Independent Health

NEW EMPLOYER GROUP APPLICATION

ACCOUNT / BILLING DEMOGRAPHICS

Account Name _____

DBA and/or Affiliated Company (if applicable) _____

Employer 9-digit Tax Identification Number (TIN)_____ Effective Date of Coverage _____

Account Address _____

Account Phone # _____ Account Fax # _____

Benefits Manager _____ Benefits Manager Phone # _____

Benefits Manager Email Address _____

Billing Contact _____ Billing Contact Phone # _____

Billing Contact Email Address _____

Billing Address (if different) _____

ACCOUNT SIZE VERIFICATION

Please check the box indicating your group size based on the definitions below and provide your company's total # of full-time equivalent (FTE) employees.

☐ Account Size Is **Large** (Total FTE employees is **greater than 100 over the previous calendar year**)
Total # of FTE employees: _____

☐ Account Size Is **Small** (Total FTE employees is **between 1-100 over the previous calendar year**)
Total # of FTE employees: _____

Note: Upon your upcoming effective date, you must have at least one common law employee who is not the sole owner of the business or the spouse of the sole owner of the business. For more information please visit: https://www.irs.gov/businesses/small-businesses-self-employed/employee-common-law-employee

For more information about calculating group size, visit: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

Total Number of Employees: _____ (over the previous calendar year)

Required by CMS for Medicare Secondary Payer reporting. More information can be found here - https://www.cms.gov/medicare/coordination-benefits-recovery/mandatory-insurer-reporting-group-health-plans

BROKER INFORMATION

Do you utilize a Broker for Health Insurance? ☐ Yes ☐ No If yes, please provide:

Broker Firm _____ Broker Contact _____

Application Continued on Next Page

ADDITIONAL ACCOUNT INFORMATION

Employer New Hire Policy *(please check one)*:

☐ On Date of Hire (DOH) ☐ 90 days following DOH

First of the month following: ☐ Hire Date ☐ 30 days ☐ 60 days ☐ Other: _____

Previous Carrier(s): _____

Will you be offering other carriers in addition to Independent Health?

☐ No ☐ Yes If yes, please specify: _____

Sub-Accounts

Classification(s) of employees offered coverage: Attach an additional document if more space is needed
(Examples – hourly/salary; part-time/full-time):

_____

_____

☐ Please check here if your business is not subject to ERISA

For more information about ERISA, visit: https://www.dol.gov/general/topic/health-plans/erisa

Make-Available Riders

Please confirm by checking the box next to each rider that you have selected or declined to offer the rider as part of your Independent Health offering(s).

1. Young Adult Dependent coverage to age 30 ☐ Selected ☐ Declined
2. Unlimited Skilled Nursing Facility coverage (SNF) ☐ Selected ☐ Declined
   (Applicable only when plan does not already include unlimited SNF)
3. Domestic Partner ☐ Selected ☐ Declined

Required Tax Documentation ***(For small group only; to be returned with this form)***

a. Most recent NYS-45.
b. Corporation – most recent K-1 to Form 1120S or Schedule F; or Form 1120, followed by a NYS-45-ATT-MN upon receipt.
c. Partnerships – most recent 1065K-1 for each partner.
d. New Business – SS4 (application for employer identification number) along with articles or certification of incorporation and a copy of the payroll listing or W4 for each employee. New partnerships may submit a Partnership Agreement and a W4 for each employee.
e. New employees not yet showing on NYS-45 – W4 form and/or a copy of their payroll check stub.
f. Tax exempt entities – payroll records or W4 with a letter from company's accountant listing all employees.
g. Any other documentation necessary to show that a "common law" employer-employee relationship exists.

This form cannot be processed if not completed in its entirety. I understand that Independent Health will conduct an annual audit to ensure compliance with enrollment guidelines, which may require us to provide verification of our being a bona fide employer.

I understand that Independent Health reserves the right to request additional information prior to approving this form. This form is only an application and does not guarantee coverage. Insurance is not provided until an Agreement has been executed by the Employer and by Independent Health Benefits Corporation.

I certify that all the information furnished on this form is current, true and complete to the best of my knowledge and I have read and agreed to this statement. I understand that 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.

Account Administrator's Signature: _____

Account Administrator's Name: _____ Date: _____

New Sales Fax: (716) 631-8554 **OR** Email to: SalesAdministration@Independenthealth.com