

Application for a Small Group Health Benefits Policy

Please Print or Type:

New Policy Change in Policy

Requested Effective Date: _____

Note: The Effective Date will be on or after the date CIGNA HealthCare approves the application.

CIGNA HealthCare
New Jersey Small Business
Northeast Small Group Sales
Two College Park Drive
Hooksett, NH 03106



E-Mail: nesmallgroup@CIGNA.com
Phone: 800.456.6575
Fax: 603.268.7973

SECTION I: GROUP INFORMATION

1. Policyholder (full legal name of company): _____
2. Tax Identification Number: _____ ERISA Number: _____
3. Main Address: _____
(Street) (City) (State) (Zip Code)
Mailing Address: _____
(Street) (City) (State) (Zip Code)
E-mail Address: _____ Telephone: (____) _____ Facsimile: (____) _____
4. Name of Correspondent (Group Contact): _____
5. Type of Organization: Corporation Partnership Proprietorship Other
(If Other, please explain): _____
6. Nature of Business (specify): _____ SIC Code: _____
7. Number of eligible employees in your company: _____
(Eligible employees are those who work at least 25 hours per week. Please refer to the New Jersey Small Employer Certification for the definition of an eligible employee.)
8. Number of eligible employees to be insured: _____
9. Class or classes to be excluded: _____
10. Insurance requested for: Employees Only Employees & Dependents
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? Yes No
If Yes, should the plan provide for coverage of children of a covered domestic partner? Yes No
11. Is the Employer subject to the requirements of COBRA? Yes No
12. Is the Employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? Yes No
If Yes, due to disability? Yes No
13. Waiting period before employees become insured (may not exceed 6 months):
 Present Employees: _____ New or Rehired Employees: _____
 If checked, I wish to waive this waiting period at open enrollment.
14. What percentage of the premium will the employer pay for: Employee _____ % Dependent _____ %
15. Deposit: \$ _____

Monthly 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 and Location | Number of Eligible Employees in this Company | Number of Eligible Employees to be Insured |
|-------------------------|--|--|
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SECTION II: SPECIFICATIONS FOR COVERAGE

HEALTH BENEFITS (check one)

STATE MANDATED: SM HMO SM OPT A (INDEMNITY) SM OPT B (INDEMNITY)
 SM OAP OPT C SM OAP OPT D SM OPT E (INDEMNITY)

OAP PLANS: A A-1 C D
 E F G
 J K L
 M N O

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): _____

Name of Insurance Carrier(s): _____

2. Name of Present or Prior Group Carrier: _____

Effective Date of Prior Coverage: _____ Cancellation/Termination Date: _____

3. Is the coverage applied for in this application replacing other group insurance? Yes No

If Yes, give reason: _____

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

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

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

7. 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.

| Name of Employee/Dependent | Date of Birth | Type of Continuation State/Federal/Extended Benefits | Reason for Termination/Disability/Other | Continuation Dates Start End |
|----------------------------|---------------|---|--|---------------------------------|
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If additional space is needed, attach a separate sheet, signed and dated.

8. To the best of your knowledge:
 Are any employees or dependents presently incapacitated? Yes No
 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.

9. Does the employer participate in an arrangement with a Professional Employer Organization? Yes No
 (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes Professional Employer Organizations.)

SECTION IV: AGENT/PRODUCER INFORMATION

Broker Name: _____ CIGNA ID #: _____

Agency Name: _____

SECTION V: 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 of New Jersey, Inc. to make or modify any request or application for insurance or to bind CIGNA HealthCare 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 CIGNA HealthCare of New Jersey, Inc. 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 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.

OTHER ITEMS REQUIRED WITH SUBMISSION OF POLICY

WR30

ATTACH A COPY OF YOUR WR30 (WAGE & PAYROLL) FOR THE LASTEST QUARTER OR APPROPRIATE TAX DOCUMENTATION

- ✓ OXFORD REQUIRES NO WR30
- ✓ AETNA REQUIRES WR30 FOR LESS THAN 5 ENROLLING, BUT IT IS A 6 EE ELIGIBLE GROUP
- ✓ ALL OTHER CARRIERS REQUIRE WR30 2-5 ELIGIBLE. IN OTHER WORDS IF THE GROUP HAS 6 ELIGIBLE EMPLOYEES, BUT ONLY 3 ENROLLING, WR30 IS NOT NECESSARY UNLESS UNDERWRITING COMES BACK AND MAKES A REQUEST TO SEE IT.

