FIRST NAME M.I.			POLICY ID. NUMBER	EFFECTIVE DATE	

IV. DID YOU HAVE PRIOR HEALTH COVERAGE? <input type="checkbox"/> YES Please provide a 12-month history of all coverage in this section (Use additional pages if you need more space) <input type="checkbox"/> NO GO TO SECTION V							
NAME AND ADDRESS OF INSURER		TELEPHONE NUMBER OF INSURER	NAME OF POLICYHOLDER		POLICY I.D. NUMBER	EFFECTIVE DATE OF CURRENT OR PRIOR POLICY	TERMINATION DATE OF CURRENT OR PRIOR POLICY

V. PRE-EXISTING CONDITIONS

Pre-existing conditions will not be covered during the first twelve (12) months of enrollment in the EmblemHealth CompreHealth program or during the first eleven (11) months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth InBalance EPO, EmblemHealth InBalance PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice or treatment was recommended or received during the six (6) month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the twelve (12) month or eleven (11) month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed sixty-three (63) days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a certificate of creditable coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

Please call EmblemHealth at 1-877-VIA-EMBLEM (1-877-842-3625) for more information about the pre-existing condition limitation.

VI. SUBSCRIBER AUTHORIZATION	
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 five thousand dollars and the stated value of the claim for each such violation.	
If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to EmblemHealth.	
Your signature is required to process this form. Your signature attests that you have read the above, and the reverse side of this form.	
_____	_____
Applicant must sign here	Date

VII. EMPLOYER INFORMATION - TO BE COMPLETED BY EMPLOYER (SMALL GROUP EMPLOYERS MUST READ AND COMPLETE SECTION BELOW)

SUBSCRIBER EMPLOYMENT STATUS			EMPLOYEE WAITING PERIOD				
<input type="checkbox"/> Employed	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> COBRA: <input type="checkbox"/> 18 mo. <input type="checkbox"/> 36 mo.	<input type="checkbox"/> Retiree/RDS - Effective Date _____	<input type="checkbox"/> YES NUMBER OF WAITING PERIOD DAYS _____	<input type="checkbox"/> NOT APPLICABLE	NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____
Check one: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change to Individual Policy STATUS CHANGE: <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Reason for Change: _____ TRANSFER: <input type="checkbox"/> To Another Carrier <input type="checkbox"/> EmblemHealth Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No							
NAME OF GROUP		GROUP NUMBER: MED/HOSPITAL: DENTAL		SELECT ONE: <input type="checkbox"/> EmblemHealth CompreHealth (small groups only) <input type="checkbox"/> EmblemHealth PPO <input type="checkbox"/> EmblemHealth ConsumerDirect PPO <input type="checkbox"/> EmblemHealth CompreHealth EPO (large groups only) <input type="checkbox"/> EmblemHealth InBalance EPO <input type="checkbox"/> EmblemHealth ConsumerDirect EPO <input type="checkbox"/> EmblemHealth EPO <input type="checkbox"/> EmblemHealth InBalance PPO			
REQUESTED EFFECTIVE DATE MEDICAL: _____ DENTAL: _____	HIRE DATE	DATE SUBMITTED TO EMBLEMHEALTH	APPROVED BY (Group Plan Administrator)/Title	TYPE OF COVERAGE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPLOYEE & SPOUSE <input type="checkbox"/> EMPLOYEE & CHILD			

Instructions to Group Plan Administrator: For Groups with 50 employees or less, you **MUST** complete the following documentation section. Required documentation **MUST** be attached to this Transaction Form to be processed.

