

Excellus



Commercial Underwriting Package

Commercial health insurance coverage is available to employer, trust and association groups, subscribers and dependents that meet the qualifications specified in 4235 (c) (1) of the New York State Insurance Law and the Underwriting Guidelines of Excellus Health Plan, Inc, doing business as Excellus BlueCross Blue Shield ("Health Plan").

The attached documents must be completed by an Employer enrolling in the Health Plan's insurance.

EXCELLUS SMALL GROUP ENROLLMENT UNDERWRITING CHECKLIST

All forms listed below should be completed in their entirety and signed by the decision maker at the group.

1. _____ **New Business Group Information**
2. _____ **Tax Returns and Business Documentation** (See documentation requirements)

Note: For new businesses that have not filed their first **NYS45-ATT**, copies of the **W-4** may be submitted.

If you are submitting enrollment applications for partners or business owners not listed on the **NYS 45-ATT**, then please submit one of the following:

- **Partnerships:** a copy of the most recent **1065 K-1** form for all partners showing 100% ownership of the business.
- **Sole Proprietors:** a copy of the most recent **Schedule C** form.
- **Corporations:** a copy of the most recent **1120C, 1120E** or **1120S** form.
- **Charitable organizations:** **IRS form 990** is required unless exempt from filing tax returns from the IRS, then a copy of the exemption is required.

Note: If a business with 2 or more employees has been in operation for less than one year, a copy of the **DBA certificate, partnership certificate, certificate of incorporation** or other similar tax documentation verifying the business is authentic.

3. _____ **Attestation Form** – Must be signed for any newly hired employees, owners, partners or retirees **not** listed on the **NYS 45-ATT** and all sole proprietors.
4. _____ **Group Enrollment Form** – Must be completed and signed by each employee enrolling in coverage.
5. _____ **Waiver of Group Coverage Form** – Must be completed by **all** employees **not** taking coverage.
7. _____ **Signed Rate Sheet for selected plan** - Must be downloaded from RBA website. Go to download forms page on RBA website and click on rate sheets link.
8. _____ **Eligibility Policy Form** – Must be completed by all groups including sole proprietors.
9. _____ **Copy of a voided check from member firm**
10. _____ **Company check payable to RBA for premium**

Upon completion please email, fax or mail all forms along with credit card or check payable to RBA to:

Nina Shelton
Rochester Business Alliance
150 State Street
Suite 400
Rochester, NY 14614
Phone: 585/256-4644
Fax: 585/263-3679
Email: Nina.Shelton@RBAAlliance.com

Documentation Requirements:

- **For groups with 2 or more employees:**

1. Each Employer with 2 or more employees must provide a copy of the most recent **NYS45-ATT-MN**, with notations indicating eligible employees (those working a minimum of 20 hours per week) and ineligible employees (part-time employees working fewer than 20 hours per week, seasonal employees and other persons not eligible for health insurance).

Note: If the Employer's rules require a minimum of more than 20 hours per week in order to be eligible for coverage (e.g., 30 hours), then the notations should be based on the employer's eligibility rule.

2. If there are any persons who are eligible for health insurance and are not listed on the **NYS45-ATT-MN**, the Employer must provide the following forms of documentation to demonstrate the person works at least 20 hours per week or is otherwise eligible for coverage:
 - (i) Partnerships, a copy of the most recent **1065K-1 for each partner**; OR
 - (ii) Corporations, a copy of the most recent Schedule **K-1** to Form **1120S**, or Schedule **F**; or Form **1120** AND
 - (iii) The Attestation is always required for eligible employees not listed on the **NYS45-ATT-MN** (e.g. retirees, new hires, COBRA/NYS extension). For a new business that has not yet filed an NYS-45-ATT-MN, all employees must be listed on the attestation.
3. If the employer group has been in existence for less than one year, it must provide a copy of a **DBA** certificate, certificate of incorporation, business certificate or letter from the IRS assigning a new business its EIN number.

- **For persons in business alone (sole proprietors with no employees).**

1. If the employer group has been in operation for MORE than one year, it must provide a copy of one of the following tax forms: Schedule **C**, Schedule **F** or **W-2**.
2. If the employer group has been in operation **LESS** than one year, it must provide a business certificate, a **DBA** certificate, OR similar tax documentation that the business is authentic and in operation.
3. Each employer must provide a signed Attestation to attest that the sole proprietor works at least 20 hours per week in the business.
4. If applicable, a copy of the most recent NYS-45-ATT-MN. If the sole proprietor does not file an NYS-45-ATT-MN, a copy of a pay stub, estimated tax form or other documentation of active employee status will be accepted.

Section One: General Group Information

1. Group name or DBA name, if applicable: _____
2. Legal entity name, if different than group name: _____
3. Name of owner/partners: _____
4. Physical location of employer: _____
5. Mailing address of employer (if different than physical address): _____
6. Information for contact person at employer group:

Name	Title	Phone #	Email Address
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7. Description of business: _____ SIC code: _____ EIN/TIN #: _____
8. Type of group sponsor: (check one)
 Employer ___ Union ___ Trustees of Fund ___ Association ___ Other: _____
9. Organization type: (check one) State government ___ Local government ___ Church group ___
 Nonprofit ___ Trust ___ Publicly traded organization ___ Privately held corporation ___
 Privately held non-incorporated ___ Not-for-profit ___ Other: _____
10. Is coverage obtained through a Chamber Trust or Association, including a Professional Society?
 Yes ___ No ___ (check one)
 CTA Name _____ Professional Society Name _____
11. Are you a subsidiary company? Yes ___ No ___ (check one)
 If yes, list parent company name & address _____
12. Are you a parent company with subsidiary companies? Yes ___ No ___ (check one)
 If yes, please attach a list of the related companies, the locations and the number of eligible employees working at each location
13. Are there any other health plans in place for your group? Yes ___ No ___ (check one)
 If yes, type of plan(s) _____ Number of employees enrolled in this plan _____

PLEASE SUBMIT ALL REQUIRED UNDERWRITING DOCUMENTATION WITH THIS FORM

REFER TO SMALL GROUP ENROLLMENT CHECKLIST FOR REQUIRED DOCUMENTATION

Section Two: Regulatory Information

	Medical	Dental
14. Group Size		
a) Total number of employees at all locations	_____	_____
b) Total number of eligible full-time & part-time employees at all locations	_____	_____
c) Total number of eligible retirees at all locations	_____	_____
d) Total number of employees enrolled due to COBRA/NYS Continuation at all locations	_____	_____
e) Total eligible employees: (e = b + c + d)	_____	_____
f) Employees working at other locations not eligible for the programs offered through our plan	_____	_____
g) Eligible employees declining coverage due to a valid waiver (please see instructions)	_____	_____
h) Retirees who are offered a Medicare Advantage or Retiree Health Plan group product	_____	_____ <u>NA</u> _____
i) Net eligible employees for our health plan (i = e - f - g - h)	_____	_____
j) Eligible employees enrolling in group products (excluding those enrolled in a Medicare Advantage or Retiree Health Plan group product)	_____	_____
k) Group participation percentage (k = j ÷ i)	_____	_____
15. Group size for federal Mental Health Parity and federal medical loss ratio reporting average number of total employees, at all locations, for the prior calendar year	_____	_____
16. Do you employ any Vermont residents who work at employer locations in Vermont, including telecommuters working from their home in Vermont? Yes _____ No _____ (check one) If yes, please provide the number	_____	_____
17. Do you employ any other out-of-state residents who work at out-of-state employer locations other than Vermont? Yes _____ No _____ (check one) If yes, please provide the number	_____	_____

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.

