

2010 Underwriting Requirements for **Sole Proprietors** within
Chambers and Associations applying for coverage through
Univera Health Care

- ___ 1. Member Firm Information Form (see "Instructions for Group Information Form" for assistance)

- ___ 2. Sole Proprietor Tax Documentation (most recently filed Schedule C or Form 1099, DBA, and/or Schedule K-1 showing sole 100% ownership)

- ___ 4. Attestation Form

- ___ 7. Completed Univera Enrollment Form

- ___ 8. Completed Student Verification Form (if applicable)

- ___ 9. Cancel letter to terminate current insurance coverage (must be on company letterhead)

- ___ 10. Check for the first month's premium made payable to Bene-Care

Member Firm Information Form
Member Firms with 50 or fewer eligible employees

(Must be completed by an Employer enrolling in Univera Healthcare)

1. Name and Physical Location of Member Firm _____

2. Name, Title and Phone # of Contact Person at Member Employer Group _____ TIN# _____
 _____ () - _____
 Name Title Telephone

3. Type of Business _____ SIC Code: _____

4. Desired effective date of insurance coverage. _____

5. The date you became a member of the Association _____
 If the date in above is more than 30 days prior to the current date, the reason you did not apply for coverage when you initially became a member of the Chamber, Trust or Association _____

6. Enrollment Questions (*for detailed instructions see page 2*)
- _____ a) Individuals actively working at all locations of the member firm (See Instructions 6a)
 - _____ b) Total number of retirees eligible for coverage (if any)
 - _____ c) Total number of COBRA / New York State extension participants
 - _____ d) Number of active employees **NOT** eligible for coverage (See Instructions 6d)
 - _____ e) Total number of eligible employees and retirees (**e = a+b+c-d**)
 - _____ f) Number of eligible employees **NOT** taking coverage due to a valid waiver
 - _____ g) Total number of net eligibles (**g = e-f**)
 - _____ h) Net eligible employees enrolling in this product offering through Univera Healthcare
 - _____ i) Group participation percentage (**h÷g**)

7. Name of Owner(s)/Partner(s) _____

8. Are you a subsidiary company, or a parent company with subsidiary companies? Yes / No

9. Employer Contribution: Medical: Single _____ % Family _____ % Other _____
 Dental: Single _____ % Family _____ % Other _____

10. See page 3 for required tax documents and attach.

11. Signature. The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least 20 hours per week.

Signature of Contact Person Date Fax Number or E-Mail Address

Signature of CTA Plan Administrator Date Chamber, Trust, Association Name

Instructions for Member Group Information Form

1. Please fill in the name and address of the member firm. Provide the physical street address. P.O. boxes should be used for billing purposes only.
2. TIN# - the member firm's tax identification number.
3. Describe in general the type of business (i.e. computer software, independent contractor).
4. Indicate the effective date insurance coverage is to begin.
5. Please indicate when the member firm joined the Chamber, Trust or Association.
6.
 - a. Enter the total number of all active employees working at the member firm. This number should include owners and employees working at all locations of the company.
 - b. Enter the total number of retirees eligible for coverage. The member firm must have a consistently applied business policy governing retirees and their dependents
 - c. Enter the number of people who have elected continuation of coverage through COBRA or New York State extension.
 - d. Enter the number of active employees not eligible for coverage.

New hires not meeting the member firm's new hire eligibility policy	
Employees working less than 20 hours per week	
Seasonal employees	
Employees covered through a union sponsored health plan	
Total (<i>Enter this number in 6 d.</i>)	

- e. Add lines **6a** through **6c**, subtract **6d** and enter total.
- f. Valid waivers include:
 - Spousal coverage through a commercial carrier
 - Spousal coverage through Tricare
 - Coverage with a parent through a commercial carrier
 - Retiree coverage through a former employer through a commercial carrier
- g. Subtract the number entered on line **f** from line **e**. (**g = e - f**)
- h. Enter the total number of eligible employees enrolling in this product.
- i. To determine member firm participation, divide line **6h** by line **6g**.
7. List the name of the Owner(s)/Partner(s) of the member firm.
8. If yes, please attach a list of the related companies, the locations and the number of eligible employees working at this location.

ATTESTATION

I, _____, the _____
(Name) (Title)
at _____
(Name of Employer)

do hereby attest that:

Check which applies

_____ Member Firms with 2 or more employees, including businesses with only one employee who is eligible for health insurance coverage. With respect to member firms with 2 or more employees, the following individual(s) *work at least 20* hours per week at the above-named Employer or are otherwise eligible for coverage under a group health insurance plan to be issued by Excellus Health Plan, Inc.

Other individuals eligible for coverage can include partners, owners of the business but not technically an employee, and retirees when the consistent policy of the business is to cover retirees.

Include a notation for each person indicating New Employee (**E**) with date of hire, Partner (**P**), Business owner (**O**), Retiree (**R**), or COBRA (**C**).

OR

_____ Sole proprietor. With respect to an applicant for coverage as a sole proprietor, the following individual *works at least 20* hours per week at the above-named Employer. If you are applying for coverage as a sole proprietor, only one (1) name will be listed.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least 20 hours per week.

