A plan for better health...
Crystal Run Health Plans

109 Rykowski Lane
Middletown, NY 10941

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CrystalRunHP.com

CRYSTAL RUN HEALTH PLANS

SMALL GROUP APPLICATION/CHANGE FORM

1. **REASON FOR APPLICATION: (Check One):** New ☐ Change/Renewal ☐
   Please indicate the **effective** date: MM / DD / YYYY
2. **GROUP INFORMATION**

Group Applicant

Legal Name of Group: Tax Identification Number

D/B/A, if applicable

Mailing Address of Group

City State Zip Code

Phone Fax E-mail

Authorized Group Contact:

Last Name First Name

Title Phone Fax

Email

Group Affiliate or Subsidiary (If Applicable)

Legal Name of Affiliate or Subsidiary: Tax Identification Number

D/B/A, if applicable

Mailing Address of Group

City State Zip Code

Phone Fax E-mail

Billing Contact Information (If Applicable):

Name Title

Mailing Address

City State Zip Code

Phone Fax E-mail

3. GROUP ELIGIBILITY

To be eligible for small group coverage, a group must have employees who live, work or reside in a county where we offer coverage and have at least one (1), but not more than one hundred (100), full time equivalent employees.

Number of Employees (see worksheet):

1. Total number full time and full time equivalent employees this group had during the prior calendar year: .....
2. Average number of full time equivalent employees employed by the group during the prior calendar year (Note: this number shall not be used to calculate group size.): .....
3. Total number of eligible employees: .....
4. Total number of eligible employees being offered coverage through this product: .....
5. If the employer offers retiree coverage, how many eligible retired former employees does this group have? .....
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 CRYSTAL RUN 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? .....

7. Total number of employees waiving coverage for the following reasons:
   a. Spousal _____
   b. Parental waiver _____
   c. Medicare _____
   d. Medicaid _____
   e. Veteran's coverage _____
   f. All other waivers _____

8. Total number of valid waivers (a + f): ..... ☐

9. Is the Employer offering other group or HMO coverage to employees who are eligible for coverage in a CRYSTAL RUN product? Yes ☐ No ☐
   If yes, provide the name of the insurer or HMO. _____

10. Is the group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)? Yes ☐ No ☐

Eligible Employee Classes, Waiting Period, Termination

CLASS I	**CLASS II**
Class Defined: (Choose One)	Class Defined: (Choose One)
Eligibility:	Eligibility:
☐ Option 1: First day following Waiting Period (not to exceed 90 days): _____	☐ Option 1: First day following Waiting Period (not to exceed 90 days): _____
☐ Option 2: First day of the month following Waiting Period (not to exceed 90 days) _____	☐ Option 2: First day of the month following Waiting Period (not to exceed 90 days) _____
Termination: Last day of calendar month: ____ Date of event: _____	Termination: Last day of calendar month: ____ Date of event: _____
Waiting Period Waived for Rehires?: Yes ☐ No ☐ If "**yes**", waived if rehired within _____ months.	Waiting Period Waived for Rehires?: Yes ☐ No ☐ If "**yes**", waived if rehired within _____ months.

4. Benefit Plans: [1]

REQUIRED:	☐ Domestic Partner: Yes ☐ Domestic Partner: No

EPO Platinum 2017
- ☐ Platinum EPO 1
- ☐ Platinum EPO 3

EPO Gold 2017
- ☐ Gold EPO 1
- ☐ Gold EPO 3
- ☐ Gold EPO 4
- ☐ Gold EPO 5 HDHP

EPO Silver 2017
- ☐ Silver EPO 3
- ☐ Silver EPO 5
- ☐ Silver EPO 6 HDHP

EPO Bronze 2017
- ☐ Bronze EPO 3 HDHP

PPO 2017
- ☐ Platinum PPO 1
- ☐ Gold PPO 3 HDHP
- ☐ Gold PPO UCR

HMO 2017
- ☐ Platinum Standard HMO
- ☐ Gold Standard HMO
- ☐ Silver Standard HMO
- ☐ Bronze Standard HMO
- ☐ Platinum Non-Standard HMO
- ☐ Gold Non-Standard HMO
- ☐ Silver Non-Standard HMO
- ☐ Bronze Non-Standard HMO
- ☐ Gold Non-Standard HDHP HMO
- ☐ Silver Non-Standard HDHP HMO