Signature of Member Firm Administrator	Date	Fax Number or Email Address
Signature of CTA Plan Administrator	Date	Chamber, Trust Association Name

14. Group size

This information is required for community rated and experience-rated groups to verify that the group meets the participation requirements of the New York State Insurance Department and our health plan. If you are a community rated group, questions 14 (a-e) pertain to the NYSID requirement to verify small group eligibility by reviewing the total number of eligible employees within each group. Eligible employees are individuals who are eligible to enroll in your health plan(s) through all carriers.

a) Total full-time and part-time number of employees at all locations

- Enter the total number of all employees actively working at the employer group. This number should include full-time, part-time and seasonal employees working at all locations of the company. The owners and partners should be included. This is all active employees not just the employees eligible for coverage through your health plan.

b) Total eligible full-time and part-time employees

- This includes only those full-time and part-time individuals who are eligible to enroll in your health plan through any of your locations. Do not list total employees, only those eligible for coverage.
- Include all individuals eligible for health insurance, including all owners and partners.
- Do not include full-time and part-time employees who have not met your new hire waiting period for eligibility for health insurance.
- Do not include seasonal employees if they are not eligible to enroll in your health plan, and/or have not worked at least three months.
- Do not include union employees if coverage is offered directly through their union.

c) Eligible retirees

- Include those retirees who are eligible to enroll in the same plan as the actives.
- Include those retirees eligible for Medicare Advantage or a retiree health plan specifically designed for Medicare eligible.
- If your group does not offer health insurance to retirees, please enter zero.
- Do not include spouses enrolled under their own name, e.g., surviving spouses.

d) Individuals enrolled in your health plan due to COBRA/New York state continuation coverage

- Include any individuals who have experienced a qualifying event and have elected to temporarily continue their health plan coverage and pay the premiums themselves. They may be entitled to continue their coverage due to COBRA or New York state law.
- Do not include spouses or children enrolled under their own names, e.g., divorced spouses, dependents enrolled in their own policy, such as a "young adult" option.

e) Total eligible employees calculation

- Add together lines b + c + d
- Total eligible employees should not be 0. If you believe 0 is correct, please contact your account consultant for assistance.

f) Employees working at other locations not eligible for our plan

- Include only those employees working at other locations not eligible for insurance for our health plan.

g) Eligible employees declining coverage due to a valid waiver

- Spousal coverage through a commercial carrier or Tri-Care
- Coverage with a parent through a commercial carrier
- Retiree coverage through a former employer through a commercial carrier
- Coverage with Family Health Plus
- Coverage with Medicare
- Coverage with Medicaid
- Coverage with Healthy NY
- Coverage with the Veterans Administration

h) Medicare-eligible retirees offered Medicare Advantage or another retiree health plan group product.

- *Include only those retirees offered Medicare Advantage or a retiree health plan specifically designed for Medicare-eligible.*
- *Do not include retirees eligible for the plan the group offers to their active population.*

i) Net eligible employees for our health plan

- *Subtract lines f-h from line e; these are the eligible employees that will be used in the participation calculation.*

j) Eligible employees enrolling in our health plan

- *Include only those eligible employees enrolled in our health plan. Do not include employees who are enrolled in other health plans.*
- *Do not include retirees enrolled in a Medicare Advantage or Retiree Health Plan group product*

k) Group participation percentage

- *Divide line j by line i to calculate participation percentage.*

15. Group Size for federal Mental Health Parity and federal medical loss ratio reporting.

Question 15 pertains to the federal government's requirement to identify the average number of total employees within each group for the purposes of mental health and substance abuse benefit determination and for medical loss ratio reporting.

Who qualifies as an employee?

- *All individuals that you employ, regardless of whether they are eligible for your health plan.*
- *Include full-time and part-time employees who have not met your new hire waiting period for eligibility for health insurance.*
- *Include part-time and seasonal employees, even if they are not eligible to enroll in your health plan, and/or have not worked at least three months.*
- *Include union employees who are offered coverage directly through their union.*

How do I calculate the average number of total employees?

