



Employer Notice of Election

HealthPass
4409 Parkbreeze Court
Orlando, FL 32808-1021
Fax (888) 354-7277

I. Company Information

Full Name of Company _____

Street Address (P.O. Box not acceptable) _____ County or Borough: _____

City/State/Zip _____ Federal Tax I.D. Number _____ Year Company Founded _____

Contact Person _____ E-Mail Address _____

Business Phone _____ Ext. _____ Fax _____

Billing Address (if different) _____ City/State/Zip _____

Do you currently offer group health insurance? Yes No If yes, name of current insurance co. _____

Employer Industry: Health High Tech Legal Mfg. Retail Service Tourism Other

II. Eligibility Requirements

Desired Effective Date _____ (Must be 1st or 15th of the month)

To be eligible for coverage employees must work _____ hours per week. (Must be between 20 and 40 hours and must be uniformly applied to all employees.)

What is your waiting period before employees become eligible for coverage? 0 days 30 days 60 days 90 days

Total Number of Employees (full and part-time) _____ Number of Eligible Employees _____ (Must attach NYS-45 or applicable tax form from most recent quarter.)

Number of Enrollments with HealthPass _____ Number of employees who have other health coverage _____ (Must attach copy of group bill for employees covered under another employer-sponsored plan.)

Number of employees covered by collective bargaining agreement _____

What dollar amount are you contributing toward employee-only premium? _____ What dollar amount are you contributing toward dependent coverage? _____

Are any former employees covered under COBRA/state continuation? Yes No If so, how many? _____

III. Benefit Options

Medical, Dental and EverGuard

Select a tier structure which will apply to both medical and dental coverage.

Two Tier (Employee Only, Family) Four Tier (Employee Only, Employee and Spouse, Employee and Child(ren), Family)

Select a pharmacy option (will be included in each employee's coverage.)

\$5 generic, \$15 preferred brand, \$35 brand \$10/\$20/\$40 with \$50 deductible and \$2000 calendar year cap
 \$10 generic, \$20 preferred brand, \$40 brand No pharmacy benefit

Would you like to offer dental coverage? (If you enroll in medical coverage on the 15th of the month, you may enroll in dental on the subsequent 1st of the month.)

I want to offer dental. I do not want to offer dental.

Would you like to offer EverGuard coverage? (If you enroll in medical coverage on the 15th of the month, you may enroll in EverGuard on the subsequent 1st of the month.)

I want to offer EverGuard. I do not want to offer EverGuard.

IV. Payment Method

A business check for the full premium due must accompany this application. If a 15th of the month is requested, you must include payment for 1 1/2 months premium. Applications submitted with less than the full premium amount due or with personal checks will not be processed.

After the first payment, how do you prefer to pay for your coverage? Please bill me monthly. Please electronically transfer funds (EFT) for monthly payment.

I understand EFT is not available until the banking connection has been approved and may take 60 days to initiate. I will pay by check until I receive verification of EFT on my monthly bill. _____ (Please initial.)

I hereby authorize HealthPass to initiate electronic funds transfer (EFT) from my account for the payment of my monthly cost of coverage. I understand the debit transaction will occur within four working days of the payment due date as specified on the HealthPass billing statement. In the event that I make changes to my banking arrangements, I understand that I must notify Health Pass to effect the changes for payment collection. All changes must be reported 20 days prior to the effective date of the change.

Bank Name _____ Address _____

Phone Number _____ Please deduct funds from my checking account savings account

Bank Account Number _____ Please attach a voided check or deposit slip.

V. Broker Information

To be completed by selling broker before notice is signed by employer.

General Agent (if applicable) _____ HealthPass GA I.D. _____

Selling Broker _____ HealthPass Broker I.D. _____

Pay Commissions To: _____ SSN or Tax ID # _____

VI. Employer Authorization

IN WITNESS hereof, the Employer, by its duly authorized officer, certifies the Employer meets the eligibility requirements and has executed the Trust Participation Agreement under the terms set forth on the reverse side of this form.