(Signature)

(Date)

Tax Documentation Needed:

- **For groups with 2 or more employees:** This category also includes businesses with several employees, but only one is eligible for health insurance coverage.
 1. Each Employer with 2 or more employees must provide a copy of their most recent **NYS45-ATT-MN**, with notations indicating eligible employees (those working a minimum of 20 hours per week) and ineligible employees (part-time employees working fewer than 20 hours per week, seasonal employees and other persons not eligible for health insurance).

Note: If the Employer's rules require a minimum of more than 20 hours per week in order to be eligible for coverage (e.g., 30 hours), then the notations should be based on the employer's own eligibility rule.
 2. If there are any persons who are proposed for health insurance and ARE NOT listed on the **NYS45-ATT-MN**, the Employer must provide one of the following as documentation that the person works at least 20 hours per week or is otherwise eligible for coverage:
 - (i) for partnerships, a copy of the most recent **1065K-1 for each partner**; OR
 - (ii) for business owners, a copy of the most recent Schedule **K-1** to Form **1120S**, or Schedule **F** to Form **1120F**; OR
 - (iii) the Attestation is for individuals not listed on the **NYS45-ATT-MN**, or for individuals being proposed for coverage when the business is new and has not yet filed a **NYS45-ATT-MN**, work at least 20 hours per week or are otherwise eligible for coverage (e.g., retired, new hires-**W4**'s). The owner or partners of a business should always be listed on the attestation.
 3. If the Employer has been in existence for less than one year, it must provide a copy of its **DBA** certificate, certificate of incorporation, business certificate or receipt of tax ID form.
- **For persons in business alone (sole proprietors).**
 1. Each Employer must provide a copy of their most recent **NYS45-ATT-MN**. If the sole proprietorship does not file the **NYS45-ATT-MN**, it must provide a copy of a pay stub, estimated tax form or other documentation of active employment status.
 2. If the Employer has been in operation for MORE than one year, it must provide a copy of one of the following tax forms: Schedule **C**, Schedule **E**, or **W-2**
 3. If the Employer has been in operation **LESS** than one year, it must provide a business certificate, a **DBA** certificate, OR similar tax documentation that the business is authentic and in operation.
 4. Each Employer must provide a signed Attestation that the sole proprietor or employee works at least 20 hours per week in the business.

**SMALL GROUP ENROLLMENT UNIT
ELIGIBILITY WAITING PERIOD POLICY**

Please complete **Section I** if policy is different from the Chamber, Trust or Association.

OR

Complete **Section II** if following the Chamber, Trust or Association policy.

Section I

Member Firm Name: _____

Member Firm's waiting period for eligibility for health insurance is:

- Date of Hire
- First of the month following date of hire
- First of the month following 30 days of employment
- First of the month following 60 days of employment
- First of the month following 90 days of employment
- First of the month following 6 months of employment
- Other (must select between 0 days and 365 days) _____

Our standard rehire waiting period for eligibility for health insurance is:

- Same guidelines as new hire
- Date of rehire
- First of the month following rehire
- Other: _____

Minimum hours worked per week to be eligible for coverage is:

- 20
- 30
- 40
- Other: _____

(Minimum of 20 hours / Maximum of 40 hours)

Section II

To be completed by the Chamber, Trust, Association:

Chamber, Trust, Association Name: _____

Eligibility Waiting Period: _____

Minimum hours worked per week to be eligible for coverage: _____



Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Please Check All That Apply:

I waive my employer's group **health** insurance coverage for myself and my dependents (if any).

I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

Reason for Waiving Coverage - Please Check One:

Covered through spouse's employer Covered through a parent's employer

Under 65 Retiree covered by previous employer's insurance program

Other Please specify: _____

Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage
- At the time of my employer's open enrollment.

Employee Signature: _____ Date: _____

A Group Enrollment Form is not required for a change of address or correction to a date of birth. Please contact Customer Service at the number listed on your member ID card.

DESIRED ACTION Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the Event Date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible (11)	CE – Cobra End Date (29)
CP -- Commercial (09)	SR – Subscriber Request (02)
CB – Cobra Begin Date	SD – Subscriber Deceased (05)
CD – Cobra Disabled Date	MC – Medicaid
TT – Transfer to Traditional	MX – Medicare (03)
TH – Transfer to HMO (73)	
TP – Transfer to POS (73)	

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA – Marriage (25)	MB – COBRA Begin Date
OA – Dependent Over Age (20)	MR – Subscriber Request (02)
DM – Deceased (05)	DV – Divorce (25)
MS – Ineligible Student (28)	CB – Cobra Begin Date
	MX- Medicare 03)

DESIRED COVERAGE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than five members please use an additional form.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group:
 - Unmarried child, natural, adopted or stepchild
 - Chiefly dependent on you for support
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.
Dependents pending adoption, foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a handicapped dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Univera Healthcare.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Univera Healthcare to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Univera Healthcare to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**
I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

EMPLOYER INFORMATION

This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative.

Or, visit us at: www.univerahealthcare.com