Religious Exemption from Family Planning: Confirmed: _____
HIOS/QHP (to be completed by CRHIC) #43477NY00

Has the Employer obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NYSOH-certified stand-alone dental plan offered outside the NYSOH?
Yes ☐ No ☐

If the Employer answered "**yes**", please provide the name of the company issuing the stand-alone dental coverage. _____

[1] HMO underwritten by Crystal Run Health Plan, LLC. EPO and PPO underwritten by Crystal Run Health Insurance Company, Inc.

If the Employer answered "**no**", CRHP will provide coverage through an arrangement with Healthplex Insurance Company, Inc. (for HMO enrollees), or Delta Dental Of New York, Inc. (for EPO/PPO enrollees).

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5. Agent/Broker Information:

Agent or Broker of Record Name		Tax Identification or Social Security Number
Company Name		
City	State	Zip Code
Phone	Fax	E-mail

Authorization for Broker to Act as Benefit Administrator (If Applicable):

The undersigned applicant hereby requests CRYSTAL RUN to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's CRYSTAL RUN 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. ☐

- or -

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 authorization does not authorize anyone to receive individually identifiable health information about any Member. I acknowledge that I must notify CRYSTAL RUN in writing to void this agreement in the event of a change in my company's Broker of Record.

6. Agreement and Signature

This Application is subject to approval, by CRYSTAL RUN. 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 as permitted by applicable state law.

I, the undersigned, on behalf of the above named company (the "Applicant") am applying for small 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 information that was not disclosed.

The Applicant confirms that the group employs no more than 100 full time equivalent employees.

The Applicant understands that, except during an open enrollment period that begins November 15 and extends through December 15 of each year, it must meet minimum participation requirements applicable to EPO and PPO coverage issued by Crystal Run Health Insurance Company, Inc. HMO coverage issued by Crystal Run Health Plan, LLC is not subject to minimum participation requirements.

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 does 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 hereby acknowledges and understands that this application does not constitute any obligation by CRYSTAL RUN to offer coverage and no insurance will be effective unless and until the application is formally accepted, in writing, by CRYSTAL RUN. 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 CRYSTAL RUN. 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 Contract.

Any intentional material misrepresentation within the application or the addenda 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 Contract. 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 dependents 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, or conceals for the purpose of misleading, 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 such violation.

x

Signature of Authorized Company Representative Title

x

Witness Duly Licensed Resident Agent/Broker

Date: _____

Full legal name of firm:

Worksheet for Group Eligibility

Question 1. Calculating Full Time Equivalent Employees:

(1) For each month during the calendar year, count all full time employees (those that work an average of 30 or more hours per week);

(2) for each month during the calendar year, count all hours worked by part time employees and divide by 120;

(3) Add the number from (2) to the number from (1) for each month during the calendar year. If the number is equal to or more than 101, then verify that seasonal workers working less than 120 hours are not counted.

(4) Divide (3) by 12.

Question 2. Calculating Average Total Number of Employees:

Add all the employee totals and then divide by the number of months the employer was in business during the prior calendar year. Note: this calculation shall not be used to determine group size.

Question 3. Calculating Eligible Employees:

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 must meet the definition of a common law employee. Eligible employees do not include retirees or those on state or federal continuation.

Question 4. Determining Classes of Employees Eligible for Coverage

An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment; i.e., geographic location, method of compensation, hours, occupational duties. If coverage is limited to specific classes, the classes must be identified on the application form at question 11.