

 **To speed enrollment process,
please be thorough and fill out all sections that apply.**

Groups with 2 to 50 employees

Enrollment Application/Change/Cancellation Request for Medical Coverage

To speed enrollment process, please be thorough and fill out all sections that apply.

- Enroll Address Change
 Cancel Name Change
 Change Date of Change ___/___/___

A. Employee Information

First Name	M.I.	Last Name	Social Security #/Employee ID #		
Street Address	Apt. #	City	County	State	Zip Country
Home Phone	Work Phone	How many hours do you work per week?		E-mail Address <input type="checkbox"/> Home <input type="checkbox"/> Work	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Physician*		Physician's ID No. Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

B. Family Information

Dependents to be enrolled, cancelled, changed: (Attach sheet if necessary)

Check appropriate box	Last Name	First Name	M.I.	Sex	Birthdate	Relationship**	Full-Time Student	Physician*	Are you a Current Patient?
	Dependent Social Security No.							Physician's ID Number	
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# -	M F				<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# -	M F				<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	SS# -	M F				<input type="checkbox"/> Yes <input type="checkbox"/> No School Name:		<input type="checkbox"/> YES <input type="checkbox"/> NO	

IMPORTANT:** Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care), for yourself and each of your covered dependents for UnitedHealthcare Select and Select Plus only. *For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.**

C. Product Selection (check all that apply)

MEDICAL BENEFITS: <input type="checkbox"/> Employee Only Coverage <input type="checkbox"/> Employee/Spouse Coverage <input type="checkbox"/> Employee/Children Coverage <input type="checkbox"/> Employee/Spouse/Children Coverage <input type="checkbox"/> No Medical Coverage (complete Section E)	DENTAL BENEFITS: <input type="checkbox"/> Employee Only Coverage <input type="checkbox"/> Employee/Spouse Coverage <input type="checkbox"/> Employee/Children Coverage <input type="checkbox"/> Employee/Spouse/Children Coverage <input type="checkbox"/> No Dental Coverage	<input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my spouse <input type="checkbox"/> I decline coverage for my children Reason: <input type="checkbox"/> Covered under another plan <input type="checkbox"/> Other: _____
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OVERTURE PLAN DESIGN (Check one selection if your employer has offered an Overture Package.)

- UnitedHealthcare Overture Classic
 UnitedHealthcare Overture Performance
 UnitedHealthcare Overture Premier

D. To Be Completed By Employer

Company Name	Group #	Plan Variation	Medical _____ Dental _____	Report Code	Date of Employment
<input type="checkbox"/> New Enrollment/Additions: (Check one) Date of Hire ___/___/___ Requested Date of Coverage ___/___/___ (attach COBRA Election Form) <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change (PT to FT) <input type="checkbox"/> Return from Leave/Layoff <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption (attach legal documentation) <input type="checkbox"/> Court ordered dependent (attach documentation) <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> COBRA/Continuation start date _____ stop date _____ <input type="checkbox"/> Annual Open Enrollment Requested Effective Date of Enrollment ___/___/___			<input type="checkbox"/> Cancellations: Last Date of Employment ___/___/___ Requested Effective Date of Cancellation ___/___/___ <input type="checkbox"/> Cancel all coverage <input type="checkbox"/> Cancel listed above – Section B Reason: (check one) <input type="checkbox"/> Death <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Divorce <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Dependent reached student/dependent max age <input type="checkbox"/> Other (describe) _____		

Product Selections – Check all that apply

<input type="checkbox"/> Union	<input type="checkbox"/> Non-union	<input type="checkbox"/> Salaried	<input type="checkbox"/> Hourly	<input type="checkbox"/> Active	<input type="checkbox"/> Retired/Date _____
<input type="checkbox"/> UnitedHealthcare Choice Plus <input type="checkbox"/> UnitedHealthcare Managed Indemnity <input type="checkbox"/> UnitedHealthcare Select Plus HMO <input type="checkbox"/> Individual Policy Healthy New York <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Small Business Employee	<input type="checkbox"/> UnitedHealthcare Select HMO <input type="checkbox"/> UnitedHealthcare Options PPO <input type="checkbox"/> UnitedHealthcare Options PPO 80/80 <input type="checkbox"/> UnitedHealthcare Overture Package _____ (A-S)	DENTAL PLANS <input type="checkbox"/> UnitedHealthcare Dental Managed Indemnity <input type="checkbox"/> UnitedHealthcare Dental Options PPO			

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm employee completed the appropriate information. 2) Complete section D. 3) Please provide your signature and today's date.

