



# 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)

INTERNAL USE ONLY  
CONTROL NUMBER

I. SUBSCRIBER INFORMATION										
LAST NAME		FIRST NAME			M.I.	TELEPHONE NUMBERS <b>HOME</b>		<b>WORK</b>		<b>FAX</b>
HOME ADDRESS (Include Apartment Number)					<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>MARITAL STATUS</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____			
CITY	STATE		ZIP CODE		<b>EMPLOYMENT STATUS</b> <input type="checkbox"/> Employed <input type="checkbox"/> Not-Employed <input type="checkbox"/> Retired <input type="checkbox"/> COBRA			<b>PRIMARY LANGUAGE SPOKEN</b>		

II. ENROLLMENT INFORMATION												
NAME			DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY NUMBER	SEX	RELATION- SHIP	MAILING ADDRESS (If different from above)	EMAIL ADDRESS	FULL TIME STUDENT (✓)	ADD (✓)	DELETE (✓)	RACE/ETHNICITY (CODES BELOW)
LAST SUBSCRIBER	FIRST	M.I.				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 OTHER INSURANCE CARRIER			TYPE OF CONTRACT <input type="checkbox"/> Group <input type="checkbox"/> Individual		NAME OF POLICY HOLDER		LAST NAME		FIRST NAME	M.I.
CARRIER'S ADDRESS			CITY	STATE	ZIP CODE	POLICY 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 <input type="checkbox"/> NO GO TO SECTION VI								
	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
HOSPITAL								
MEDICAL								

V. EMPLOYER INFORMATION									
GHI CERTIFICATE NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER			DATE OF HIRE		EMPLOYEE WAITING PERIOD <input type="checkbox"/> YES NUMBER OF WAITING PERIOD DAYS _____ <input type="checkbox"/> NOT APPLICABLE NUMBER OF ACTIVE EMPLOYEES IN YOUR GROUP _____				
<b>Check one:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination									
<b>STATUS CHANGE:</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Reason for Change: _____									
<b>TRANSFER:</b> <input type="checkbox"/> To Another Carrier <input type="checkbox"/> GHI Group # Change: From _____ To _____ Is applicant currently working at least 20 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No									

VI. SUBSCRIBER AUTHORIZATION				GROUP 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 concerning 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, shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.							
Subscriber Signature _____				Authorized Signature _____			
Date _____				Date _____ Phone Number _____			

VII. GROUP NAME AND ADDRESS			EFFECTIVE DATE OF TRANSACTION	GHI GROUP NUMBER
			MEDICAL	MEDICAL
			HOSPITAL	HOSPITAL
			DENTAL	DENTAL

**RACE/ETHNICITY CODES:** (Optional) A = ASIAN I = NATIVE AMERICAN OR ALASKAN NATIVE B = BLACK OR AFRICAN AMERICAN P = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER C = CAUCASIAN O = OTHER H = HISPANIC OR LATINO **SEE INFORMATION/EXPLANATION ON REVERSE SIDE**

## IMPORTANT INFORMATION

- 1- The subscriber must complete sections I through IV. The group plan administrator must complete section V. Both the subscriber and the administrator must complete section VI.
- 2- All effective dates of transactions may not exceed thirty (30) days retroactive from the next billing date.
- 3- For group accounts with student dependent coverage: A full-time dependent student is a person who meets all of the following 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. The student must be listed as a dependent when you enroll for coverage.  
To enroll the dependent as a full-time student, attach a complete Student Dependent Certification Form or attach a copy of the most recent Bursar's receipt. See your group plan administrator for a Dependent Student Certification Form.
- 4- Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, etc.) will delay the processing of the transaction.
- 5- Failure to have the proper signatures and authorization will require GHI to return this transaction form to the employer group administrator.

### Why We Ask You for Race/Ethnicity Information

National studies show that differences in access to health care occur along ethnic lines. In our effort to ensure that everyone we serve receives appropriate care, GHI, along with other health insurers, is collecting data on ethnicity with the goal of improving access to care and outcomes for groups who often have poorer results. Information will only be used by our Medical Department to improve access to needed care and will not be available to any other staff. Answering this question is voluntary.

### GHI Web Site

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit GHI's secure Web site at [www.ghi.com](http://www.ghi.com). Available around the clock, on the site you can also find provider listings, order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

### Translation Services

If English is not your primary language and translation services are needed when calling GHI Customer Service, a representative can help you.

## **USFSB 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, received an acknowledgement letter from USFSB verifying that their application has been sent to the appropriate carrier 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. USFSB continues to make every effort to keep up with the rules, regulations, terms of coverage, availability and guidelines that the insurance carriers determine; however, USFSB cannot guarantee that the website has been updated to reflect the current rules, regulations, terms of coverage, availability and guidelines.
- C. Rates change periodically depending on the carrier, open enrollment for the carrier and the type of available insurance products. USFSB continues 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. There will be situations where insurance products will have the same coverage or benefits but different rates solely due to multiple tier structures (for example. GHI HMO in NY). In addition, not every product found in a statewide search will be available in every county.

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.



**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**

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**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 Insurance Checklist**

1. USFSB Membership Application with \$60 dues payable to USFSB.
2. Signed Notice of Election form for each employee enrolling in the plan (Original signature of each employee)
3. Proof of business – listed on the USFSB Guidelines
4. 1<sup>st</sup> month's premium made payable to USFSB
5. Applications need to be submitted by the date indicated on the bottom summary of benefit page.

All the above are to be sent to:   USFSB  
  249 Green Street  
  Schenectady, NY 12305

- The 1<sup>st</sup> month's premium and yearly dues can be in one check
- Dues only can be paid by credit card.



# 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](http://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](http://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.