

HIP SmartStart Health Insurance

The **HIP SmartStart** health insurance plan is a welcomed choice for sole proprietors and small businesses. **HIP** has created a unique model for keeping health insurance costs low without compromising on coverage. **SmartStart** is an EPO (no gatekeeper) providing routine physician care, hospital, surgery, emergency room treatment, chiropractic and more.

Brief Benefits Outline:

- \$25 Office Co-Pay
- \$250 Hospital Co-pay (1st two days, \$100 thereafter, \$1400 max)
- Maternity Coverage
- Children Covered to age 19 or 25 (Full Time Students)
- Prescription Drug Card

Application Process:

1. Complete and sign application.
2. Include 1st month premium check from a business account made out to: **HIP Health Plan**
3. Please enclose latest tax document to support business along with your application packet. Required tax documentation includes one of the following: 1040 with Schedule C for sole proprietors, 1120 S for corporations, 1065 for partnerships, or NYS-45.

**Return to: Life and Health Quote Corp.
HIP SmartStart Plans
560 Broad Hollow Road, Ste. 313
Melville, N.Y. 11747**



GROUP APPLICATION

Section 1 – APPLICANT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Requested Effective Date:							
Company's Legal Name:						SIC Code:	
Company DBA, if applicable:							
Company's Address (No. and Street):				Billing Address, if different:			
City	State	Zip	County	City	State	Zip	County
Company Officer:				Title:		Telephone:	
Company Contact Person:				Title:		Telephone:	
E-mail Address:				Fax Number:			
How long has your company been at the current address?				Indicate your Company's State Employer Identification Number:			

What is the nature of the Business or Organization?

Which of the following describes your Company or Organization?

- Employer/Employee Group
 Business Association
 Fraternal/ Religious Organization
 Sole Proprietor
 Partnership
 Non-Profit Organization
 Other Group, please describe

Is your Company or Organization a Subsidiary, Division or an Affiliate of another Company?

- Yes
 No
 If Yes, please complete the following:

Company Name	Address	Number of Total Employees

Select Product Coverage:

<input type="checkbox"/> HIP PRIME	<input type="checkbox"/> HIPaccess I	<input type="checkbox"/> HIP PRIME Dental PPO	<input type="checkbox"/> HIP PRIME EPO
<input type="checkbox"/> HIP PRIME POS	<input type="checkbox"/> HIPaccess II	<input type="checkbox"/> HIP VIP Medicare	<input type="checkbox"/> HIP PRIME PPO
<input type="checkbox"/> HIPIC SELECT EPO	<input type="checkbox"/> HIPIC SELECT PPO	<input type="checkbox"/> HIP Classic	<input type="checkbox"/> Other: _____

Section 2 – EMPLOYEE INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Eligible Employees: Employees on your payroll whose regular work schedule is at least [20.0] hours per week.

A - Total Number of Employees _____

B* - Number of Employees Eligible for Coverage _____

C - Number of Employees Enrolling for Coverage _____

D - Number of Employees Waiving Coverage (B-C) = _____

Reasons for Waiver(s):

***PLEASE ATTACH A COPY OF YOUR NEW YORK STATE DEPARTMENT OF TAXATION AND FINANCE FORM, "EMPLOYER'S QUARTERLY REPORT OF WAGES PAID TO EACH EMPLOYEE" (NYS-45)"**

WAITING PERIOD:

PRESENT EMPLOYEES' ELIGIBILITY — Will all current employees be covered as of the effective date of coverage?

Yes No If no, explain: _____

FUTURE EMPLOYEES' ELIGIBILITY — New employees will be eligible for coverage:

Date of Hire First day of the month following date of hire

____ Month(s) following the date of hire Other _____

CONTRIBUTIONS: Will the Group contribute 100% of the cost of the coverage? Yes No If no, complete below:

	Group Contribution		
	Dollar Amount	or	Percentage
<input type="checkbox"/> Employee only coverage	\$ _____		_____ %
<input type="checkbox"/> Employee and Spouse	\$ _____		_____ %
<input type="checkbox"/> Employee and Child(ren)	\$ _____		_____ %
<input type="checkbox"/> Family	\$ _____		_____ %

PREMIUM BILLING/PAYMENT FREQUENCY:

Monthly Quarterly Semi- Annually Annually

Section 3 – REPLACEMENT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Does this Group Contract replace other coverage? Yes No

If "Yes", please attach a copy of a billing statement from 12 months ago* (or more recent, if necessary) and complete the following:

Effective Date	Termination Date	Prior Carrier	
HMO	_____	_____	_____
POS	_____	_____	_____
Indemnity	_____	_____	_____
PPO/EPO	_____	_____	_____
Dental	_____	_____	_____
Other	_____	_____	_____

* Note: A billing statement from 12 months ago will reduce the probability that employees will need to provide evidence of prior coverage. Eligible employees with less than 12 months of continuous coverage may be required to submit a 'Certificate of Creditable Coverage' with their enrollment form.