Signature _____	Date _____	Grp/Subgrp/Bnft Grp
Employer Position _____		Plan Variation
Phone Number _____		Reporting Code/Branch

E. Other Medical Coverage Information / Waiver**(This section must be completed)**

Applicant Name _____

Have you or your dependents had any other medical coverage in the last 12 months? YES NO Will this coverage be terminated? YES NO

Insurance Company Name (use extra paper if needed)	Coverage Start Date	Coverage Stop Date	If Yes, Date
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Coverage type: Group Policy Individual Policy Medicare/Medicaid Other _____

Is this coverage through your spouse's employer? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide employer's name	Name, date of birth and Social Security # of policy holder
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Employee's relationship to policyholder	Names of family members with other continuing medical coverage (Including Medicare)
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Medicare effective date Parts A&B	Reason for Medicare eligibility: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease	Medicare Claim #
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WAIVER I decline to enroll for this coverage for myself, my spouse, and my dependent children due to:
 Existence of other health coverage Spousal coverage Other Reason (Explain) _____
Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption. I have read and understand the "Important Information" located on the back of this form.

X Employee Signature _____ Date Signed _____
 (only sign if you are waiving coverage)

F. Medical Research Studies / Additional Products & Services

- Please do not send me information regarding medical research studies.
- Please do not send me information regarding additional products and/or services.

Signature (Form must be signed)

I confirm that the information I have provided on this form is complete and accurate.
 I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.
 I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.
 I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

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.

Date _____ Employee Signature _____ Spouse Signature _____
 (if possible) and applicable

NEW YORK INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN NEW YORK TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials do not answer your questions. Further information is available at 1-800-705-1691.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your physician's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your physician about these arrangements.
7. We encourage physicians to talk with you about medical care you or your physician think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage.

I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents, I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person names in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Medical Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Medical Coverage and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

Group Medical Insurance provided by or through:
UnitedHealthcare of New York, Inc.
UnitedHealthcare of Upstate New York, Inc.
United HealthCare Insurance Company of New York

Small Group Employer Application



To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Complete the Coverage and Benefit Options page(s) and attach to the application (if applicable).
4. Submit the most recent billing statement listing those currently insured and current status.
5. Submit most recent wage and tax statement.
6. Include a deposit check for the first month's premium.

Plan Design _____
Copayment _____
Coinsurance _____
Annual Deductible _____
Rx Option _____

- UnitedHealthcare Choice Plus
 - UnitedHealthcare Select HMO
 - UnitedHealthcare Managed Indemnity
 - UnitedHealthcare Options PPO
 - UnitedHealthcare Select Plus HMO
 - UnitedHealthcare Options PPO 80/80
 - [UnitedHealthcare Overture Yes No Overture Package _____ (A-S)]
 - Healthy New York
- UnitedHealthcare Dental Benefits
- Dental Managed Indemnity Yes No
 - Dental Options PPO Yes No

General Information

Requested Effective Date _____

Group Name _____

Address _____ Tax ID _____

City _____ State _____ Zip Code _____ County _____

Contact Person _____ Telephone (____) _____ Fax (____) _____

Billing Address (if different) _____ Email Address _____

Multi-location group? # of Locations _____ Address (please list locations on additional sheet)
 Yes No

Years in Business/Date _____ Nature of Business _____ Industry Code/SIC Code _____

Type of Organization C-Corporation Limited Liability Company Nonprofit Organization S-Corporation Independent Contractor Other _____ List names of eligible employees/dependents currently on COBRA/Continuation _____ See attached list

Total # Employees	# Full Time Employees	# Part Time Employees	# Applying (Please include those employees in their waiting period)	# Waiving	# Hours/week to be considered Eligible (Minimum 20-NY, 30-NJ)
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# Termed in 12 months	Wait Period for New Hires <input type="checkbox"/> First of the policy month following _____ (0-180) days of employment <input type="checkbox"/> Effective _____ (0-180) days after the date of hire	Waiting Period Waived at Initial/Open Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Employees outside service area
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Name of Current Medical Carrier _____ # Yrs Covered _____ Name of Current Dental Carrier _____ # Yrs Covered _____

Employer Contribution – Single _____ % Medical Family _____ %	Employer Contribution – Single _____ % Dental Family _____ %	Classes Excluded <input type="checkbox"/> Union/Non Union <input type="checkbox"/> Other _____
------------------------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------------------------------------

Worker's Comp Carrier _____ List Owners/Partners not covered by WC _____ Amount of deposit check _____

Yes No In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

Yes No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity be placed voluntarily into bankruptcy?

COBRA Continuation State Continuation Under federal law if your group had 20 or more employees on at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had less than 20 employees, you must provide State Continuation.