- *This is an average number of employees that you have employed on business days during the prior calendar year, not the number of employees you employ today. This includes each full-time, part-time and seasonal employee.*
- *For employers who were not in existence throughout the prior calendar year, please use the number of employees you expect to employ on business days during the current calendar year.*

16. Vermont residents working at employer locations in Vermont

- *Include only employees who live and work in Vermont, including those who live in Vermont and telecommute from their residence.*
- *Do not include residents of other states working or telecommuting from their home in Vermont.*
- *Do not include residents of Vermont who work at employer locations in New York.*

17. Other out-of-state residents working at out-of-state employer locations other than Vermont.

- *Include only employees who live and work out of state, including those who live out of state and telecommute from their residence.*
- *Do not include residents of Vermont working or telecommuting from their home in Vermont.*
- *Do not include out-of-state residents who work at employer locations in New York.*

Employer Contribution Instructions (page 3 of New Business Group Information Form):

Information regarding how you contribute to your eligible employees' premium is required for the medical loss ratio rebate and to verify underwriting eligibility. A separate attachment is included to capture this information. If your plan's contribution strategy changed during the calendar year, you will need to complete a separate form for each change.

Class name

- *If your contribution strategy differs by class, please list the employee class in this column and provide the information for each class. The standard class names are listed on the form. If it is not a standard class, please indicate the class name in this section. If you do not have more than one class of employees, or you contribute the same amount to each class, you can indicate "All" in this column. If your employer group has more than two classes of employees, you may need to complete a separate form for the additional classes.*

Plan

- *List all of our plans you offer in this column. Include Dental, Medicare Advantage and retiree health plan group products if offered. If your employer group exceeds the number of plans on the form, you may need to complete a separate form for the additional plans.*

Tier

- *Complete the amount contributed toward each tier based on the number of tiers you have. Provide the contribution information for the calendar year the coverage is effective.*

HSA/HRA contribution

- *If you have an HSA or HRA attached to your high-deductible health plan, please include the monthly amount you contribute to the deductible in this column for each class.*

Attestation

I, _____, the _____
(Name) (Title)
at _____
(Name of Employer)

do hereby attest that: (Check one)

_____ For groups with 2 or more employees, including businesses with only one employee who is eligible for health insurance coverage. Please list the individuals eligible for coverage who are not listed on the NYS-45-ATT. Eligible individuals include partners or owners of the business if actively engaged in the business, COBRA/NYS continuants, new employees, and retirees when it is the consistent policy of the business to cover retirees.

The individual(s) listed below work at least 20 hours per week at the above-named Employer or are otherwise eligible for coverage under a group health insurance plan to be issued by us. Include a notation for each person indicating New Employee (E) with date of hire, Partner (P), Business Owner (B), Retiree (R), COBRA (C), or other (O) with explanation.

OR

_____ Sole proprietors. With respect to an applicant for coverage as a sole proprietor, the following individual works at least 20 hours per week at the above-named Employer. If you are applying for coverage as a sole proprietor, only one (1) name will be listed.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

I certify that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including that the persons proposed for coverage work at least 20 hours per week or are otherwise eligible for coverage.

I understand that 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 \$5000 and the stated value of the claim for each such violation.

(Signature)

(Date)

Mailing Address Apt or Suite
 City State Zip
 Work Phone Number Home Phone Number Cell Phone Number
 Date of Birth Gender M F Social Security Number
 Marital Status: Single Married Legally Separated Divorced/ Marital Status Event Date
 Medicare Number (if applicable) Part A Effective Date Part B Effective Date
 If Medicare eligible due to ESRD please check type of dialysis: Self administered Facilitated Date started

5 - Other Coverage Information Have you ever been a member of Excellus BlueCross BlueShield? Yes No

In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health? No Yes / Dental? No Yes

If answering "Yes", are you keeping the additional health and/or dental coverage? Health? No Yes / Dental? No Yes

Who did the other plan cover? Self Spouse Children

Other insurance carrier name:
 Other insurance name of policyholder:

Policy ID Number: Effective Date Termination Date

6 - Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber Medical Dental / Reason Date

Dependent (list each dependent in section 7) Medical Dental / Reason Date

7 - Dependent Information

Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name

Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name M.I.