CARRIER BILL

A COPY OF YOUR LAST BILLING STATEMENT SHOWING ALL THE EMPLOYEES ENROLLED FROM YOUR PREVIOUS CARRIER

PREMIUM CHECK

ALL NEW CASES MUST SUBMIT A CHECK MADE OUT TO THE CARRIER WITH THE ESTIMATED MONTHLY PREMIUM AMOUNT FROM THE QUOTE. THIS MUST BE A COMPANY BUSINESS CHECK

QUOTE

ATTACH A COPY OF THE QUOTED ESTIMATED PREMIUM. PLEASE CIRCLE THIS PLAN DESIGN AND AMOUNT AND HAVE THE CLIENT SIGN THEIR NAME ANYWHERE WITHIN THE PLAN DESCRIPTION OR BY THE RATES. THIS IS AN ACKNOWLEDGEMENT OF PLAN DESIGN/RATES QUOTED.

TERMINATION OF PRIOR CARRIER

DON'T FORGET TO SEND A LETTER OFF TO THE PRIOR CARRIER, CANCELLING THE COVERAGE. PLEASE DO NOT DO SO UNTIL YOU RECEIVE APPROVAL ON THE COVERAGE THAT YOU ARE APPLYING FOR. PLEASE NOTE THAT ALL CARRIERS REQUIRE YOU TO CANCEL PRIOR OR 30 DAYS BEFORE YOUR EFFECTIVE DATE OF YOUR RENEWAL. OTHERWISE, THEY HAVE THE RIGHT TO BILL YOU. SO, YOU MAY WANT TO PUSH OUT YOUR NEW COVERAGE EFFECTIVE DATE. PLEASE CONSULT YOUR BROKER TO CHECK ON TIMEFRAMES.



2 College Park Drive
 Hooksett, NH 03106
 800-456-6575

SMALL EMPLOYER CERTIFICATION

CIGNA HealthCare of New Jersey, Inc.

| | |
|-----------------------------------|---|
| Legal Name and Address of Company | Group Policy Number or Group Number (if a current customer) |
|-----------------------------------|---|

Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

| <u>Work Location (list by State)</u> | <u>Number of Employees</u> | | | | |
|--------------------------------------|----------------------------|------------------|----------------|---------------------------------|--------------|
| | <u>Full-time</u> | <u>Part-time</u> | <u>Retired</u> | <u>COBRA or State Continues</u> | <u>Other</u> |
| | | | | | |
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For Existing Small Employer Groups in the State of New Jersey OR New Applicants

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____

Total # Eligible Employees applying/enrolling for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, or any other Health Benefits Plan offered by the Employer _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____

Total # Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? Yes No
 (You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? Yes No
 (You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

**CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY
IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B**

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

“Small Employer” means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Employees on the first day of the Plan Year, and
- the majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

I certify that I qualify as a Small Employer in the State of New Jersey.

AND

I certify that the information provided to “Carrier” is true and complete. I understand that if the above information is not complete or is not provided to “Carrier” in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Signature of Officer, Partner or Owner

Title

Date

Print Name of Officer, Partner or Proprietor

Signature of Witness

Date

I certify that I am NOT a Small Employer in the State of New Jersey as defined above.

Signature of Officer, Partner or Owner

Title

Date

Print Name of Officer, Partner or Proprietor

Signature of Witness

Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

- a employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.
- b employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

- F:** Full-time employee who works 25 or more hours per week
- P:** Part-time employee who works less than 25 hours per week
- T:** Temporary employee
- I:** Independent Contractor
- D:** Totally Disabled employee
- C:** Continue under state or federal law
- U:** Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

| Name | Job Title | Date of Employment | Hours worked per week | Status | Work Location (State) | Gender | Date of Birth |
|------|-----------|--------------------|-----------------------|--------|-----------------------|--------|---------------|
| 1 | | | | | | | |
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| 30 | | | | | | | |

*If additional space is needed, attach a separate sheet.

