

Instructions for Completing GHI Group Health Application

1. Complete details of application.
2. Fill out one Transaction Form (page 8) for each employee participating in the plan. An employer who is taking coverage will also complete this form. Make additional copies of Transaction Form for multiple employees.
3. Submit company tax documentation. Provide a signed copy of one of the following **accepted tax documents**:
 - a. 1120, 1120S including K-1's, 1065 w/ Schedule K-1
 - b. NYS-45
 - c. CT-4s New York State Corporation Franchise Tax Form
 - d. 1040 with Schedule C
 - e. For new employees, W-4 or proof of employment along with completed Transaction Form (p.8).
 - f. For sole proprietors, Schedule SE- Self-Employment Tax Form.
4. For companies with newly hired employees, have Letter of Certification Form (p.10) completed by an accountant. This form will verify that a new employee is working full-time for the company and has not been included on the latest company tax return. This form may also be used for a new company that has yet to file a tax return.
5. The Dependent Student Certification Form (last page of application) should be filed only if an applicant has a full-time dependent student age 19 or older.
6. Provide copy of last paid invoice from present or previous health insurance company.
7. For companies domiciled outside of New York State with 2-50 employees with New York residences, include an office address within New York State for delivery of insurance contract. Employees receiving 1099's are not eligible for this coverage.
8. Include first month's premium written on a company business check made out to: **GHI**

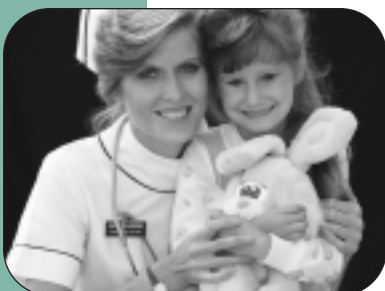
Mailing Address:

**Life and Health Quote Corp.
GHI Group Health Insurance Plan
328 Hillside Ave.
Williston Park, N.Y. 11596**



SMALL EMPLOYER GROUP

Group Application



Group Administration
441 Ninth Avenue
Second Floor
New York, NY 10001-1681

GHI HMO
25 Barbarosa Lane
Kingston, NY 12401-0118

www.ghi.com

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 _____

SECTION II BILLING

Premium invoices should be sent to: _____ Telephone No. _____ E-Mail Address _____
() _____

Address _____

Contact Person (if different than above) _____ Telephone No. _____ E-Mail Address _____
() _____

SECTION III GROUP ADMINISTRATION

A. Number of Eligible Employees _____
(Employees working at least 20 hrs a week)

B. Exclusion Class _____

C. Number of Employees Applying _____

D. Number of COBRA Participants _____

Indicate number of enrollees by type:

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

Was your Group Policy Terminated for Non-Payment in the last 12 months? Yes No

Pre-Existing Condition Limitation: Yes No 11 Month exclusion applies to late entrants only. Yes No

Other group health or HMO coverage: Indicate below other group health coverage which is still in force or which terminated within the past year.

Please complete the information below for your existing policy.

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

SECTION IV PRODUCT SELECTION

Plan Name _____ Desired Effective Date _____

PPO EPO High Deductible Plan (HDP) DENTAL POS
 OTHER (Please specify) _____ PPO/HMO POS/HMO

Is this a replacement policy? Yes No Is this an option? Yes No

SECTION V ENROLLMENT POLICIES CLASS: _____

<p>EMPLOYER CONTRIBUTION</p> <p><input type="checkbox"/> Employee: _____ % or \$ _____</p> <p><input type="checkbox"/> Family: _____ % or \$ _____</p> <p><input type="checkbox"/> Other</p>	<p>NEW HIRE ELIGIBILITY POLICY</p> <p><input type="checkbox"/> Date of Hire</p> <p><input type="checkbox"/> First of the month following date of hire</p> <p>Plus: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> Other (please specify) _____</p> <p>Waived for Rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If rehired within _____ months</p> <p>Desired Effective Date: _____</p>	<p>TERMINATION POLICY</p> <p><input type="checkbox"/> Date Terminated _____</p> <p><input type="checkbox"/> End of Month _____</p> <p><input type="checkbox"/> Other _____</p>
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If more than one class will be covered, please complete Section (V-A) below

SECTION V-A ENROLLMENT POLICIES CLASS: _____

<p>EMPLOYER CONTRIBUTION</p> <p><input type="checkbox"/> Employee: _____ % or \$ _____</p> <p><input type="checkbox"/> Family: _____ % or \$ _____</p> <p><input type="checkbox"/> Other</p>	<p>NEW HIRE ELIGIBILITY POLICY</p> <p><input type="checkbox"/> Date of Hire</p> <p><input type="checkbox"/> First of the month following date of hire</p> <p>Plus: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> Other (please specify) _____</p> <p>Waived for Rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If rehired within _____ months</p> <p>Desired Effective Date: _____</p>	<p>TERMINATION POLICY</p> <p><input type="checkbox"/> Date Terminated _____</p> <p><input type="checkbox"/> End of Month _____</p> <p><input type="checkbox"/> Other _____</p>
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SECTION VI

The information provided in this application is true to the best of my knowledge. I hereby authorize any person, or other entity to release to GHI any information requested by GHI in connection with the processing of this application.

