Employer Application Form

Please Print

Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-5000 or 1-800-993-7299

This application is hereby made with CDPHP for enrollment of eligible members in accordance with the contract of the employer named below for coverage subject to the group meeting group eligibility.

Group Effective Date: 02 01 11 End Date: Group ID:

EMPLOYER INFORMATION *(REQUIRED)*

1. Legal company name
HARLEM VALLEY CHAMBER OF COMMERCE

Fed Tax ID

SIC code

Street address

City

State ZIP

2. Decision contact name

Phone

Fax

Street Address

ZIP

City

State

E-mail

3. Billing contact name

Phone

Fax

Street Address

ZIP

City

State

E-mail

4. Broker contact name
SCOTT MICHAELS

Broker agency
LIAZON

Is this your broker of record? Y X N

5. Total eligible employees working ≥ 20 hours

Total eligible nationwide

Total eligible in CDPHP service area

Total enrolled in any plan

CLASSIFICATION OF COVERED EMPLOYEES

The group agrees that membership enrollment applications will be submitted only for eligible employees subject to the enrollment provisions set forth in the contract and subject to the following eligibility guidelines. Member enrollment applications should be submitted no later than 30 days prior to the effective date.

6. Eligible employee definition *(check one)*: Full-time only X Full-time and part-time *(20 hours or more)*

ENROLLMENT CLASS

7. Class description *(i.e., hourly and salary employees)*:

Waiting period for new hire: FOM FOLLING 30 DAYS OF EMPLOYMENT

Employer contribution % or $ Single: Employee + Spouse: Parent + Child(ren): Family: Medicare:

Non-Medicare retiree: Employees will be terminated *(check one)*: X End of month Date of termination

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8. Class description *(i.e., hourly and salary employees):*

Waiting period for new hire:

Employer contribution % or $ Single: Employee + Spouse: Parent + Child(ren): Family: Medicare:

Non-Medicare retiree: Employees will be terminated *(check one):* ☐ End of month ☐ Date of termination

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9. Is CDPHP sole carrier? [X] Y ☐ N 14b. If no, list other carriers: ☐ 2nd open enrollment?

Date:

Have you ever had coverage through CDPHP before? ☐ Y [X] N If yes, under what legal name?

INTERNAL USE ONLY

Rep code: Broker #: Parent group ID#:

Facets group type: ☐ Employer Group ☐ Individual ☐ Chamber ☐ Association ☐ Sole Proprietor

Group size: ☐ Large ☐ Small ☐ Individual ☐ Sole Prop

Total replacement? ☐ Y ☐ N Send bill to: ☐ Group ☐ Subgroup ☐ Broker

Special Instructions (billing requirements, additional locations, reporting requirements, etc.):

SIGNATURE AUTHORIZATION

MEDICARE: A subscriber who is eligible for Medicare and employed by an employer group with fewer than 20 employees or a retiree for an employer with more than 20 employees, must have both Parts A and B of Medicare and attach a copy of his/her Medicare card to the enrollment application. Employers are not required to offer coverage to retirees.

Please Note: Benefits on your signed rate sheet may NOT be altered or modified until contract renewal, unless statutorily mandated. Requests for changes to this application must be made in writing. Employers are responsible for the administration of any continuation of coverage.

Authorization: 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 for the claim for each such violation.

Employer's signature: Date:

Print name:

Employer's title:

Broker's signature: Date:

Print name:

Account rep's signature: Date:

Print name: