Health Republic Insurance of New Jersey

Broker Checklist for Enrolling NJ Small Group

- o Company Check Payable to "Health Republic Insurance of New Jersey"
- o All Size Groups 2-50 MUST provide Tax Documentation (i.e. – WR-30)
- o Group Application
- o New Jersey Employer Certification
- o Copy of prior carrier bill listing employees by name
- o Member Enrollment/Change Forms
- o Completed and signed Waiver Forms (if applicable)
- o Signed copy of Proposal
- o **Broker to be Paid**_____

Please be reminded that for your protection and ours, we cannot alter any paperwork submitted to us, and we cannot submit any paperwork which is missing critical information.

REMINDER – Please attach a copy of the group's termination letter that you or the client sent to the prior carrier.

For New Business Submission Deadlines please visit our website at:

http://www.savoyassociates.com/SubmissionDeadlines.aspx

New Business: 1st & 15th

INCOMPLETE PAPERWORK CANNOT BE PROCESSED

***Please submit to your Dedicated Business Development Team**

GENERAL AGENT:**SAVOY ASSOCIATES**

One Penn Plaza
17th Floor, Suite 1706
New York, New York 10119
212.616.7090

25B Hanover Road, Suite 220
Florham Park, NJ 07932
973.377.2220

4 AAA Drive, Suite 205
Hamilton, NJ 08691
609.584.8112

200 Continental Drive, Suite 209
Newark, DE 19713
888.992.6755

150 N. Radnor Chester Road, Suite F200
Radnor, PA 19087
610.977.2424

HEALTH REPUBLIC
INSURANCE

New Jersey Small Group (2-50 Employees)

UNDERWRITING GUIDELINES

The following underwriting guidelines must be met for Health Republic Insurance of New Jersey (HRINJ) to accept this application:

1. The 1st and the 15th effective dates of coverage may be selected as long as all information is received by HRINJ seven (7) business days on or before the requested effective date. If the initial effective date is on the 1st of the first of the month, the group will renew on the first of that same month every year.

2. The Employer must contribute at least 10% toward the total group premium (off SHOP Marketplace).

3. Class carve outs are allowed as long as the employer is not sponsoring another plan for the excluded employees/classes.

4. Dual Options will be allowed.

5. Participation: New Jersey Small Group (2-50) requires that 75% of eligible employees after valid waivers be enrolled in an HRINJ product. Valid waivers are a Group Health Plan offered by spouse, parent, or another employer, Medicare, Medicaid, NJ Family Care, TRICARE or other Federal or State sponsored Health Plan.

6. In establishing the percentage of employee participation, a one-to-one credit shall be given to each employee covered by a Group Health Plan offered by spouse, parent or another employer, Medicare, Medicaid, NJ Family Care, TRICARE or other Federal or State sponsored Health Plan.

   For example: a small group has five eligible employees and three of those employees each have coverage under their spouse's plan. The three employees are to be included in the count for the number of enrolling employees when determining the participation percentage. The employees with coverage under a spouse's plan are considered to have health coverage; and, therefore, count toward the employee participation. In this way, a group is not penalized if they have employees covered by a Group Health Plan offered by spouse, parent, or another employer, Medicare, Medicaid, NJ Family Care, TRICARE or other Federal or State sponsored Health Plan.

7. Documentation Requirements:

- First month's Premium Check
- Group Application
- New Jersey Employer Certification
- Most recent prior carrier bill including list bill summary
- Completed and signed waiver form, if applicable
- Signed copy of the proposal. Please note: Final rates are based on final enrollment by plan design

- Proof of Business:
    1. Schedule C or Schedule K-1
    2. IRS Form 1065 (Partnership Income)
    3. IRS Form 1120 (Corporate Income)
    4. IRS Form 990 (Tax-exempt return)
    5. IRS Form 941 (Non-profit)
    6. Business license
    7. For newly formed business only: Articles of Incorporation, Certificate of Formation, Certificate of Incorporation (signed and completed with a stamp or receipt with issuing date) or Partnership agreement (stamped by state or notarized)
- Proof of Employment:
    1. New Jersey WR-30 – Employer Report of Wages Paid for all employees of the group
    2. W-4 (for new hires only)
    3. Payroll documents showing withholdings
    4. Schedule C or Schedule K-1 (for owners only)

Send to: Health Republic Insurance of New Jersey
One Gateway Center
Suite 2600
Newark, NJ 07102
Fax: 201.308.8605
Attn.: Small Group Department

HEALTH REPUBLIC INSURANCE

Group Application

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Health Republic Insurance of New Jersey
1 Gateway Center
Suite 2600
Newark, NJ 07102

Contract information will be provided: ☐ Electronically ☐ Hard Copy

☐ New Policy ☐ Change in Policy ☐ Requested Effective Date: _____

Section I: Policy holder information

1. Policyholder (full legal name of Company): _____
2. Tax ID Number: _____
3. Business Address: _____
   Street City State Zip

   Mailing Address: _____
   Street/P.O. Box # City State Zip

   Telephone: ( ) _____ Fax: ( ) _____
4. Name of Group Administrator: _____
5. Email Address: _____
6. Type of Organizaton: Corporation Partnership Proprietorship Other (explain) _____
7. Nature of business: (specify) _____ SIC Code: _____
8. Number of eligible employees in your company: _____
   Please Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.
9. Number of eligible employees to be insured: _____
10. Class or classes to be excluded: _____
11. Insurance requested for: ☐ Employees & Dependents (with spouse) ☐ Employees & Dependents (without spouse)
    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
    If yes, should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No
12. Are you subject to the requirements of COBRA? ☐ Yes ☐ No
13. Is your employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
    Is your employer subject to the requirements of Medicare as a Secondary Payor Rules for eligibility due to disability? ☐ Yes ☐ No
14. Waiting period before employees become insured (May not exceed 90 days):
    Present Employees _____ New or Rehired Employees _____
15. What percentage of the premium will the employer pay? (must be a minimum of 10%) _____
16. Deposit: $ _____
17. **Affiliates, subsidiaries or branches: (must be included for purpose of participation)**

Legal Name	Address	Number of eligible employees in this company	Number of eligible employees to be insured

Section II: Specifications for Coverage

Plan Designs:

☐ Prime

- ◯ Bronze: Deductible - $2,500 (person)/$5,000 (family), Max Out-of-Pocket - $6,350 (person)/$12,700 (family), 50% coinsurance
- ◯ * Silver: Deductible - $2,000 (person)/$4,000 (family), Max Out-of-Pocket - $6,350 (person)/$12,700 (family), 30% coinsurance
- ◯ Gold: Deductible - $1,500 (person)/$3,000 (family), Max Out-of-Pocket - $2,500 (person)/$5,000 (family), 50% coinsurance

☐ Core

- ◯ Silver: Deductible - $2,000 (person)/$4,000 (family), Max Out-of-Pocket - $6,350 (person)/$12,700 (family) $20/35 CoPay, Rx - $10/30/30%, 30% coinsurance
- ◯ Gold: Deductible - $2,000 (person)/$4,000 (family), Max Out-of-Pocket - $3,000 (person)/$6,000 (family), $10/25 CoPay, 30% coinsurance
- ◯ Platinum: Deductible - $750 (person)/$1,500 (family), Max Out-of-Pocket - $1,250 (person)/$2,500 (family), $10/25 CoPay, 50% coinsurance

☐ Solid

- ◯ Bronze: Deductible - $2,500 (person)/$5,000 (family), Max Out-of-Pocket - $6,350 (person)/$12,700 (family), 50% coinsurance
- ◯ Silver: Deductible - $2,000 (person)/$4,000 (family), Max Out-of-Pocket - $4,500 (person)/$9,000 (family), 20% coinsurance
- ◯ Gold: Deductible - $1,750 (person)/$3,500 (family), Max Out-of-Pocket - $2,000 (person)/$4,000 (family), 20% coinsurance

*1st 4 PCP visits no charge, no charge generic drugs

Have you purchased a separate Pediatric Dental Plan?

☐ Yes ☐ No

If Yes, include Insurer and Plan: _____

If No, please note that purchasing a Pediatric Dental Plan is required.

Section III:

1. Is there any Group Health Plan now in force and to be continued? ☐ Yes ☐ No **If yes, identify:**
   a. Name of the Group Health Plan(s): _____
   b. Description of the plan(s): _____
   c. Name of insurance carrier(s): _____
2. Is there any Group Health Plan currently being applied for through another carrier? ☐ Yes ☐ No **If yes, identify:**
   a. Name of the Group Health Plan(s): _____
   b. Description of the plan(s): _____
   c. Name of insurance carrier(s): _____
3. Is the coverage being applied for in this application replacing other group insurance? ☐ Yes ☐ No
   a. If yes, explain reason: _____
   b. Name of present or prior group carrier: _____
   c. Plan being replaced: _____
   d. Effective date: _____
   e. Cancellation/Termination date: _____
4. Has your firm been uninsured for 3 or more months prior to this application? ☐ Yes ☐ No
5. What forms of insurance are now, or were in force?
   Please attach copies of Booklet/Certificate and most recent Billing Statement.
   ☐ Health Benefits
   ☐ Prescription Drug Benefits
   ☐ Dental Benefits
   ☐ Vision Benefits
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

a. If yes, please provide the following information for each current/former employee or dependent on health continuations:

Name of Employee / Dependent	Date of Birth	Type of Continuation State/ Federal Extended Benefits	Continuation Dates	
			Start	

If additional space is needed, please attach a separate sheet, signed and dated.

7. To the best of your knowledge are any employees or dependents presently incapacitated? ☐ Yes ☐ No

8. To the best of your knowledge are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Section IV: Agent/ Producer Information

Agent/Broker Name: _____

Section V: Signature

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Health Republic Insurance of New Jersey (HRINJ) to make or modify any request or application for insurance or to bind Health Republic Insurance of New Jersey (HRINJ) by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Health Republic Insurance of New Jersey (HRINJ). 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 the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

_____ _____

Print name of Officer, Partner, or Proprietor Signature of Officer, Partner, or Proprietor

Witness to Signature _____

Note: If there are any modifications to the statement and answers given in this application (i.e. crossed out, whited-out, erased, etc.), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

HEALTH REPUBLIC INSURANCE

Small Employer Health Benefits Waiver of Coverage

Group Policy No.: _____

Policyholder: _____

Employee Name: _____
Last First

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment ___/___/___ (MM / DD / YYYY) Date of Birth ___/___/___ (MM / DD / YYYY)

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Health Republic Insurance of New Jersey (HRINJ). I ***REFUSE*** the following:

☐ Employee, Spouse and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ Other fully insured Group Health Plan sponsored by this employer

☐ Other Group Health Plan sponsored by my spouse's employer

☐ Other group coverage sponsored by another organization

☐ Covered under Medicare

☐ Other reasons (please explain)

_____

Please identify Group Health Plan(s) and provide names(s) of Policyholder(s), carrier(s) and policy number(s).

Policyholder Name: _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder Name: _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder Name: _____
Last First MI

Carrier: _____ Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

If the reason for the refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

GROUP ENROLLMENT/CHANGE REQUEST

HEALTH REPUBLIC INSURANCE

Group Information – to be completed by Employer:

Health Republic Insurance of New Jersey	Group Name:	Group Number:	Class Code:

A. Type of Activity – to be completed by Employer. *Refer to instructions page 7 before completing this form. Print clearly.*

	Activity – Check all that apply	Effective Date/ Date of Event	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new Enrollee ☐ Add Spouse/Civil Union Partner ☐ Add Domestic Partner ☐ Add Dependent Child ☐ Add Over-Age Child as a Dependent Under 31 *(and complete section A 4)*	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	Date of Hire: _____/_____/_____ _____ _____ _____ _____
2. REMOVE	☐ Employee Withdrawal/Termination ☐ Remove Spouse/Civil Union Partner ☐ Remove Domestic Partner ☐ Remove Dependent Child ☐ Remove Over-Age Child as a Dependent Under 31	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____ _____
3. OTHER CHANGE	☐ Name Change ☐ Change Plan ☐ Other ☐ Add/Change Office ID Numbers: Primary/OB/Gyn/ Dentist	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	_____ _____ _____ _____ _____

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 29
  - Date of Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date of Qualifying Event: ___/___/___

Billing: ☐ Group ☐ Home (Section B)

**Attach proof of disability*

☐ For Spouse/Civil Union Partner*
- Length of Continuation (in months):
- ☐ 18 ☐ 36
- Date of Loss of Coverage: ___/___/___
- Qualifying Event #:_____**
- Date of Qualifying Event: ___/___/___

Billing: ☐ Group ☐ Home (what address?)
- ☐ Section B *OR*
- ☐ Section E

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ For Dependent or Over-age Child
- ☐ COBRA/NJSGC
  - Length of Continuation (in months):
  - ☐ 18 ☐ 36
  - Loss of Coverage: ___/___/___
  - Qualifying Event #:_____**
  - Date: ___/___/___
- ☐ Dependent Under 31
  - Qualifying Event #:_____**

