



APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

WellChoice Insurance of New Jersey, Inc. WellChoice HMO of New Jersey

Policy number: (WellChoice Care Use Only) _____

Please print or type New policy Change in policy Requested Effective Date: ____/____/____

SECTION I: POLICYHOLDER INFORMATION

- Company Name (full legal name of company): _____
- Tax Identification Number: _____ E-mail address: _____
- Location Address: _____
Street City State Zip County
- Billing Address: _____
Street City State Zip County
- Telephone: () _____ Fax: () _____
- Group Benefits Administrator: _____ Title: _____
- Type of Organization: Corporation Partnership Proprietorship Other _____
- Nature of Business: (specify) _____ SIC Code: _____
- Number of employees in your company: _____ Number of eligible employees: _____
- Number of eligible employees to be insured: _____
- Class or classes to be excluded: _____ Number excluded: _____

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

- Insurance requested for: Employees Only Employees and Dependents
- Are you subject to the requirements of COBRA?: Yes No NJ State continuation? Yes No
- Waiting period before employees become insured: (may not exceed 6 months)
Present Employees: _____ New/Rehired Employees: _____
- What percentage of the premium will the employer pay? _____ % (minimum 10%)
- Deposit \$ _____

Premium paid: Monthly Quarterly

Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (must be included for purposes of participation)

| Legal Name & Location | No. Employees in This Company | No. Employees to Be Insured |
|-----------------------|-------------------------------|-----------------------------|
| | | |
| | | |

SECTION II: SPECIFICATIONS FOR COVERAGE

HEALTH BENEFITS

| | | | |
|--|---|--|---|
| <input type="checkbox"/> PPO C 100/70 | <input type="checkbox"/> PPO C 90/70 | <input type="checkbox"/> HMO | Indemnity Plan: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E |
| COPAY <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 | <input type="checkbox"/> \$0 | <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 | |
| DEDUCTIBLE <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 | <input type="checkbox"/> Hospital Copay Rider | |

PRESCRIPTION DRUG BENEFITS (Check one from each section.)

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Standard \$15-\$15 Retail-Mail Order | <input type="checkbox"/> Option 1 \$15-\$0/\$5 Retail-Mail Order | <input type="checkbox"/> Option 2 \$5/\$10-\$0/\$5 Retail-Mail Order | <input type="checkbox"/> Option 3 (check each selection) \$10/\$20/\$30 Rx Deductible <input type="checkbox"/> \$0 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 Oral Contraceptives <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | Option 4 (check each selection) \$10/\$25/\$50 Rx Deductible <input type="checkbox"/> \$0 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 Oral Contraceptives <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|--|---|---|

Note: Standard and Options 1 and 2 have \$0 deductible and include oral contraceptives.

10 TELEPORT DRIVE, STATEN ISLAND, NEW YORK 10311

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
 - Now in force and to be continued? Yes No
 - Currently being applied for? Yes No
 If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):

2. Name of present or prior group carrier: _____
 Effective date of prior coverage: _____ Cancellation/termination date: _____
 Is the coverage applied for in this application replacing other group insurance? Yes No
 If "Yes" give reason _____
 Plan being replaced: A B C D E HMO Open Access POS POS PPO Other _____
 Full replacement: Yes No

3. Has your firm been uninsured for 3 or more months prior to application? Yes No

4. What forms of insurance are now or were in force? Health Benefits Prescription Drugs
 (Attach copies of Booklet/Certificates and most recent Billing Statement.)

5. 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

Please provide the following information for each current/former employee or dependent on health continuation.

| Name of Employee/Dependent | Date of Birth | Type of Continuation State/Federal/Extended Benefits | Reason for Termination Disability/Other | Continuation Dates | |
|----------------------------|---------------|--|---|--------------------|--------|
| | | | | Start | End |
| | | | | / / | to / / |
| | | | | / / | to / / |

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

SECTION IV: 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 WellChoice, Inc. or WellChoice Insurance of New Jersey, Inc. to make or modify any request or application for insurance or to bind WellChoice, Inc. and/or WellChoice Insurance of New Jersey, Inc. 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 WellChoice, Inc. and/or WellChoice Insurance of New Jersey, Inc. 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 knowingly files a statement of claim, application for insurance, enrollment form or certification containing any false or misleading information may be subject to criminal and civil penalties.

Dated on ____/____/____ at _____

Print Name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

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

SECTION V: AGENT/PRODUCER INFORMATION

General Agency Name: _____

Address: _____

Phone: _____ Fax: _____

Broker's Name/Agent of Record: _____

Social Security Number: _____ / _____ / _____ D.O.B.

Agency: _____

Address: _____

Phone: _____ Fax: _____

Broker's Signature: _____

Split: _____

2nd Broker (if applicable)

Broker's Name/Agent of Record: _____

Social Security Number: _____ / _____ / _____ D.O.B.

Agency: _____

Address: _____

Phone: _____ Fax: _____

Broker's Signature: _____

Split: _____

Are you currently licensed with WellChoice? Yes No (If no, please complete Licensing Paperwork.) If not, complete your commission payments or this account may be delayed.

SECTION VI: FOR INTERNAL USE ONLY

Effective Date: _____ Renewal Date: _____

New Account: _____ Conversion: _____

PPO HMO Unbranded HMO Indemnity

_____ Total Number of Applications Submitted

_____ Number of Waivers Pre-X Applies: Yes No

_____ Number of Refusals

_____ % of Participation

Cashier's Department

Check Amount: _____

PPO Option 1 _____ Sub _____ ACCOUNT NUMBER

PPO Option 2 _____ Sub _____ ACCOUNT NUMBER

HMO _____ Sub _____ ACCOUNT NUMBER

Unbranded HMO _____ SUB **88**

Signatures

Imp. _____ (Print) Date Received _____ Released _____

Sales Rep. _____ (Print) Sales Rep. Code _____

NJ DSC _____ (Print) Date Received _____ Processed _____

Broker Relation _____ (Print) Date Received _____ Processed _____