DOCUMENTATION BASED ON GROUP SIZE (To be completed by Small Group Plan Administrator)					
ACTION Check (✓) One	Qualifying Event	Group Type (Check One) Documentation Required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sole Proprietorship or One Subscriber Group	Association of Two or More Employees	Small Group - Less Than 50 Employees
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent copy of NYS45 showing this subscriber as an employee or copy of payroll documentation reflecting the date, employee's name and Social Security # or the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage Court Order	<input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Dependent	Birth Adoption Court Order	<input type="checkbox"/> Birth Certificate or <input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers or <input type="checkbox"/> Court Order			
<input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			

Note: No retroactive enrollments will be allowed. Members must be enrolled within 30 days from the qualifying event.

FOR EMBLEMHEALTH USE ONLY		
PROCESSED BY	RECEIVED DATE	PROCESSED DATE

IMPORTANT INFORMATION

- The subscriber must complete sections I through VI. The group plan administrator must complete section VII, and, if for a small group, the documentation section above.
- All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
- For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of these conditions: He/she is at least 19 years of age, unmarried, receives at least half of his/her support from the employee or member, and is enrolled full-time in an accredited educational institution. The institution must grant a degree or diploma.
To enroll the dependent as a full-time student, attach a completed Student Verification Parent Affidavit Form. See your group plan administrator or go to the EmblemHealth Web site at www.emblemhealth.com for a Student Verification Parent Affidavit Form.
- Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.

USFSB Direct Pay Plans through Joseph R. Cardamone Insurance Disclaimer

- A. An individual cannot assume he/she has effective insurance coverage even if he/she has filled out and submitted the application, provided proof of business, made a payment, completed a census, and/or performed any other function on the website or otherwise. An individual cannot assume that they have insurance coverage until the carrier has sent the individual a verification of coverage with the appropriate effective date.

- B. The insurance carriers have the right to change the rules, regulations, terms of coverage, availability and guidelines that are placed on the application, policies and enrollment at any time. We continue to make every effort to keep up with the rules, regulations, terms of coverage, availability and guidelines that the insurance carriers determine; however, we cannot guarantee that the website has been updated to reflect the current rules, regulations, terms of coverage, availability and guidelines.

- C. Rates change quarterly .We will continue to make every effort to verify these rates for our members; however, USFSB cannot guarantee that the website has been update to reflect the current rates.

- D. Whenever both a Joseph R. Cardamone *Summary of Benefits* and the Carrier's *Summary of Benefits* are presented, the Carrier's *Summary of Benefits* should be considered more accurate. However, in either case, the *Summary of Benefits* is simply an overview of the coverage provided by the carrier and we cannot guarantee that the information posted is current, complete or accurate.

By submitting an application, you are indicating that you have read and understand these Notices and agree to be bound by all terms and conditions for using the United States Federation of Small Businesses website.

USFSB Direct Pay Plans through Joseph R. Cardamone Insurance Checklist

1.
 - One check made payable to Emblem Health in the amount of one month premium.
 - One check made payable to USFSB in the amount of \$60 for annual dues along with a USFSB Membership Application if you choose to join.
2. Completed and signed Group Enrollment forms (original signature of owner/principal)
3. Completed an signed employee application form for each employee enrolling in the plan (original signature of each employee)
4. Proof of business as required by the carrier such as NYS-45 or other applicable tax documentation.
5. Applications must be submitted by the 15th of the month for a 1st of the next month effective date or by the 1st of the month for a 15th of the month effective date.

All of the above should be mailed to:

Joseph R. Cardamone
249 Green Street
Schenectady, New York 12305

Call 800-637-331 for more information.



NATIONAL HEADQUARTERS

249 Green Street
Schenectady, NY 12305
Phone: 800 637-3331
Fax: 518-370-4129
Fax: 888-568-3823

GOVERNMENT AFFAIRS

6916 Wolf Run Shoels Road
Fairfax Station, VA 22039
Phone: 800-637-3708
Fax: 703-978-8039

ASSOCIATION MEMBERSHIP AND INSURANCE PARTICIPATION GUIDELINES

1. The United States Federation of Small Businesses, Inc. is a national association of small businesses for small businesses.
2. Membership is applied for by the business owner and not the individual employee; however, once the business is an active member of USFSB the employees are also eligible for many membership benefits.
3. Member businesses are dues paying entities with a recognizable business structure (i.e. self-employed, partnership, corporation).
4. Member businesses must be legally recognized by their state and file taxes as a business.
5. A business check must accompany all applications.
6. One business check must be sent for all premium payments for all participating employees.
7. Documentation showing business legitimacy and verifying the number of employees must accompany the membership application. No insurance applications will be processed or sent to the insurance carrier without the required documentation.
Acceptable documentation is as follows:

ONE PERSON BUSINESS

A One Person Business is:

- A. Sole Proprietor** when the sole owner is the only employee of the business.
Documentation Required:
Most recent Schedule C, which the insurance carriers require you to sign, plus the 1040 portion of the federal tax return. A Schedule C is the profit and loss form that indicates the income and expenses for your business; or Most recent Schedule F, which the insurance carriers require you to sign, plus the 1040 portion of the federal tax return. A Schedule F shows farming income and expenses.
Alternate Proof for A New Business:
A letter from a CPA or Attorney, on their letterhead stating the business is new, the owner will work more than 20 hours per week, will earn at least \$xxxxxx per year and will send us the Schedule C or F once it is filed. Many carriers also require a copy of the filed DBA and a voided business check or letter from the bank stating that a business account has been set up and checks have been ordered.
- B. Corporation** when there is only one shareholder who is the only employee.
Documentation Required:
Most recent 1120 Corporate tax return, signed by you, showing the sole shareholder plus a copy of the Certificate of Incorporation.
- C. Limited Liability Company**
 - When the only member of the LLC is an individual and also the only employee.
Documentation Required:
Most recent Schedule C or Schedule F, which the insurance carriers require you to sign, plus the 1040 portion of the federal tax return.
 - When the only member of the LLC is a Corporation.
Documentation Required:
Most recent copy of the 1120 or 1120S Corporate tax return, signed by you.
Alternate Proof for A New LLC
Copy of the Articles of Organization showing the member involved.

BUSINESS WITH 2 OR MORE EMPLOYEES

A 2+ Person Business is:

- A. Sole Proprietor** when, in addition to the owner, there is at least one other employee on payroll.
Documentation Required:
Most recent Schedule C, which the insurance carriers require you to sign, plus a signed copy of your Quarterly Wage and Tax Report listing the employee or employees. The Quarterly Wage and Tax Report, which is submitted to your state, lists the employees' name, social security number, wages, taxes and unemployment insurance information. Ex: In New York the Quarterly Wage and Tax Report is called the NYS45. Each state has its own version of this report.
- B. Corporation** that either has more than one shareholder and/or one employee or more.
Documentation Required:
Most recent 1120 Corporate tax return, signed by you, listing the shareholders, a copy of the Certificate of Incorporation plus the most recent signed Quarterly Wage and Tax Report listing the employee or employees.