Primary Care Physician's Last Name Primary Care Physician's First Name

Ob/Gyn's Last Name Ob/Gyn's First Name

Are you a Previous Patient of PCP? Yes No Are you a Previous Patient of Ob/Gyn? Yes No

Male Date of Birth Social Security Number Are you enrolling as a Domestic Partner? Yes No

Female -- Part A Effective Date Part B Effective Date

Medicare Number (if applicable)

8 - Release/Signature

Subscriber signature required. You must sign and date this form to be eligible for insurance.

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 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature Date



GROUP ENROLLMENT FORM

DO NOT USE - INTERNAL PURPOSES ONLY

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

9 - Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name

Dependent's Last Name Dependent's First Name M.I.

Primary Care Physician's Last Name Primary Care Physician's First Name

Ob/Gyn's Last Name Ob/Gyn's First Name

Are you a Previous Patient of PCP? Are you a Previous Patient of Ob/Gyn?

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled?

Female (See last page for additional information)

Is Dependent a full time student? College/University Name Expected Graduation Date Credit hours

Dependent's Last Name Dependent's First Name M.I.

Primary Care Physician's Last Name Primary Care Physician's First Name

Ob/Gyn's Last Name Ob/Gyn's First Name

Are you a Previous Patient of PCP? Are you a Previous Patient of Ob/Gyn?

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled?

Female (See last page for additional information)

Is Dependent a full time student? College/University Name Expected Graduation Date Credit hours

Dependent's Last Name Dependent's First Name M.I.

Primary Care Physician's Last Name Primary Care Physician's First Name

Ob/Gyn's Last Name Ob/Gyn's First Name

Are you a Previous Patient of PCP? Are you a Previous Patient of Ob/Gyn?

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled?

Female (See last page for additional information)

Is Dependent a full time student? College/University Name Expected Graduation Date Credit hours

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request

To process a Subscriber or Dependent cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Handicapped/Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
Ineligible Student	Medicare

COVERAGE TYPE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than four dependents please use an additional form.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the eligible child age for your employer group:
 - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **Health Maintenance Organization (HMO)**
I understand that if I have elected a managed care product that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.
- **POINT OF SERVICE (POS)**
I understand that the Point of Service (POS) coverage is comprised of the HMO in-network product and the BlueCross BlueShield out-of-network product and that I have applied for coverage under both. I understand that the in-network benefit provides the highest level of coverage under the plan.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative.

Or, visit us at:

www.excellusbcbs.com

Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Please Check All That Apply:

I waive my employer's group **health** insurance coverage for myself and my dependents (if any).

I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

Reason for Waiving Coverage - Please Check One:

Covered through spouse's employer Covered through a parent's employer

Under 65 Retiree covered by previous employer's insurance program

Other Please specify: _____

Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage
- At the time of my employer's open enrollment.

Employee Signature: _____ Date: _____

Eligibility Policy for New Employees

Group Name: _____

Group Number {If Assigned}: _____

Our Standard new hire waiting period for eligibility for health insurance is:

(Type of employee: salaried, hourly, etc.)

- _____ Date of Hire _____
- _____ First of the month following date of hire _____
- _____ First of month following 30 days of employment _____
- _____ First of month following 60 days of employment _____
- _____ First of month following 90 days of employment _____
- _____ First of month following 6 months of employment _____
- _____ First of month following 1 year of employment _____
- _____ Other _____
Must be approved by underwriting prior to submission

Our Standard rehire waiting period for eligibility for health insurance is:

- _____ Same guidelines as new hire _____
- _____ Date of rehire _____
- _____ First of the month following rehire _____
- _____ Other _____
Must be approved by underwriting prior to submission

Minimum hours per week that an employee must work to be eligible:

- _____ 20 hours _____
- _____ 25 hours _____
- _____ 30 hours _____
- _____ 40 hours _____

Note: Employer can determine full time status as stated above but may not be less than 20 hours.

The above policies have been submitted for business indicated above. I understand that these policies are accepted and must remain in effect for at least one full year before they are eligible to be changed.

Authorized Group Signature: _____

Date Signed: _____ Date Effective: _____