

# Application for New Jersey Small Employer Health Benefits Policy

CIGNA HealthCare



<b>Please Print or Type</b>		<input type="checkbox"/> New Policy <input type="checkbox"/> Change in Policy	POLICY NUMBER (CIGNA use only)	REQUESTED EFFECTIVE DATE
<b>SECTION I: POLICYHOLDER INFORMATION</b>				
1. POLICYHOLDER (Full Legal Name of Company)			2. TAX IDENTIFICATION NUMBER	
3. MAIN ADDRESS (Street)		(City)	(State)	(Zip Code)
MAILING ADDRESS (Street)		(City)	(State)	(Zip Code)
TELEPHONE ( )		FASCIMILE ( )		
4. NAME OF CORRESPONDENT		TITLE		
5. TYPE OF ORGANIZATION <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (Explain):				
6. NATURE OF BUSINESS (Specify)			SIC CODE	
7. NUMBER OF ELIGIBLE EMPLOYEES IN YOUR COMPANY <small>* Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.</small>		8. NUMBER OF ELIGIBLE EMPLOYEES TO BE INSURED		
9. CLASS OR CLASSES TO BE EXCLUDED/INCLUDED FOR THE DEFINITION OF AN ELIGIBLE EMPLOYEE			10. INSURANCE COVERAGE REQUESTED FOR: <input type="checkbox"/> Employees Only <input type="checkbox"/> Employees and Dependents	
11. ARE YOU SUBJECT TO THE REQUIREMENTS OF COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. WAITING PERIOD BEFORE EMPLOYEES BECOME INSURED (May Not Exceed 6 Months) Present Employees   New or Rehired Employees		
13. WHAT PERCENTAGE OF THE PREMIUM WILL THE EMPLOYER PAY		14. DEPOSIT \$	PREMIUM PAID <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	
<b>Premium will be due as of the effective date. The premium for the first month of coverage must be attached.</b>				
<small>AFFILIATES, SUBSIDIARIES OR BRANCHES: (Must be included for purposes of participation)</small>				
LEGAL NAME & LOCATION	NUMBER OF ELIGIBLE EMPLOYEES IN THIS COMPANY	NUMBER OF ELIGIBLE EMPLOYEES TO BE INSURED	TYPE OF ORGANIZATION	NATURE OF BUSINESS
* CIGNA HealthCare means CIGNA HealthCare of New Jersey, Inc. and/or CIGNA HealthCare of Northern New Jersey, Inc. and/or Total Health of New Jersey (CoMED) and/or Connecticut General Life Insurance Company.				
<b>SECTION II: SPECIFICATIONS FOR COVERAGE HEALTH BENEFITS</b>				
<small>POINT-OF-SERVICE PLAN OPTIONS (HMO POS)</small>				
Plan <input type="checkbox"/> \$10 copay in-network/out-of-network (70% coinsurance)		<input type="checkbox"/> \$5 copay in-network/out-of-network (70% coinsurance)		
<input type="checkbox"/> \$10 copay in-network/out-of-network (80% coinsurance)		<input type="checkbox"/> \$5 copay in-network/out-of-network (80% coinsurance)		
Out-of-network Deductible options <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000				
<small>HMO PLAN OPTIONS</small>		<small>RIDERS (Only Available for HMO Plans and POS in-Network)</small>		
Co-payment Options <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20		Prescription Drug Rider <input type="checkbox"/> Card/Mail Order <input type="checkbox"/> None		
<small>NON STANDARD OPTIONAL BENEFIT RIDERS</small>				
In-hospital Rider <input type="checkbox"/> Waive In-hospital deductible/admission <input type="checkbox"/> None				

# Application for New Jersey Small Employer Health Benefits Policy (Continued)

## SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Healthplan: Now in force and to be continued?  Yes  No Currently being applied for?  Yes  No  
If "Yes", give a description of the plan 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  HMO POS  Dual Contract POS  Other:

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/Certificate and Most Recent Billing Statement.)

5. Are extended benefits provided in case of termination of health benefits?  Yes  No

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

Please provide the following information for each current/former employee or dependent on health continuations. If additional space is needed, attach a separate sheet, signed and dated.

NAME OF EMPLOYEE/DEPENDENT	DATE OF BIRTH	TYPE OF CONTINUATION STATE/FEDERAL/ EXTENDED BENEFITS	REASON FOR TERMINATION DISABILITY/OTHER	CONTINUATION DATES	
				START	END

7. To the best of your knowledge:

a. Are any employees or dependents presently incapacitated?  Yes  No

b. Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

## 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 CIGNA HealthCare to make or modify any request or application for insurance or to bind CIGNA HealthCare 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 CIGNA HealthCare. 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 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.