CIGNA HealthCare Small Group Sales
2 College Park Dr
Hooksett, NH 03106
Telephone: 800-456-6575
Facsimile: 603-268-7973



LATE PAPERWORK FORM

Producers, if group enrollment paperwork is not received 15 calendar days prior to the requested effective date, this form must be filled out by the group administrator and submitted with their completed paperwork to our Small Group Sales Office.

Group Name: _____

Address: _____

We the undersigned understand that if we are requesting a coverage date that will put our enrollment paperwork in CIGNA's office 15 calendar days or less prior to our effective date the following will apply:

The group cannot be submitted to underwriting if all the necessary information has not been received.

System activation may not occur on or before the effective date.

ID cards will be delivered 10-15 business days AFTER the group has been approved in underwriting.

If a group comes in prior to 15 calendar days before the requested effective date the above conditions will apply if all of the required information has not been submitted.

Name (please print): _____

Signature: _____

Date: _____

Insured and/or Administered by
Connecticut General Life Insurance Company,
a subsidiary of CIGNA Health Corporation
CIGNA HealthCare of New Jersey, Inc.



Enrollment/Change Request

Refer to instructions on back before completing this form.
Print clearly.

Employer Group Information - To be completed by Employer

| | | |
|---------------|-----------------|-------------|
| EMPLOYER NAME | CIGNA ACCT. NO. | BRANCH CODE |
|---------------|-----------------|-------------|

A. TYPE OF ACTIVITY - To be completed by Employer

| | | | |
|---|---|---|---|
| 1. Enrollment <input type="checkbox"/> New Enrollee Effective Date: / / Date of Hire: / / | 2. Change - Check all that apply. Date of Event: / / Reason: _____ <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Change Plan <input type="checkbox"/> Other | 3. Remove or Terminate - Check all that apply. Effective Date: / / Reason: _____ <input type="checkbox"/> Remove Spouse* <input type="checkbox"/> Remove Dependent Child* <input type="checkbox"/> Employee Withdrawal/Termination NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D. | 4. Continuation of Coverage, i.e., COBRA, State, Total Disability Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos. <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. <input type="checkbox"/> Total Disability* Date of Loss of Coverage: / / Date of Qualifying Event: / / *Attach proof of total disability |
|---|---|---|---|

B. EMPLOYEE INFORMATION - Complete Sections B-G

| | | | | | |
|---|--------------|-----------------------------|-----------------------|-------------------------------------|--|
| SOCIAL SECURITY NUMBER/EMPLOYEE IDENTIFICATION NUMBER | | LAST NAME, FIRST NAME, M.I. | | EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) | |
| HOME TELEPHONE () | HOME ADDRESS | APT. NO. | CITY, STATE | ZIP CODE | |
| EMPLOYER NAME | | | WORK TELEPHONE () | | |
| WORK ADDRESS | | | CITY, STATE | ZIP CODE | |
| DATE OF EMPLOYMENT | | | HOURS WORKED PER WEEK | | |

C. PLAN OPTION - Your selection must be offered by your employer. Check One.

| | | |
|--|---|---|
| MANAGED CARE MEDICAL OPTIONS: <input type="checkbox"/> Point-of-Service (or DPP or CHA) <input type="checkbox"/> HMO <input type="checkbox"/> Network (or EPP) (ASO only) <input type="checkbox"/> Point-of-Service Open Access | <input type="checkbox"/> HMO Open Access <input type="checkbox"/> Network Open Access (ASO only) <input type="checkbox"/> Open Access Plus <input type="checkbox"/> Open Access Plus In-Network (ASO only) | <input type="checkbox"/> CIGNA Care Network (ASO only) <input type="checkbox"/> Decline Coverage OPTION # (if applicable): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 |
| OTHER MEDICAL OPTIONS: <input type="checkbox"/> Preferred Provider Option (PPO) <input type="checkbox"/> In-Network PPO or EPO (ASO only) <input type="checkbox"/> Preferred Provider Access (PPA) <input type="checkbox"/> Medical Indemnity | <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> Pharmacy HRA <input type="checkbox"/> Dental HRA | <input type="checkbox"/> with PPO <input type="checkbox"/> with Open Access Plus <input type="checkbox"/> with Open Access Plus In-Network (ASO only) <input type="checkbox"/> with EPO (ASO only) <input type="checkbox"/> with Indemnity CIGNA Choice Fund Annual Amount: _____ |
| DENTAL OPTIONS: <input type="checkbox"/> CIGNA Dental Care (CDC) <input type="checkbox"/> Dental PPO <input type="checkbox"/> Dental Indemnity <input type="checkbox"/> Decline Coverage | | |