Billing: ☐ Group*** ☐ Home (what address?)
- ☐ Section B *OR*
- ☐ Section F

***Qualifying event #s: see list in Instructions. ***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J.*

B. Employee Information – to be completed by the Employee	Name (Last, First, MI):	SSN:

Home

Street/Apt:_____
Street/Apt:_____
City:_____ State:_____ Zip Code: _____

Birthdate (mm/dd/yyyy): ☐ Male ☐ Female

Phone: (_____)_____
Email: _____

Work

Employer Name:_____
Address:_____
City:_____ State:_____ Zip Code: _____

Phone: (_____)_____
Email:
_____
Employment Date: _____/_____/_____
Hours worked per week:_____

Activity

☐ Add ☐ Remove ☐ Continuation ☐ Other Change *If a name change, indicate prior name:*

Primary Care Provider Name: _____Loc#:_____ NPI #: Current Patient: ☐ Yes ☐ No
address: zip+4

Ob/Gyn Name _____ Loc#:_____ NPI #: Current Patient: ☐ Yes ☐ No
address: zip+4

Current Patient: ☐ Yes ☐ No

Other Health Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any:

Other Rx Coverage? ☐ Yes ☐ No *If yes:*
Payer Name: _____
Policy #: _____
Medicare ID#, if any:

C. Plan Option – to be completed by the Employee *Check one Plan.*

☐ PrimeBronze Deductible: $2,500 (person) / $5,000 (family)	☐ CoreGold Deductible: $2,000 (person) / $4,000 (family)
☐ PrimeSilver Deductible: $2,000 (person) / $4,000 (family)	☐ CorePlatinum Deductible: $750 (person) / $1,500 (family)
☐ PrimeGold Deductible: $1,500 (person) / $3,000 (family)	☐ SolidBronze Deductible: $2,500 (person) / $5,000 (family)
☐ CoreSilver Deductible: $2,000 (person) / $4,000 (family)	☐ SolidSilver Deductible: $2,000 (person) / $4,000 (family)
	☐ SolidGold Deductible: $1,750 (person) / $3,500 (family)

D. Other Individuals Covered – to be completed by the Employee. *Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.*

1. Spouse; Domestic or Civil Union Partner	**2.Child**	**3. Child**	**4. Child**
☐Add ☐ Remove ☐Other ☐Continue Spouse ☐Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue	☐ Add ☐ Remove ☐Other ☐ Continue
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ _ F:_____ _ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female

Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ _ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Health Coverage ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:
Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:	Other Rx Coverage: ☐ Yes ☐ No *If yes:* Payer Name: _____ Policy #: _____ Medicare ID #:
Primary Care Provider Name: NPI#:_____ Address:_____ _____ _____zip+4_____ Current Patient? ☐Yes ☐ No	Primary Care Provider Name: NPI#:_____ Address:_____ _____ _____zip+4_____ Current Patient? ☐ Yes ☐ No	Primary Care Provider Name: NPI#:_____ Address:_____ _____ _____zip+4_____ Current Patient? ☐Yes ☐ No	Primary Care Provider Name: NPI#:_____ Address:_____ _____ _____zip+4 _____ Current Patient? ☐Yes ☐ No
Ob/Gyn Name: NPI#:_____ Address:_____ _____ _____zip+4_____ Current Patient? ☐Yes ☐ No ☐ NA	Ob/Gyn Name: NPI#:_____ Address:_____ _____ _____zip+4 Current Patient? Yes No NA ☐ ☐ ☐	Ob/Gyn Name: NPI#:_____ Address:_____ _____ _____zip+4_____ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Name: NPI#:_____ Address:_____ _____ _____zip+4_____ Current Patient? ☐Yes ☐No ☐ NA

Employed? ☐ Yes ☐ No *If yes, complete Section E.*	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____	If last name is different from [Employee's], please explain: _____ _____
Home or billing address same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee. If *not applicable, please mark as "NA."*	1. Employer Name:_____ Employer Address:_____ City, State, Zip Code:_____ Employer Phone: ( )
2a. Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____	2b. Please explain why the address is different: _____ _____

F. Additional Child Information – to be completed by Employee. *Provide information below about children listed in Section D,* **if** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____	Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____

G. Race/Ethnicity – to be completed by the Employee, at his/her option. *NOTE: your response is appreciated but NOT required!*	*Choose a category that most closely describes you:* ☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin
H. Employee Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me. Signature:_____ Date:_____
I. Over-Age Child's Signature	I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election. Signature:_____ Date:_____