By _____ Print Name _____

Title _____ Date _____

HealthPass Use Only: Accepted by _____ Effective Date Assigned _____

VII. Employer Certification

Please read and consider each point carefully, assuring that you are in compliance before signing the authorization on the front of the form.

I attest that:

- I have at least 2 eligible employees as defined in state law at initial enrollment.
- I have a bona fide business street address in one of the five boroughs of New York City, Westchester, Rockland, Orange, Nassau or Suffolk counties.
- All employees who work on a full-time, regular basis with a normal work week of at least 20 hours per week have been offered coverage. I understand I may define a higher minimum hours worked for eligibility between 20 and 40 hours per week as long as the eligibility criteria is applied uniformly among all the employees.
- I have not used age, sex, health status or occupation to determine employee eligibility. Temporary or seasonal employees, consultants, and independent contractors are not considered eligible employees.
- At least 75% of my eligible employees have insurance, either through my small business, through a spouse's group plan, Medicare or Medicaid. All employees waiving coverage have filled out the appropriate sections on the Enrollment/Change form. If more than 10% of my employees live outside the tri-state service area, I understand those employees are not eligible for coverage through HealthPass. However, those employees will not be counted toward participation requirements.
- I understand there is no minimum employer contribution requirement for medical or dental. However, if I make a contribution, it must be consistent for all employees. If I contribute 100% of the employee-only premium, participation of eligible employees must be 100%. If I pay 100% of employee and dependent premium, then all dependents must also be covered.
- I understand that if I select a 15th of the month effective date for the group, the rates will be guaranteed for 11 1/2 months during the initial coverage year and renewal will occur on the first of the month each subsequent year.

"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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

HEALTHPASS® INSURANCE TRUST TRUST PARTICIPATION AGREEMENT

The undersigned employer, in order to establish a plan or plans of Group Health Insurance for its employees and their dependents, hereby requests participation in the New York Health Purchasing Alliance, Inc. HealthPass Insurance Trust (the "Trust") which provides health insurance benefits under Group Contracts issued by several health insurers and health maintenance organizations to the Trustee of the HealthPass Insurance Trust.

If the undersigned employer's participation is approved by the Trustee or the Administrator appointed by the Trustee (the "Administrator"), said employer shall become Participating employer (as defined in Trust Agreement) as of the effective date endorsed hereon by the Trustee or the Administrator. The undersigned employer understands and acknowledges that even if it is approved as Participating Employer in the HealthPass Insurance Trust, its employees and their dependents are not automatically insured, but must each satisfy any eligibility requirements of the Trust and of the applicable Group Contract. The employer agrees to make the coverage under Group Contracts available to all of its present and future eligible employees. The undersigned employer hereby agrees:

- A. To be bound by all the terms of the Trust Agreement and of the Group Contract(s) (as each are from time to time amended), copies of which are available from the Trust or the Administrator upon request.
- B. To furnish any information requested by the Trustee, Administrator or any of the Insurers or Health Maintenance Organizations which is reasonably required for the proper administration of the Trust or of the Group Contract.
- C. To distribute to its eligible employees any materials provided by or on behalf of the Trustee, Administrator, Health Insurer or Health Maintenance Organization describing Trust or the Group Contract.
- D. That it has no right, title or interest in or to the Trust Fund created under Trust.
- E. Coverage under any Contract through the Trust shall only apply to the extent provided in the Group Contract held by Trustee, and all claims for and benefits provided will be made payable to the insurance company or HMO issuing the Group Contract.
- F. The Trustee does not have any obligation under any of the Group Contracts.

The Participating Employer may withdraw from the Trust and cancel coverages provided under Group Contract on the first day of any month following thirty (30) days prior written notice to the Trustee or the Administrator. Failure to remit premium when due shall automatically constitute such withdrawal and cancellation of all coverage as of the date to which premiums were paid.