D. INDIVIDUALS COVERED - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

| | (A) Add (C) Change (R) Remove | LAST NAME, FIRST NAME, M.I. | SEX | | BIRTHDATE MM DD YYYY | SOCIAL SECURITY NUMBER | OTHER HEALTH COVERAGE? Yes | PRIMARY OFFICE ID NUMBER | CURRENT PATIENT? Yes | DENTAL OFFICE ID NUMBER (if applicable) | CURRENT PATIENT? Yes | PREVIOUS COVERAGE? Yes |
|----------|-------------------------------------|-----------------------------|--------------------------|--------------------------|-------------------------|------------------------|-------------------------------|--------------------------|--------------------------|--|--------------------------|---------------------------|
| | | | M | F | | | | | | | | |
| Employee | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Spouse | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child | | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |

E. OTHER/PREVIOUS INSURANCE

IS YOUR SPOUSE EMPLOYED? Yes No IF "YES", GIVE NAME & ADDRESS OF SPOUSE'S EMPLOYER

IF "YES" TO OTHER HEALTH COVERAGE (SECTION D), GIVE NAME & POLICY NUMBER OF INSURANCE CARRIER, HMO, OR OTHER SOURCE IF ENROLLED IN MEDICARE PARTS A AND/OR B, IDENTIFY THE COVERAGE AND PROVIDE THE MEDICARE ID #.

IF "YES" TO PREVIOUS COVERAGE (SECTION D), IDENTIFY NAME(S) OF PERSONS, GIVE EFFECTIVE DATE AND DATE COVERAGE TERMINATED, NAME OF PREVIOUS CARRIER AND PLAN NUMBER.

F. DEPENDENT INFORMATION

DOES ANY DEPENDENT LISTED IN SECTION D LIVE AT A DIFFERENT ADDRESS THAN THE EMPLOYEE? Yes No IF "YES", WHO AND WHAT ADDRESS?

EXPLAIN THE CIRCUMSTANCES

IF ANY DEPENDENT'S LAST NAME DIFFERS FROM YOURS, EXPLAIN THE CIRCUMSTANCES.

If you have questions concerning the benefits and services provided by or excluded under this Plan or Group Policy, contact a CIGNA HealthCare representative at 1-800-244-6224 (option 3) before signing this form.

G. EMPLOYEE SIGNATURE

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

| | | |
|------------------------------------|------|----------------|
| EMPLOYEE SIGNATURE - Required X | DATE | E-MAIL ADDRESS |
| | / / | |

H. EMPLOYER VERIFICATION - To be completed by Employer

| | | |
|------------------------------------|-------|------|
| EMPLOYER SIGNATURE - Required X | TITLE | DATE |
| | | / / |

MEB/NL (12-03)
NJ-Health Group
586975c

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with CIGNA HealthCare prior to visiting a specialist or admission to a hospital.

INSTRUCTIONS

EMPLOYER

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting enrollment/change request.
- Complete **Section II - Employer Verification** in the lower right corner of the form.
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the application in order for it to be processed.

EMPLOYEE - Complete Sections B-G

Section B - Employee Information:

Complete all information in order for your enrollment/change request to be processed.

Section C - Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay and/or Individual Deductible Amount (if applicable).
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section E - Previous Insurance.
- From the appropriate provider directory, locate the **10-digit** office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.

Section E - Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the enrollment/change request in order for it to be processed.

Section H - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the enrollment/change request in order for it to be processed.