J. Employer Verification	The requested activity is believed eligible and is approved by the Employer. In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No Employer Representative: _____ Date: _____ Representative's Title: _____

CONDITIONS OF ENROLLMENT -- APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Health Republic Insurance of New Jersey, or any consumer reporting agency acting on behalf of Health Republic Insurance of New Jersey, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Health Republic Insurance of New Jersey has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Health Republic Insurance of New Jersey will provide coverage in accordance with the terms of the contract for the group plan policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (11 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI number by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

HEALTH REPUBLIC
INSURANCE

NEW JERSEY EMPLOYER CERTIFICATION

Legal Name and Address of Employer	Group Policy Number or Group Number (if a current customer)

For purposes of certification as a New Jersey Small Employer, an Employer is considered to be a Small Employer if the Employer satisfies **either** of the definitions set forth below. Check which definition applies to the Employer named above.

☐ (A) Small Employer pursuant to N.J.S.A. 17B:27A-17 modified as required by 26 U.S.C. 4980H

This definition counts eligible employees. Eligible employee means a full-time employee who works a normal work week of 25 or more hours. Eligible employee excludes sole proprietors, a partner in a partnership, independent contractors, spouses and employees working fewer than 25 hours per week, employees working on a temporary or substitute basis and employees participating in an employee welfare arrangement pursuant to a collective bargaining agreement.

In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least one, but not more than 50, eligible employees on business days during the preceding Calendar Year, and
- employs at least one eligible employee on the first day of the Plan Year.

Eligible employees and any dependents to be covered must live, work or reside in the service area of the Group Health Plan.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

☐ (B) Small Employer pursuant to 45 C.F.R. 155.20

This definition counts employees. Employee means an individual who is an employee under the common law standard. Employee excludes a sole proprietor, a partner in a partnership and a 2 percent S corporation shareholder as well as immediate family members of such individuals. Employee also excludes a leased employee.

In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer with a business location in the state of New Jersey who:

- employed an average of at least one but not more than 50 employees on business days during the preceding calendar year; and
- who employs at least one employee on the first day of the Plan Year.

Employees and any dependents to be covered must live, work or reside in the service area of the Group Health Plan.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.
Add the number of full-time Employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.
Complete the following sections if the Employer is a Small Employer as defined in (A) or (B) above.

Please indicate below the number of employees by work **location/State**. **All** employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (list by State)	Number of Employees				
	Full-time	Part-time		COBRA or State Continuees	Other

The following information will be used to calculate the **participation** rate. Refer to the definition of "eligible employee" on page 1.

Total # *Eligible Employees* _____

Total # Eligible Employees applying/enrolling for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's or parent's group coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan **through a different employer** _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan **issued by another carrier and offered by the small employer** : _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____ _____

_____ _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's or parent's group coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan _____

Total # Employees in an ineligible class or classes _____

The following information will be used to determine how certain federal laws apply to the Small Employer.

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? ☐Yes ☐No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

What is the **average** number of employees you employed during the entire **previous calendar year** regardless of whether they were eligible for enrolled for group coverage? _____
(When answering this question please count any employee for whom your company issues a W-2 and include full-time, part-time and seasonal workers.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY

For a Group Health Benefits Plan

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer which is an "either or" definition. .

❑ I certify that I qualify as a Small Employer in the State of New Jersey using definition ☐(A) ☐(B)

AND

❑ I certify that the information provided to Health Republic Insurance of New Jersey (HRINJ) is true and complete. I understand that if the above information is not complete or is not provided to HRINJ in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

_____ _____

Signature of Officer, Partner or Owner Title

_____ _____

Print Name of Officer, Partner or Proprietor Date

_____ _____

Signature of Witness Date

❑ **I certify that I am NOT a Small Employer in the State of New Jersey as defined in either (A) OR (B)above.**

_____ _____

Signature of Officer, Partner or Owner Title

_____ _____

Print Name of Officer, Partner or Proprietor Date

_____ _____

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

Complete this section if you have certified that the Employer is a Small Employer using definition (A) or (B)

* CENSUS INFORMATION

Please include the following persons in the following list:

a employees, owners, partners, and officers who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b employees, owners, partners and officers who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

O: Owner, partner or officer
F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
S: Seasonal employee
D: Totally Disabled employee
C: Continuee under state or federal law
U. Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours worked per week	Status	Work Location (State)		Date of Birth
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

*If additional space is needed, attach a separate sheet.