Section 4 -- GENERAL AGENT/BROKER INFORMATION

General Agent Name: _____

Address: _____

Telephone: _____ Fax _____

Number: _____

E-mail Address: _____

Broker Name: _____

Address: _____

Telephone: _____ Fax _____

Number: _____

E-mail Address: _____

For Office Use Only

HIP Marketing Representative and Code: _____

Broker/Agent: _____

Group Number (To Be Completed by Underwriting): _____

THE GROUP AGREES TO DO THE FOLLOWING:

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify HIP Health Plan of New York of the termination or addition of any Member(s) covered or to be covered by HIP.
- Promptly provide HIP Health Plan of New York with any information necessary to properly administer the coverage.
- Ensure compliance with TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to group's coverage.

IT IS UNDERSTOOD THAT:

- If an acceptable employee enrollment form is received prior to the eligibility date coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt.
- All group applications are subject to approval by HIP Health Plan of New York.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the census of the actual enrollees. Any material misrepresentation within this group application or the group's census, whether intentional or unintentional, will permit HIP Health Plan of New York to terminate this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents; and I will provide to HIP Health Plan of New York an enrollment form or a waiver of coverage form (applicable to groups with 2-50 eligible employees) signed by each eligible employee within thirty (30) days of his/her eligibility date.

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. HIP Health Plan will refund the premium deposit submitted with this application if coverage does not become effective.

Subject to applicable State and Federal laws pertaining to preexisting conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from the effective date of this Contract.

All statements in this application for coverage under a Contract from HIP Health Plan of New York shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at: _____ On the ____ Day of, _____, 20____

By: _____ Title: _____
(Printed name of authorized officer)

By: _____
(Signature of authorized officer)

Please return this completed application and the following items:

- "Employer's Quarterly Report of Wages Paid to Each Employee (NYS — 45)"
- Copy of a 12 month old (or more recent, if necessary) billing statement
- First month's premium

To: **HIP Health Plan of New York**
New Business/Sales
Attn: Broker Administrative Rep.
7 West 34th Street
New York, NY 10001

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING



Group Name

COPAYMENT OPTIONS (Select One from each category)

- PCP Office Visit \$25
- Specialist Office Visit \$25
- Hospital Admission Confinement \$250 each day for the first two days; \$100 each day thereafter up to a maximum of \$1,400 per Benefit Period.
- Ambulatory Surgery \$25
- Emergency Room \$50

BENEFIT RIDERS

SKILLED NURSING FACILITY CARE

45 days; \$100 each day for the first fifteen (15) days, up to a maximum of \$1,500 per Benefit Period.

INPATIENT THERAPIES

\$250 each day for the first two (2) days, and \$100 for days three (3) through sixty (60) up to a maximum of \$1,400 per Benefit Period.

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students

Dependent Children

23 End of month

19 End of Month

MONTHLY RATES (to be completed by your broker or HIP)

3 TIER

Individual \$ _____

Two Persons \$ _____

Family \$ _____

HIP SmartStart Subscriber/Member Enrollment Form

Last Name		First Name			M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number			
Street Address		Apt.	City		State		Zip Code			
Are you covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: ___/___/___		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Birth Date Mo. Day Yr.		Tel #: Home: (____) _____ E-Mail Address: _____		Work: (____) _____ Qualifying Event Date: Mo.____ Day____ Yr._____		
Prior Health Insurance Information Carrier Name _____ Coverage Begin Date ___/___/___ Coverage End Date ___/___/___		Qualifying Event: <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Hire <input type="checkbox"/> _____			Is your spouse covered by any other Health Insurance or Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate: Insurance Co. Name: _____ Insurance Co. Telephone #: _____ Type of Coverage: _____ Policy #: _____ Effective Date: ___/___/___			SUBSCRIBER <i>Please select a hospital and indicate your choice below</i> Hospital Name: _____ Hospital I.D. _____ Brookhaven Memorial HospitalBKMH Good Samaritan HospitalGSAM Mercy Medical CenterMERC New Island HospitalNEWI Saint Catherine HospitalSCAT St. Charles-JT MatherSCJM S Nassau CommunitySNAS Winthrop University HospitalWINT Hospital I.D. Selection _____		
Have you or any of your dependent(s) ever been a member of HIP? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, indicate member ID number(s) or the former employer and your name (if different from shown): _____										