By signing this application, I certify under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business. I hereby authorize any person or other entity to release to GHI any information requested by GHI in connection with the processing of this application.

I understand that any person who knowingly and with the 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.

Print Name

Signature

Title

Date

Please check current employer status below to ensure proper reimbursement for your Medicare Eligible Active Employees (you must check one of the boxes below):

- 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.

SECTION VII

GHI Group No: _____ Marketing Rep: _____

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 _____

General Agency <input type="checkbox"/> To be Credentialed	
GA No. _____	Override: _____
Contact _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

Selling Agent <input type="checkbox"/> To be Credentialed	
SA No. _____	Commission: _____
Name/Agency Name _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

Selling Agent <input type="checkbox"/> To be Credentialed	
SA No. _____	Commission: _____
Name/Agency Name _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

Selling Agent <input type="checkbox"/> To be Credentialed	
SA No. _____	Commission: _____
Name/Agency Name _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

- | | | |
|--|------------------------------|-----------------------------|
| Deposit Check Attached | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Proof of Employment | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Last Paid Premium Invoice from Current Carrier | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| COBRA Letters of election | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Proof of Medicare eligibility, Part A and B | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |

Amount: \$ _____

GA Authorized Signature _____

Date _____



Group Administration
441 Ninth Avenue, Second Floor
New York, NY 10001

www.ghi.com

Group Name	Effective Date
Networks <input checked="" type="checkbox"/> Tri-State	

Rating Structure:

Sole Proprietor 2-Tier
 Groups of 2-50 2-Tier 4-Tier

EPO PLHEPO100A, PLHEPO100y

	Copay	Amb Surgery/Hospital	Skilled Nursing	ER Copay	RX Options Circle One
<input type="checkbox"/>	\$10	\$0	\$0	\$50	A B C E F
<input type="checkbox"/>	\$15	\$0	\$0	\$50	A B C E F
<input type="checkbox"/>	\$20	\$0	\$0	\$50	A B C E F
<input type="checkbox"/>	\$30	\$250/\$500	\$200 day / \$600max	\$100	A B C E F G
<input type="checkbox"/>	\$30	\$500/\$750	\$200 day / \$600max	\$100	A B C E F G
<input type="checkbox"/>	\$30	\$750/\$1000	\$200 day / \$600max	\$100	A B C E F G H

Optional rider for EPO plans above
 PLH 5329 Referred Amb

See below listing of Rx options available

EPO Share Plan PLHSGC995, PLHSGC994

	Copay	Deductible Ind/family	Coinsurance	Coins Max Ind/family	RX Options Circle One
<input type="checkbox"/>	\$25	\$500/\$1500	90%	\$500/\$1500	C E F G
<input type="checkbox"/>	\$25	\$1000/\$3000	90%	\$500/\$1500	C E F G
<input type="checkbox"/>	\$25	\$2000/\$6000	90%	\$500/\$1500	C E F G
<input type="checkbox"/>	\$30	\$500/\$1500	90%	\$500/\$1500	C E F G
<input type="checkbox"/>	\$30	\$1000/\$3000	90%	\$500/\$1500	C E F G
<input type="checkbox"/>	\$30	\$2000/\$6000	90%	\$500/\$1500	C E F G H
<input type="checkbox"/>	\$30	\$2000/\$6000	80%	\$3000/\$9000	C E F G H

See below listing of Rx options available

Prescription Drug Plan Options

	Retail Generic/Preferred/ Non Preferred	Deductible	Annual Max	Home Delivery Generic/Preferred/ Non Preferred	
Option A	\$5/\$20/\$35	\$0	none	\$10/\$40/\$70	<div style="border: 1px solid black; padding: 5px;"> PLH-500-077-A1 PLH-500-077-A2 PLH-500-077-A3 PLH-500-084-1 PLH-500-084-2 PLH-500-088 PLH-500-089 </div>
Option B	\$10/\$25/\$40	\$0	none	\$20/\$50/\$80	
Option C	\$10/\$25/\$40	\$0	none	\$20/\$50/\$80	
Option E	\$15/\$25/\$40	\$50	\$750/\$2250	\$30/\$50/\$80	
Option F	\$10/\$25/\$40	\$50	\$1000/\$3000	\$20/\$50/\$80	
Option G*	\$10/\$25/NC	\$50	none	\$20/\$50/NC	
Option H*	50%/50%/NC	\$100	none	50%/50%/NC	