- C. **Limited Liability Company** that either has more than one member and/or one employee or more.
Documentation Required:
Most recent 1120 or 1120S Corporate tax return, signed by you, plus the most recent signed Quarterly Wage and Tax Report listing the employee or employees; or Copy of the most recent 1120, 1120S or 1065, signed by you, plus the most recent signed K-1s for all partners and the most recent signed Quarterly Wage and Tax Report listing the employee or employees.
- D. **Partnership** that either has more than one partner and/or one employee or more.
Documentation Required:
Most recent 1065 Partnership tax return, signed by you, plus most recent signed K-1s for all partners. Plus the most recent signed Quarterly Wage and Tax Report listing the employee or employees.
Alternate Proof for A New Partnership
Certificate of Partnership listing all partners and the percentage of ownership with a letter stating the K-1s will be sent once they are filed.
- E. A W-4 must be provided for all new employees who are enrolling in health insurance plans. A signed copy of your Quarterly Wage and Tax Report must also be provided even though the new employee is not on it. A copy of the Quarterly Wage and Tax Report listing the new employee must be provided within 90 days of the new person's employment.
8. If you are unable to file your taxes by the required date, you can file for an extension by using Form 4868 for a Sole Proprietor, Form 7004 for a Corporation or Form 8736 for a Partnership. A signed copy of this form along with the prior years filed tax documents is acceptable proof of business for some insurance carriers.
 9. Insurance carriers have different annual business income requirements. For example, Blue Shield of Northeastern New York requires \$15,000.
 10. Many health insurance carriers have specific group enrollment forms to be filled out and submitted along with the insurance application, including a waiver form to be filled out by any employee electing not to enroll in the coverage.
 11. In many cases, the number of employees, including the owner, in the business will determine the premium rate.
 12. In some cases insurance products will have the same coverage or benefits but different rates solely due to multiple tier structures.
 13. Some carriers have Participation Requirements which means they require a minimum number of employees or a specific percentage of the employees to enroll in their health plan.
 14. Membership and health applications are reviewed upon receipt. USFSB may request additional information at any time to verify the business status. This is done on a case-by-case basis.
 15. Health insurance carriers have the legal right to ask for reverification of business status and/or updated information at any time. In most cases, this information will be requested once a year. If the requested information is not provided, the health insurance coverage will be cancelled by the carrier.
 16. Member businesses applying for health insurance must be located in the requested insurance company's service area.
 17. Health insurance participants must be actively working owners or employees of the member business and must be on the company payroll. Each insurance carrier determines the number of working hours in a week necessary to be eligible for their insurance plan. The week runs from Sunday to Saturday.
 18. Eligible employees must enroll in the health insurance plan at the time the business chooses to participate, or they must wait for open enrollment or enroll within 30 days of a qualifying event.
 19. A new employee must apply for insurance coverage within 45 days of employment to guarantee coverage takes effect within the required 90 days of employment. If they do not do so, they must wait until the insurance plan's open enrollment or within 30 days of a qualifying event unless otherwise indicated by the insurance carrier and employer upon enrolling the business in a group plan.
 20. A married employee enrolling as an individual subscriber in the health plan cannot add the spouse or existing dependents until open enrollment or within 30 days of a qualifying event. If a qualifying event occurs such as a spouse loses their job or their health insurance, we can request a review of this policy and in some cases an exception to the enrollment procedures can be made.
 21. A newborn must be added within 30 days of birth or must wait until open enrollment or within 30 days of a qualifying event.
 22. A business owner has the option to change their health plan benefits, with their existing insurance carrier, each year on the open enrollment date for that particular plan.
 23. Completing and submitting an insurance application is not a guarantee of coverage. The acceptance of the application is subject to carrier approval. Please do not cancel your current insurance until you receive verification from the new insurance carrier of your policy effective date. Please review your current carrier's insurance contract and termination policy. In some cases you are required to provide the health carrier with a 30 day written notice prior to a cancellation.
 24. These guidelines are subject to change based on the specific underwriting requirements of each insurance carrier and state regulations.
 25. Insurance carrier guidelines are regulated by the state's insurance department in which the company does business.

**NATIONAL HEADQUARTERS**

249 Green Street
Schenectady, NY 12305
Phone: 800 637-3331
Fax: 518-370-4129
Fax: 888-568-3823

GOVERNMENT AFFAIRS

6916 Wolf Run Shoels Road
Fairfax Station, VA 22039
Phone: 800-637-3708
Fax: 703-978-8039

CANCELLATION & REINSTATEMENT PROCESS

1. All payments must be received by the specified due date. If they are not received by that date, your insurance will be cancelled on the first of the coverage month that has not been paid for. A person who is cancelled for nonpayment of premium may not be able to enroll with the same health insurance carrier for one year.
2. If you choose to cancel your policy, we must receive your written cancellation request prior to the actual cancellation date.
3. All reinstatements are subject to the carrier's approval. Reinstatement payments may be required to be in the form of "guaranteed funds" i.e.: money order, bank check, cashier's check, etc. If a reinstatement is approved a reinstatement fee may apply.
4. Some insurance carriers do not allow reinstatements at any time.