CONDITIONS OF ENROLLMENT

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

- a) I authorize the sources stated below to give to CIGNA HealthCare or Connecticut General Life Insurance Company, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
- b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which CIGNA HealthCare or Connecticut General Life Insurance Company has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
- c) I know that I have a right to receive a copy of this authorization if I request one.
- d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a CIGNA HealthCare or Connecticut General Life Insurance Company plan or group policy, coverage is provided by CIGNA HealthCare or Connecticut General Life Insurance Company in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by CIGNA HealthCare or Connecticut General Life Insurance Company.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

**Small Employer Health Benefits
Waiver of Coverage**



| | |
|---------------------|-------------------|
| Group Policy Number | Policyholder Name |
|---------------------|-------------------|

| | |
|---------------------------------|-------------------|
| Employee Name (Last, First, MI) | Social Security # |
|---------------------------------|-------------------|

| | | |
|---|--------------------|---------------|
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | Date of Employment | Date of Birth |
|---|--------------------|---------------|

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by CIGNA. I *refused* the following:

- Employee
- Employee, Spouse and Child(ren) coverage
- Spouse Coverage
- Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

- Other group coverage sponsored by my employer
- Other group coverage sponsored by my spouse's employer
- Other group coverage sponsored by another organization
- Other reasons (please explain) _____

Please provide name of carrier and policy number: _____

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and Health Statement, and coverage may be subject to a preexisting conditions exclusion.

| | |
|-----------------------|------|
| Signature of Employee | Date |
|-----------------------|------|

| | |
|----------------------|------|
| Signature of Witness | Date |
|----------------------|------|

**CUSTOMER ACKNOWLEDGMENT FORM (CAF-1)
TRADITIONAL INSURED CASES**

CIGNA HealthCare

a

To be completed by:
Customer and Field Sales

Producer of Record:

Effective _____, I hereby acknowledge

Producer (Individual/Firm to Whom Compensation will be paid)

(% share if other than 100%)

Producer (Individual/Firm to Whom Compensation will be paid)

(% share if other than 100%)

to be designated the producer of record for _____

Customer Name

Account/Group Number

HMO Site (if applicable)

Authorized Customer Signature

Date

Authorized Customer Name (Print)

Customer Address

To comply with New York's four percent (4%) limit on compensation paid to brokers on HMO contracts, CIGNA HealthCare will not pay more than four percent (4%) commissions on HMO, POS (formerly CHA), POS Open Access and HMO Open Access products for membership covered by CIGNA Healthcare of New York, Inc.



PRODUCER ACKNOWLEDGMENT FORM

(PAF)

| | | |
|--|--|---|
| To be completed by: Field Sales and Producer | Segment: <input type="checkbox"/> Small Case <input type="checkbox"/> Mid-Market <input type="checkbox"/> National | Contract/Situs State(s): _____ Are there any NY HMO or POS members? Yes <input type="checkbox"/> No <input type="checkbox"/> Are there any Virginia CHMO or DHMO members? Yes <input type="checkbox"/> No <input type="checkbox"/> |
|--|--|---|

| Account Name | All Account Numbers* | HMO Site | Coverage Name | Comp. Eff. Date | Estimated Annual Premium | Total Account Comp. Rate | Producer Share % | \$ Flat Amt (Not for Small Case and CDH) |
|--------------|----------------------|----------|---------------|-----------------|--------------------------|--------------------------|------------------|--|
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*Please Indicate Healthsource Provident Account Number if Applicable

All commission levels are subject to Underwriting approval. Commission payments shall be reduced to conform to any applicable legal limits. Flat percentages or dollar amounts may be adjusted during the policy year in response to fluctuations in premium.

| | |
|---|---|
| Producer Name (Signature) _____ Date _____ Producer Name (Print) _____ SSN _____ Birth Date _____ (Must hold appropriate resident or non resident license & appointment) Firm Name _____ Street Address, P.O. Box # _____ City _____ State _____ ZIP _____ Phone Number _____ FAX Number _____ E-Mail Address _____ | <p align="center">****CHECKS ARE TO BE MADE PAYABLE TO****</p> <hr/> Producer or Firm Name (Print) _____ SSN/TAX ID _____ (Must hold appropriate resident or non resident license & appointment) <p align="center"> Cigna General Agent Professional Group Marketing 50 Broadway Hawthorne, NY 10532 GA# 103502 </p> <p align="center">****GENERAL AGENCY (if applicable)****</p> <hr/> Comp Rate % _____ General Agent Name _____ Tax ID# _____ |
|---|---|

| | |
|---|--|
| CIGNA Sales Representative's Signature _____ Date _____ CIGNA Sales Representative (Print) _____ | Underwriter's Signature _____ Date _____ Underwriter Name (Print) _____ |
| Sales Office _____ Telephone Number _____ | Underwriter Office _____ Telephone Number _____ |