*** If you are enrolling for your spouse and/or children, please list each one below - see Election of Coverage for eligibility**

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date Mo. Day Yr.	Check if disabled	Spouse Hospital I.D. Selection _____
SPOUSE							
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___	
ADDITIONAL DEPENDENTS (List oldest first)							
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___	
ADDITIONAL DEPENDENTS (List oldest first)							
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___	
ADDITIONAL DEPENDENTS (List oldest first)							
Prior Health Insurance Information		Carrier Name _____		Coverage Begin Date ___/___/___		Coverage End Date ___/___/___	

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form

Applicant must sign here: _____ Date _____

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group		Group Number		Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child	
Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by (Representative of Benefits Administrator)	
Instructions to Benefit Administrators or Group Representatives: For Groups with 50 employees or less, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Enrollment Form to be processed.				FOR HIP USE ONLY	
PROCESSED BY			RECEIVED DATE		PROCESSED DATE

ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

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

HIP PRIME POS and HIP^{access} II applicants please note that your benefits are provided under two separate contracts: a HIP HMO contract issued by the Health Insurance Plan of Greater New York, and a HIP PRIME POS and/or HIP^{access} II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP^{access} II coverage ends.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A

DOCUMENTATION BASED ON GROUP SIZE

(To be completed by Benefits Administrator)

Group Type (Check One)

**Sole Proprietorship
or One Subscriber
Group**

**Association of
Two or More
Employees**

**Small Group -
Less Than 50
Employees**

ACTION Check (✓)One	Qualifying Event	Documentation Required			
<input type="checkbox"/> Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly provide a recent Copy of NYS45 showing this subscriber as an employee or copy of Payroll documentation reflecting the date, employee's name and Social Security # or the employee's current year W4 form.	Not Eligible		
<input type="checkbox"/> Add Spouse	Marriage	Marriage Certificate			
<input type="checkbox"/> Add Dependent	Birth	<input type="checkbox"/> Birth Certificate or			
	Adoption	<input type="checkbox"/> Formal Adoption Papers or <input type="checkbox"/> Court Approved Guardianship Papers			
<input type="checkbox"/> Add Spouse	Loss of Coverage	Certificate of Creditable Coverage			
<input type="checkbox"/> Add Dependent					

Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.



REFUSAL OF HIP INSURANCE FORM
FOR SMALL BUSINESSES WITH FEWER THAN 51 ELIGIBLE EMPLOYEES

(Please Print)

Group Policy Number: _____

Name of Employer: _____

Employee's Name: _____
(Last, First, MI)

Social Security Number: _____

Marital Status: Single Married Divorced Widower

Number of Eligible Dependent Children: _____

I was given the opportunity to enroll in a group insurance plan offered by my employer and insured by HIP Health Plan of New York (HIP) and HIP Insurance Company of New York.

I am refusing:

(Note: Benefits provided on a noncontributory basis cannot be refused.)

HIP/HMO:

- Employee & Dependents
- Spouse
- Child(ren)

Choice Plus:

- Employee & Dependents
- Spouse
- Child(ren)

ANSWER IF YOU ARE REFUSING ANY COVERAGE:

Are you or your dependents now covered by any other group plan? Yes No

If yes,

Policyholder's Name: _____

Carrier: _____

I understand that I may be required to furnish, at my expense, EVIDENCE OF INSURABILITY satisfactory to HIP Health Plan of New York and HIP Insurance Company of New York if I later wish to enroll for any of the coverages refused.

Signature of Employee

Date

Signature of Witness

Date

SECTION VIII – NEW BUSINESS CHECKLISTS

HIP's Underwriting Guidelines Checklist for Small and Large Business

- The account indicated below qualifies for small business rates and benefits because the group's membership includes TWO (2) TO FIFTY (50) eligible employees.
- For large business 50 plus eligible employees.

