Large Group Application

CareConnect Insurance Company, Inc.
Attention: Group Enrollment Department
2200 Northern Boulevard, Suite 104, East Hills, NY 11548
855-706-7545 CareConnect.com

Group Information

I. Full Legal Name of Group:_____

II. Doing Business as (DBA) name:_____

III. Primary Address of Group:_____

City_____State_____ZIP_____

IV. Plan Administrator/Contact:

1. Name_____
2. Title_____
3. Address_____

City_____State_____ZIP_____

4. Phone Number_____
5. Fax Number_____
6. Email Address_____
7. Additional Contact_____
8. Additional Phone Number_____

Billing Information

I. Send Billing Statements to:

1. Name_____
2. Title_____
3. Address_____

City_____State_____ZIP_____

4. Phone Number_____
5. Fax Number_____
6. Email Address_____

II. Full legal name of each subsidiary and/or affiliated company whose employees are to be covered (if applicable):

_____

III. Tax Identification Number:_____

Large Group Application (continued)

Group Administration

To be eligible for large group coverage, you must be located within Bronx, Brooklyn (Kings), Nassau, New York, Queens, Staten Island (Richmond), Suffolk, or Westchester county (the "Service Area") where CareConnect Insurance Company, Inc. products are available. Groups must have 101 or more eligible employees.

1. Effective date: We request that this coverage be effective _____
   (Note: With respect to the group's policy, only a first of the month effective date is permitted)
2. How many total Full Time Equivalent (FTE) employees does this group have? _____

   Total FTE employees means the average number of employees, including seasonal and/or part time employees, during the prior calendar year, as calculated by 26 U.S.C. Section 4980H(c)(2).
3. How many eligible employees does this group have?_____

   Eligible employees are active employees of the employer and of all subsidiaries or affiliates of a corporate employer who work 20 or more hours per week and are eligible for health benefits through the employer's group health plan. Eligible employees include any person who is a common law employee and who performs services for the company.

   An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours and occupational duties.

   Employees who work less than 20 hours per week are not eligible employees and may not enroll in any North Shore-LIJ CareConnect Insurance Company, Inc. products. If coverage is limited to specific class(es) of employees, the classes must be specified in response to the waiting period/classes section below.

   Eligible employees must live, work or reside in the Service Area OR live, work or reside in certain states outside of the Service Area so long as the employer has a bona fide office in the Service Area.
4. Total number of eligible employees who live, work or reside in the Service Area being offered coverage through this product: _____

   If you have eligible employees living, working or residing outside the Service Area, please contact us to discuss whether we will cover some or all of those employees.
5. If the employer offers retiree coverage, how many eligible retired former employees does this group have?

   _____

   Integration with Medicare benefits: If the group offers retiree coverage, health benefits covered by Medicare Part A and B are carved out for retired employees aged 65 or over and their dependents aged 65 or over who have elected Medicare.
6. Total number of employees and former employees enrolling:_____

   Enrolling means the total number of eligible employees, COBRA or state continuation enrollees, and retired employees (if applicable) accepting coverage with any CareConnect product.

   a. Of those former employees enrolling, how many are retired?_____

   b. Of those former employees enrolling, how many are enrolling through COBRA or state continuation? _____

Large Group Application (continued)

7. Please provide complete waiver details.
Total number of employees waiving coverage for the following reasons:

a. A spouse's health benefit plan: _____

b. Parental Waiver: _____

c. Medicare: _____

d. Medicaid: _____

e. Veteran's coverage: _____

f. Other Coverage: _____

g. All other waivers: _____

h. Total number of valid waivers (a - g):_____

8a. Is the Employer offering other group or HMO coverage to employees who are eligible for coverage by a CareConnect Insurance Company, Inc. product?* ☐ Yes ☐ No

8b. Does the employer wish to have a location carve out based on multiple office locations? ☐ Yes ☐ No

9. List current and previous carriers, and length of time with each:*

_____ _____

_____ _____

10a. Are there any employees, dependents, or COBRA enrollees who had claims in the last 12 months or expect to have claims in the next 12 months in excess of $20,000?

10b. If yes, please provide details attached with this application.

11. Contribution basis: Employee health benefits: _____% Family health benefits: _____%

12. Does the employer wish to utilize this plan as an HRA? ☐ Yes ☐ No
If so, what percentage of the deductible does the employer plan on contributing to? _____%

13. Plan exclusions and limitations: please refer to your group certificate for a complete list of exclusions and limitations.

14. Deductible accumulator: Plan Year ☐ Calendar Year ☐

Waiting period/classes

If coverage is being limited to particular class(es) of employees, specify class definition(s) below. An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic situs of employment, earnings, method of compensation, hours, and occupational duties. Although an employer may establish a class of employees who work less than 20 hours per week, CareConnect Insurance Company, Inc. products are not available to employees who work less than 20 hours per week.

If classes and waiting periods are not specified below, all eligible employees who work 20 or more hours per week will be eligible for group health benefits under a CareConnect Insurance Company, Inc. policy without a waiting period.

**Coverage will not be denied based on responses to these questions*

Large Group Application (continued)

CLASS I

Definition of Class I:_____

A) Eligibility/Effective Date of Coverage and Termination

Please choose one of the following two choices:

☐ Employees are eligible for coverage as of the date on which the employee completes _____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the date of termination of employment.

☐ Employees are eligible for coverage as of the first day of the calendar month coinciding with or next following the date on which the employee completes_____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the last day of the calendar month.