Medicare Primary Health Plan Primary Under federal law if your group had 20 or more employees on at least 50% of the employer's working days in the preceding calendar year, health plan benefits would be primary. If your group had less than 20 employees, Medicare benefits would be primary.

Yes No Are you a member of a "controlled group of corporations" as that term is defined by United States Code section 414(b) (Internal Revenue Code)? If yes, please give the legal names of all other corporations within the control group and the number of employees employed by each.

Broker Information

Broker Name	Agency	Agent Code	Tax ID Number
Signature	Email Address	Social Security #	Date
Rep Name	Rep #		

The Company certifies that the information provided above is complete and accurate. Company shall notify the Insurer promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, Company shall notify Insurer promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. Insurer shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under this Policy.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the health benefit plan(s) indicated on this Application may be transmitted electronically to me and to the Company's employees.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependent who have elected continuation of insurance benefits. I understand that material omissions misrepresentations or misstatements in the information requested on this form can result in the voiding or reformation of insurance.

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.

Signature (Form must be signed)

Signature _____ Date _____ Title _____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Scheduled Direct Debit Authorization Form

Enrollment Instructions

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.

STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Debit, I agree to and/or understand all of the following on behalf of my group:

It may take up to one month to establish this process. If a customer is overdue on a prior bill, a delinquency letter will be sent to the customer, and must be paid to ensure the account is not cancelled prior to the process being set up.

I authorize UnitedHealthcare to debit my group's checking or savings account for all monthly charges for coverage.

I ensure sufficient funds are in my group's checking or savings account to cover my premium invoice.

If the necessary funds are not on deposit in the account at the beginning of the month, my group's coverage may be subject to termination under the terms stated in the contract with UnitedHealthcare. Also, my group may be subject to additional fees incurred by UnitedHealthcare subsequent to the termination date as a result of insufficient funds.

I will promptly notify UnitedHealthcare of any change to my group's checking or savings account. If a change occurs it is my responsibility to provide UnitedHealthcare with the current information.

AUTHORIZATION

I hereby authorize UnitedHealthcare to initiate debits (payments) to the financial institution indicated below for the purpose of paying my group's monthly bill. This financial institution is authorized to debit my account. This authority is to remain in full force and effect until either my group revokes it by giving 30 days prior written notice to UnitedHealthcare; it is cancelled by UnitedHealthcare under the conditions stated above, or upon termination of my group's coverage with UnitedHealthcare. I have also read and, on behalf of my group, agree to the terms and conditions outlined above.

Authorized Signature

Date

Employer Name/Customer Name/Policy Name

Employer Email Address

Customer Number and Bill Group(s)

Name of Your Financial Institution and Location State

Phone Number of Financial Institution

Transit / American Bankers Association #

Number can be found in lower left corner of your check

Account Number to Debit

Debits to your account will be made on the beginning of each month

Employer eServices

Becoming a UnitedHealthcare customer has its privileges!

As a UnitedHealthcare customer, the group contact listed on the Employer Group Application will automatically be enrolled in Employer eServices and emailed a User ID and Password. The Employer eServices Web site provides easy access to benefit administration, with 24 hour convenience to make benefit management simpler, easier and better!

With Employer eServices, you have real-time administration to:

- Verify eligibility
- Review enrollment information
- Add employees and dependents
- Change eligibility
- Reinstate employees
- Terminate employees
- Request employee ID cards
- Select or Change Primary Care Physician (as required by plan)
- Delegate benefits administration work to additional staff

Once you receive your User ID and Password, simply go to www.employereservices.com.

We believe in putting the power of information into the hands of our customers!

Verification Form

New York State Small Groups



UnitedHealthcare of New York, Inc.
United HealthCare Insurance Company of New York

Company Name: _____ (“Company”)

Address: _____

Company acknowledges that in accordance with New York Insurance Law, Section 3231, and New York Insurance Regulations, Part 360, it is is not a Small Group. Part of the definition of a Small Group in New York Insurance Law, Section 3231, is that a Small Group includes between two and fifty employees or members of the group exclusive of spouses and dependents. Employees working more than twenty hours per week must qualify as eligible employees.

Company acknowledges that any omissions, misrepresentations or misstatements concerning this matter may result in termination of group coverage or other penalties.

Signature of Authorized Representative of Company

Date

Please Print Name

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.

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.

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. Two checks
 - One check made payable to USFSB in the amount of \$60 for annual dues along with a USFSB Membership Application
 - One check made payable to Aetna in the amount of one month premium
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 – listed on the USFSB Guidelines
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:

USFSB
249 Green Street
Schenectady, New York 12305