Group Name _____

Completed by: Broker Signature _____ Date _____

CONTRIBUTION: Will group contribute toward the cost of coverage? Yes No
If "YES", will the group contribute the cost of:

- Employee Only Percentage _____ Dollar Amount _____
- Family _____

ELIGIBLE MEMBERS: (Check ALL boxes that apply to this group)

- Owners of the group/corporate officers/partners.
- Members of the Board of Directors.
- Employees on the group's payroll whose regular work schedule is at least 20 hours per week (if more than 20 employees, include active employees over 65 and spouse over 65.)
- Commissioned employees (no 1099s) with a base salary and commission.
- Eligible dependents of the group employees.
- Retirees & their spouses if the employer pays part or all premium as a retirement benefit.
- Former employee/dependants (COBRA continuation of coverage).
- Eligible union members (members must be employed by the same employer).

WHO MUST BE EXCLUDED FROM THE GROUP: (Check ALL boxes that apply to this group).

- Part-time employees who work less than 20 hours a week.
- Seasonal employees whose employment is six months or less each year.
- Temporary employees (HIP does not cover temporary workers).
- Employees who do not "work or reside" in the HIP service area.
- Employees in the armed forces of any government other than for duty of 30 days or less.
- Union-affiliated employees.
- HIP does not cover babysitter or personal maids.

TYPES OF ORGANIZATIONS: (Check ONE box that applies to this group).

- Sole proprietorship.
- Business establishment.
- Partnership or corporation.
- Not-for-profit organization (employees must work a minimum of 20 hours).
- Government body (state, county or municipal).
- Union or Union Management Welfare Fund (members and/or employees of a union and their dependents).
- Association, Chamber of Commerce, Professional Society.
- OTHER (Describe): _____

DOCUMENTS THAT MUST BE SUBMITTED TO ENROLL:

- Completed Group Application.
- Employee(s) ENROLLMENT APPLICATION(S) with PRE-EXISTING CLAUSE:
See "Election of Coverage and Authorization", paragraph 3.
(Employer must sign bottom of form.)
- Requested EFFECTIVE DATE MUST be the 1st or 15th of the month.**
- Waiver Forms (For Groups of 2-24 employees).
(For employees with other coverage who are excluded or who refuse coverage.)
- Copy of the NYS-45. Must indicate NYS Tax ID.
- Business check for the first month's premium for both large & small businesses.

ADDITIONAL REQUIRED DOCUMENTS:

- For any employee NOT listed on the NYS-45, submit a copy of the payroll check showing the company's name along with the employee name, SS# and a W-4.
- College/university STUDENT VERIFICATION of active full time status (minimum of 12 credits).
- Owners/Partners of the business NOT reflected on the NYS-45, submit a copy of any other official document substantiating the name of the owners/partners and the company's name.
- NEW BUSINESS: Submit an accountant's letter indicating the date the business started and the number of eligible employees, along with a business certificate.
- MEMBERS OF THE BOARD OF DIRECTORS, submit a copy of the annual report indicating the names of the directors.
- COBRA Continuees:
 - Copy of the company's last NYS-45 which includes the former employee.
 - Copy of the individual's COBRA election form. In the absence of the election form, a letter from the former employee/dependant resulting continuation of coverage and the date of the qualifying event may be submitted.

SMALL GROUP ONLY PRE-EXISTING CONDITIONS INFORMATION

- ❑ For new business: Copy of the premium billing statement (or statements if more than one insurance carrier provided coverage) from 12 months preceding the effective date of HIP coverage. For any employee NOT listed on that bill, a "Certificate of Credible Coverage" must be submitted verifying their previous health insurance.

**FOR SECURITY REASONS, PLEASE MAKE ALL CHECKS PAYABLE TO:
HIP HEALTH PLAN OF NEW YORK (NOT HIP)**

MARKETING REP'S NAME _____
Please Print

BROKER'S NAME _____
Please Print

**PLEASE RETURN A COMPLETED COPY OF THIS FORM PLUS ALL OTHER REQUIRED
DOCUMENTS AS INDICATED ABOVE TO:** _____

Important Deadlines:

Any groups received from the 1st through the 15th of the current month can be processed with an effective date of either the 1st or 15th of the current month.

All groups received on the 16th through the end of the current month can be processed ONLY for the effective date of the 1st of the following month.

Other dates will ONLY be considered if HIP is taking over coverage from another POS plan.