STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue, New York, NY 10022

GROUP HEALTH PLANS
EMPLOYER APPLICATION

INSURERS ADMINISTRATIVE CORPORATION

EMPLOYER GROUP NAME:_____

THIS PLAN REQUEST WAS PREVIOUSLY PRE-SCREENED ON: _____

PRODUCER INFORMATION (to be filled out by the producer ONLY)

1. YES NO Are you currently licensed in the state in which you solicited this application?
2. YES NO Are you currently appointed with Standard Security Life through IAC?
3. YES NO Do you carry an Errors & Omission Policy? If yes, who is the carrier: _____

_____

PRODUCER'S STATEMENT

To the best of my knowledge:

- ☐ I hereby represent that all the information contained in the Employer Application is correct and I know of nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the Employee Applications) that has not already been disclosed.
- ☐ I have complied with the underwriting rules and regulations and have explained in detail the proposed coverage for the member firm and its Employees.
- ☐ I have explained to the Employer and Employees the pre-existing condition limitation and the late enrollee extended pre-existing limitation for those Employees not applying at this time.

_____ Signature of Producer

_____ Date Application(s) Sent to General Agency

PRODUCER'S INFORMATION

Company Name: _____ Street Address: _____

Producer's Name: _____ City/State/Zip: _____

IAC Agent #: _____ Business Phone:_____

Social Security #: _____ Home Phone: _____

Federal ID #: _____ E-mail Address:_____

State License #: _____ Fax #: _____

Web Site Address: _____ Mobile #: _____

GENERAL AGENT INFORMATION (to be filled out by the GA ONLY)

General Agency #:_____ GA's Phone #:_____

Name of Agency: _____ GA's Fax #: _____

Name of General Agent:_____ Date Application(s) Sent to IAC: _____

GROUP HEALTH PLANS

EMPLOYER APPLICATION

Insurance underwritten by Standard Security Life Insurance Company of New York, New York, New York

A. EMPLOYER INFORMATION (please print in ink)

COMPANY NAME: (LEGAL NAME)	TYPE OF BUSINESS: ❑Corporation ❑Sole Proprietor ❑Partnership ❑Other_____	
DBAs:	PHONE NUMBER:	FAX NUMBER:
COMPANY ADDRESS: (STREET)	TAX ID NUMBER:	SIC:
CITY: STATE: ZIP:	LENGTH IN BUSINESS:	WEB SITE ADDRESS:
COUNTY:	NATURE OF BUSINESS:	E-MAIL ADDRESS:
CHIEF EXECUTIVE OFFICER OR PROPRIETOR:	NAME AND ADDRESS OF SUBSIDIARIES, AFFILIATES, OR SEPARATE LOCATIONS TO BE INSURED.	
NAME OF COMPANY CONTACT:	# OF EMPLOYEES BY LOCATION:	

B. COVERAGE INFORMATION

PLEASE COMPLETE *THE EMPLOYER BENEFIT SELECTION FORM* AND SUBMIT ALONG WITH THIS APPLICATION.

C. EMPLOYER EFFECTIVE DATE AND SERVICE WAITING PERIOD

1. WAITING PERIOD:	❑ 30 ❑ 60 ❑ 90 Days _____
2. REQUESTED EFFECTIVE DATE:	❑ 1st ❑ 15th of _____, _____ (month, year)

D. PROVIDER NETWORK SELECTION

1. Primary Health Provider Network:

   _____

2. Will more than one provider network be needed due to other Employer locations outside of the primary provider service area? ❑ YES ❑ NO

   Please identify business location and Network desired:_____

E. PRIOR COVERAGE CREDIT

❑ YES ❑ NO Will this Plan replace an existing Employer-sponsored Health Plan of coverage?

If yes, in order for those individuals who are eligible to receive credit towards the pre-existing limitations waiting period, the prior carrier should provide Evidence of Creditable Coverage. **If you are replacing an Employee group health plan with this Plan, please help ensure your Employees get appropriate credit by providing a copy of the present carrier's billing for the month in which coverage is being requested, a copy of the prior carrier's outline of coverage including the prior plan's effective date, or Certificates of Creditable Coverage required under HIPAA.**

Date Coverage Will Terminate: _____ Carrier's Name: _____ Carrier's Phone Number: _____

F. EMPLOYER CONTRIBUTION AND PARTICIPATION PERCENTAGES

1. Choose a Method:

❑ Defined Contribution Amount = $_____/per employee per month

This is a fixed dollar amount that you will contribute toward the monthly cost of your employee's (and their dependents, if any) benefit purchases.

OR

❑ % of Premium Contribution:

_____% of Employee Health Premium / _____% of Dependent Health Premium

_____% of Employee Dental Premium / _____% of Dependent Dental Premium

_____% of Employee Vision Premium / _____% of Dependent Vision Premium

2. Please calculate the participation of Employees in the Plan

	a. Total of all full-time Employees (including owners).
-	b. Minus full-time Employees who are declining coverage because of other group health insurance.
	c. Result is total "eligible" full-time Employees (a minus b).
-	d. Minus full-time Employees who are declining health coverage and have no other coverage.
	e. Result is total eligible full-time Employees applying for coverage.
%	f. Percentage of "eligible" Employees participating in the plan (e divided by c).

Dependent "units" are counted as one "unit" if they are a family, spouse or child.

	a. Total of Dependent units (spouse and/or children).
-	b. Minus Dependent units declining coverage because of other group health insurance.
	c. Result is total "eligible" Dependent units (a minus b).
-	d. Minus eligible Dependent units who are declining health coverage and have no other coverage.
	e. Result is the total eligible Dependent units applying for coverage.
%	f. Percentage of "eligible" Dependent units participating in the plan (e divided by c).

Participation Requirements

All eligible Employees are expected to apply for coverage during the Employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in their "service waiting period. The Employer may waive the service waiting period at the initial enrollment period to maximize plan participation.

Size of Group Participation	Minimum Required Participation	Minimum Required Dependent Participation (No Maternity)	Minimum Required Dependent Participation (With Maternity)
2-4 Employees	100%	50% Dependent units	N/A
5-9 Employees	75%	50% Dependent units	75% Dependent units
10+ Employees	75%	N/A	N/A

G. EMPLOYEES ON CONTINUATION INFORMATION

1.	❑ YES ❑ NO	Is your firm subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and has it had more than 20 Employees (full- and part-time) in the past year?
2.	❑ YES ❑ NO	Are any Employees or Dependents currently on COBRA continuation of coverage or in the election period due to COBRA?

If, Yes Please name the individuals:

_____

An application form and a copy of the COBRA election form must be submitted for each person covered under your group because of COBRA.

H. YOUR ACKNOWLEDGEMENTS

Employer hereby applies for coverage under the Group Master Policy ("Policy") issued to [ABC Trust] ("Trust") by [Standard Security Life Insurance Company of New York] ("Insurer"). Employer hereby joins the Trust for the purpose of establishing an employee welfare benefit plan. Employer agrees that the insurance coverage which is to be placed in force is subject to all of the provisions of the Policy issued to the Trust. Employer agrees to be bound by all of the terms, provisions and limitations of the Trust, the Policy issued thereto, and this Application.

The Employer also agrees that:

- participation in the Trust is subject to written approval of this Employer Application by Insurer or its designee; no liability is created for, or assumed by, the Trust or Insurer until this application has been approved in writing; acceptance of the check submitted with the application does not constitute approval or guarantee coverage; and if for any reason this application is not so approved in writing, the sole obligation of the Trust and Insurer will be, and the Employer shall be entitled to only, a refund of any monies paid.
- the first premium payment is due as of the date coverage becomes effective; subsequent premiums are due on the first day of each succeeding month; a grace period of 31 days will be allowed for the payment of any premium due after the initial premium.
- the initial premium rates will remain in effect for the first 6 months of coverage, unless Employer elected the 12-month rate guarantee on the Employer Application. The initial premium rate may change during the rate guarantee period if (1) the Employer adds or deletes Employees; (2) existing Employees move into a higher age bracket; (3) Employer moves to another geographic area;(4) Employer modifies the plan's benefits; (5) the Provider Network fees change, (6) benefits change due to state or federal benefit mandates; or (7) any benefit changes occur during the period.
- benefits under the Policy begin on Employer's Effective Date and coverage ends as of the last day for which premium has been paid; and Insurer will not be liable for any health care claims incurred by any Insured Person after the date on which coverage has terminated.
- it will reimburse Insurer for any claims paid by Insurer for Covered Charges that are incurred by an Employee after the date coverage under the Policy terminated.
- the Group Master Policy contains precertification requirements and an Insured Person's failure to meet those precertification requirements will reduce benefits that may be payable under the terms of the Policy.
- coverage under the Policy is available for U.S. residents only; Employees must be legal U.S. residents and benefits are not payable for medical expenses for services received outside of the United States except for Emergency Care when traveling.
- it has reviewed all of the answers to the questions on this Employer Application; understands that it is Employer's responsibility to provide truthful, complete and accurate information; represents that all of the information contained herein is true and complete; acknowledges that any material misstatements or failure to report information by Employer or Employees may be used as the basis of rescission or termination of Employer's or any Employees coverage.
- its agent is an independent insurance agent representing Employer, not the Insurer, and that no agent is authorized or has authority to (1) alter the terms of the Policy or the Trust; (2) waive, alter or modify any questions on this Employer Application; or (3) permit Employer or Employees to inaccurately answer any questions.
- all eligible Employees are encouraged to apply for coverage during the Employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in a "service waiting period," and Employer may only waive the "service waiting period" for Employees when Employer's coverage first becomes effective.
- it must maintain the minimum Participation Requirements stated herein; Insurer may periodically request and inspect payroll and personnel records to verify Employee participation rates; Employer will provide any such information that is requested; Employer's failure or refusal to provide such information is ground for termination of coverage; and Employers failure to maintain minimum participation requirements may result in coverage termination or loss of protection under the Health Insurance Portability and Accountability Act.
- all capitalized terms contained herein shall have the same meaning as in the Policy.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, submits an application or files a claim containing a false or deceptive statement, commits a fraudulent insurance act, which is a crime, and subjects the person to civil and criminal penalties.

I acknowledge I am advised not to terminate any existing health coverage plans for my Employees and myself until my Agent receives notification this Application has been approved by Standard Security Life Insurance Company of New York.

I. SIGNATURE

Owner or Officer Signature	Date	Owner or Officer Name and Title (printed)