*Options G and H utilize the Select Formulary, which is a closed formulary. G and H are not available for sole proprietors.
 NC = Not Covered> (Non-preferred brand drugs covered through GHI's discount program only)
 All plans include Home Delivery and Prior Authorization programs. Option C includes voluntary Home Delivery
 PLA 70 (contraceptive coverage) included with all RX riders unless PLA 71(excludes contraceptive coverage) is requested

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, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

IMPORTANT INFORMATION

- 1- The subscriber must complete section B through E. The group plan administrator must complete section A and G. Both the subscriber and the administrator must complete section F.
- 2- All effective dates of transactions may not exceed sixty (60) days retroactive from the next billing date.
- 3- 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 will delay the processing of the transaction (e.g. group number, reason for submission, certificate number, etc.)
- 5- Failure to have the proper signature and authorization will require GHI to return this transaction form.

LETTER of CERTIFICATION

Please check or respond where appropriate (type or print):

I am:

- A Certified Public Account (CPA), or
- An Attorney,

Name: _____

Firm Name: _____

Firm Address: _____

Telephone Number: _____

Professional License and/or Association Number(s): _____

This letter of attestation is being provided on behalf of the following business entity:

Group's Name: _____

Group's Address: _____

Group's Telephone Number: _____

Group Officer's Name (from whom you received the written documentation reviewed in connection with this letter of attestation): _____

The group has a New York situs, and is a:

- Sole Proprietorship, and the proprietor works a minimum of 20 hours per week
- Partnership
- Corporation
- Limited Liability Company (LLC)
- Trust
- Other Type of Business Entity (explain) _____

(Please attach copies of supporting documentation.)

- The following new employee _____ began working for this company on _____, and is working full-time (20 hours or more per week), and will be shown on future tax documents which can be reviewed at a later date.

- This group is a new business, which started on _____ and will be filing tax documents, which can be reviewed at a future date.

I hereby certify that the information I have stated above is true based upon my review of books, records or other written documentation provided to me by the group, and that the materials I have attached to this letter in support of this certification are copies of the true and accurate records of the group. I hereby make this certification to induce GHI to offer health insurance coverage to the group based upon the information contained in my certification. I understand that GHI will retain this letter and any attached materials without regard to the acceptance or non-acceptance of the group's application for coverage.

Signature: _____

Date: _____



DEPENDENT STUDENT CERTIFICATION FORM

Section One: To Be Completed by Subscriber

Subscriber's Certificate Number:

Subscriber's Name: (Last Name) (First Name) (MI)

Subscriber's Address: (Street)
 (City) (State) (Zip Code +4) -

Student's Name: (Last Name) (First Name) (MI)

Student's DOB: (Month) - (Day) - (Year) Student's Social Security No: - -

Name of School:

Address of School: (Street) (City) (State) (Zip Code)

Semester: Fall Winter Spring Summer (Month) - (Year) Year of Study (Circle One): 1st 2nd 3rd 4th 5+

Has student served in the Armed Forces: Yes No If Yes: From (Month) - (Day) - (Year)

DEFINITION OF DEPENDENT STUDENT: 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 secondary or preparatory school or college.

I certify that my dependent, _____ meets all of the following requirements for eligibility as a dependent student

	Yes	No
A. 19 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>
B. Unmarried	<input type="checkbox"/>	<input type="checkbox"/>
C. Receives at least half of his/her support from the employee or retired employee	<input type="checkbox"/>	<input type="checkbox"/>
D. Is a full-time student in an accredited secondary or preparatory school or college	<input type="checkbox"/>	<input type="checkbox"/>
D. Expected date of graduation _____/_____/_____		

I agree to advise GHI promptly of any changes in my child's dependent student status.

(Subscriber's Signature) _____/_____/_____
(Date)

Section Two: To be Completed by Authorized Person in the Registrar's Office of the Student's Educational Institution (Affix the institution's Seal or Stamp Where Indicated Below)

The student named in this form may be eligible for health/dental coverage under his or her parent's health/dental insurance plan. See Section One, above, for definition of dependent student. In order for GHI to determine a student's eligibility, please complete the following information:

- Is the student enrolled full-time? Yes No
- Student's program of study? _____
- Student's expected degree or diploma? _____
- Is _____ Accredited Yes No
(Name of Institution)
- Registrar's Telephone Number: _____

Affix Institution Seal/Stamp Here

Authorized Signature/Title

Mail Validated Form to: GHI
P.O. Box 2821
New York, NY 10116-2821

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.