B) Waiting Period for Rehires

Maximum Waiting Period is 90 days.
Waiting Period waived for Rehires? ☐ Yes ☐ No
If yes, waived if rehired within_____months. (cannot exceed 90 days)

CLASS II

Definition of Class II:_____

A) Eligibility/Effective Date of Coverage and Termination

Please choose one of the following two choices:

☐ Employees are eligible for coverage as of the date on which the employee completes _____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the date of termination of employment.

☐ Employees are eligible for coverage as of the first day of the calendar month coinciding with or next following the date on which the employee completes_____days/months (circle one) of continuous service.

(Note: Period must not exceed 90 days. Employees will have 30 days to enroll once eligible for coverage. Coverage will be effective as of the date that the employee became eligible.)

Termination will be the last day of the calendar month.

B) Waiting Period for Rehires

Maximum Waiting Period is 90 days.
Waiting Period waived for Rehires? ☐ Yes ☐ No
If yes, waived if rehired within_____months. (cannot exceed 90 days)

Large Group Application (continued)

CareConnect EPO Plan Selection:

Options: ☐ Remove Domestic partner ☐ Remove Family Planning ☐ Offer Age 29 Coverage

Any changes must be made by calling our dedicated sales number at 855-228-0541.

Rate Information

If coverage is commencing on the group's existing anniversary date, renewal rates and percentage increases from your current carrier should be attached to this application. If coverage is commencing off-anniversary, then current rates and plan details should be attached to this application. All rates and associated plan design details should be attached to the application.

Broker/GA Information

	Broker	Co-Broker	General Agent
Name of Payee			
North Shore-LIJ CareConnect's Broker and/ or General Agency Code			
Payee's SS# or Federal Tax ID #			
Commission Split			
Sales Representative			
Comments			

Broker Consent

Authorization for Broker to Act as Benefits Administrator

The undersigned hereby requests CareConnect Insurance Company, Inc. to accept the Brokers or General Agents named above as an authorized Benefits Manager for purposes of processing any enrollment transactions for my company's CareConnect Insurance Company, Inc. policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations). This authorization shall be effective immediately and shall (check one only):

☐ Remain in place until it is expressly revoked by me in writing.

☐ Remain in place until_____

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Member. I acknowledge that I must notify CareConnect Insurance Company, Inc. in writing to void this agreement in the event of a change in my company's Broker of Record.

Large Group Application (continued)

COBRA/Extension of Benefits

1. Do you have any individuals currently covered by a COBRA continuation? ☐ Yes ☐ No

   If yes, identify the number of individuals_____

2. Are there any dependents of enrolling employees who are currently disabled or in the hospital?

   ☐ Yes ☐ No

What is the length of the prior carrier's extension of benefits period for disabled employees or dependents?_____

Applicant Agreement

This Application and the premium rates proposed by CareConnect Insurance Company, Inc. are subject to approval, in writing, by CareConnect Insurance Company, Inc. We reserve the right to modify rates in the event a plan design must be modified as a result of any change, modification or clarification in law. We also retain the right to correct typographical errors or discrepancies prior to the effective date of coverage, and take other actions (for example due to an intentional misrepresentation of a material fact) as permitted by applicable state law.

I, the undersigned, on behalf of the above-named company (the "Applicant") am applying for large group health coverage and understand that the information provided will be used to determine eligibility for coverage, premium rates and for other purposes. I confirm that all information gathered herein is accurately represented, complete, and that the Applicant is not aware of any material information that was not disclosed.

The Applicant confirms that it employs 101 or more eligible employees.

The Applicant understands that this Application may be chosen for an audit to confirm the information provided. Audits may be conducted before or after enrollment. If documents reviewed or submitted during an audit show that the information provided on an application was false or that the group did not meet underwriting requirements, the group will not be enrolled (audit completed prior to enrollment) or will be terminated (audit completed post enrollment).

The Applicant understands that other audits may be conducted while the Group Policy and Group Enrollment Agreement is in effect and agrees that all documents or other information that may impact coverage or premiums will be available for inspection.

The Applicant hereby acknowledges and understands that this application does not constitute any obligation by CareConnect Insurance Company, Inc. to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by the CareConnect Insurance Company, Inc. entity underwriting the coverage. The Applicant hereby confirms that it will not cancel any current health coverage it may currently have in anticipation that this application will be accepted by CareConnect Insurance Company, Inc. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of completion and/or submission of this Application. If coverage is formally accepted, the Applicant understands that this application and any subsequent addenda (including, but not limited to, any member application forms and renewal certifications) will become part of the Group Policy and Group Enrollment Agreement issued by CareConnect Insurance Company, Inc.

Large Group Application (continued)

Any material intentional misrepresentation within the application or the addenda (whether intentional or unintentional) may subject the group to termination or other action permitted by law. By signing below, the Applicant agrees to be bound by the terms and conditions of the Group Policy and Group Enrollment Agreement. The plan documents (including, but not limited to, the application, policy certificate(s) and riders) will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan, and will govern in the event they conflict with any benefits comparison, summary of coverage or other description of the plan.

The Applicant agrees to offer coverage to all eligible employees and that only those employees or former employees and their spouses or dependants who are eligible for coverage will be enrolled.

By signing below, you are signing the group application on behalf of the group applying for coverage and stating that (1) I am the Applicant or the agent for the Applicant and am authorized to sign this Group Application and (2) the Applicant will be legally bound by the terms and conditions of the application, this authorization and the plan documents.

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 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 $5,000 dollars and the stated value of the claim for each violation.

Dated at:_____this_____day of_____20_____

Full legal name of firm:_____

Signature of Authorized Company Representative:_____

Title:_____

Witness Duly Licensed Resident Agent/Broker:_____