USFSB DUES POLICY

1. Initial Membership Dues are refundable within 90 days of the effective date of the Membership, if you are not satisfied with your Membership, unless you wish to maintain any USFSB sponsored insurance coverage.
2. All payments of renewal Membership Dues are non-refundable.
3. You must be a dues paying member or a member of a dues paying organization to obtain and maintain any USFSB sponsored insurance coverage and/or maintain the privileges of Premium Membership.

USFSB REFUND POLICY

If you are sent a refund check, the following rules apply:

1. One time only, at your request and for good cause, we will send a reissued check upon receipt of the original check and if, for any reason, you cannot return the original check, a stop payment fee will be deducted from the amount of the reissued check.
2. If any refund check is not cashed or negotiated within six months of the date it was mailed to you, payment will be stopped, the refund will be deemed abandoned by you and no further checks will be issued.



USFSB MEMBERSHIP APPLICATION



Date _____

Company Name _____

Company Street Address _____

Mailing Address (if different) _____

City, ST _____ Zip _____

Telephone(_____) _____ Fax(_____) _____ Your Web Site _____

Owner/Principal Ms. Mr. Mrs. _____

Title of Owner/Principal _____ E-mail _____

Type of Business/Trade _____ No. of Employees _____
(including yourself)

Annual Membership Fee..... \$ 100.00

The annual membership fee will be reduced to \$60.00 if you enroll in any of USFSB's sponsored health or dental insurance, with an effective date within two months of your initial membership. Thereafter, on your membership renewal date, if you are enrolled in any of USFSB's sponsored health or dental insurance your annual membership fee will be \$60.00. If not, it will be \$100.00.

Your Premium Membership gives you the opportunity to save money!

Please visit our website, www.usfsb.com and view the many products and services available to

Premium Members including:

- Heartland Payment Systems (payroll services)
- Heartland Payment Systems (credit card services)
- LOW COST Health Insurance
- Office Products & Supplies Discounts
- International Health Insurance
- Movie Tickets & Resort Discounts
- Discount Prescription Card
- Member-To-Member Discount Program
- Free Web Pages (up to five pages)
- FedEx Shipping Discounts
- Sprint/Nextel Wireless Discounts
- McAfee Security (anti-virus software)
- LOW COST Dental Insurance
- Freightquote.com (discount freight shipping)
- Travel & Car Rental Program
- Collection Services Discounts
- LOW COST Vision Insurance
- USFSB Direct Marketing
- HighBeam Research
- FedEx Kinkos (printing service)

We are confident that you will find your Premium Membership in USFSB to be a valuable asset

JOIN TODAY on our web site: www.usfsb.com

Payment Information MasterCard VISA

Account# _____

Expiration Date (Mo/Yr) _____ / _____

Signature _____

USFSB BROKER NUMBER (IF ANY): _____

Enrollment Information

By Phone: Call 1-800-637-3331 MasterCard and VISA accepted.

By Fax: Fax 1-518-370-4129 or 1-888-568-3823 Complete the Membership Application above, including the credit card information.

By Mail: Complete the Membership Application above and mail your personal or company check to:

USFSB Inc., Attn: Membership Department, 249 Green Street, Schenectady, NY 12305

Office Hours: 9a.m.-5p.m. EST

• USFSB Use - Received: _____

• USFSB Use - Company No.: _____

Payment must accompany application. Membership dues are deductible as an ordinary business expense. If within 90 days of your initial application you are not completely satisfied with your membership, USFSB will refund the membership dues in full. You must be a dues paying member to obtain and maintain any of USFSB's sponsored insurance.