Connecticut General Life Insurance Company, the HMO subsidiaries of Healthsource, Inc., and CIGNA Dental Health

To comply with New York's four percent (4%) limit on compensation paid to brokers on HMO contracts, CIGNA HealthCare will not pay more than four percent (4%) total compensation (commissions and overrides combined) on HMO, POS (formerly CHA), POS Open Access and HMO Open Access products for membership covered by CIGNA Healthcare of New York, Inc.

BULLETIN NO. 08-16

TO: ALL NEW JERSEY LICENSED INSURERS TRANSACTING HEALTH INSURANCE BUSINESS; HOSPITAL, MEDICAL HEALTH AND DENTAL SERVICE CORPORATIONS; DENTAL PLAN ORGANIZATIONS, PREPAID PRESCRIPTION PLANS AND HEALTH MAINTENANCE ORGANIZATIONS; ALL NEW JERSEY LICENSED HEALTH INSURANCE PRODUCERS

FROM: STEVEN M. GOLDMAN, COMMISSIONER

RE: PRODUCER COMPENSATION DISCLOSURES

P.L. 2008, c. 38 (the Act), was approved on July 8, 2008 and becomes effective on January 5, 2009. Among other things, section 25 of the Act amends the New Jersey Producer Licensing Act of 2001 (codified at N.J.S.A. 17:22A-26 et seq.) by requiring licensed insurance producers to disclose to health insurance purchasers any compensation received from the sale of such policies or contracts. Section 25 of the Act states:

a. An insurance producer licensed pursuant to P.L. 2001, c. 210 (C. 17:22A-26 et seq.) who sells, solicits, or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

b. The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

N.J.S.A. 17:22A-28 defines an "insurance producer" as a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance. The term includes insurance brokers, agents and consultants, and general agents.

The purpose of this Bulletin is to notify producers, and carriers who compensate producers, of the requirements of Section 25 of the Act and to clarify the Department's position concerning implementation of this section pending the Department's proposal of regulations.

- **Scope of Disclosure:** Disclosure is required for any insurance contract that meets the definition of "health insurance" at N.J.S.A. 17B:17-4 and for any contract sold by non-insurance health carriers, such as hospital, medical, health and dental service corporations; dental plan organizations, prepaid prescription plans and health maintenance organizations. Disclosure is not required for health coverage that is an incidental part of a life or annuity contract.

- **What must be Disclosed:** Any valuable consideration, including but not limited to commissions or service fees, must be disclosed. Consideration must be disclosed even if its amount cannot be calculated or estimated. However, the precise nature of the compensation (e.g., commission vs. service fee) does not need to be disclosed. In the case of standard

commission rates, the commission percentage or the per employee amount of commission in connection with a rate proposal, binder or bill may be disclosed.

- **Who Provides Disclosure:** The Act requires that the producer provide the disclosure to the insurance purchaser, however in many cases it may be more efficient for the carrier to provide the disclosure.

- **Timing of Disclosure:** The Act does not imply that disclosure must be made at the time of proposal or prior to a contract becoming effective. Disclosure should be made no later than the effective date of the contract.

- **Form of Disclosure:** Attached is a suggested form that may be used for compliance with the Act's compensation disclosure requirements. Use of an alternate form is acceptable so long as the Act's written compensation disclosure requirements are met.

10/01/08
Date

/s/ Steven M. Goldman, Commissioner
Steven M. Goldman, Commissioner

Inoord/bbProducerComp

**DISCLOSURE OF A FINANCIAL INTEREST
IN THE SALE OF HEALTH INSURANCE POLICIES**

New Jersey law (N.J.S.A. 17:22A-41.1) requires disclosure of the compensation a licensed agent or broker (producer) receives from your purchase or renewal of health coverage. Compensation may be in the form of a commission, fee(s), or possibly other valuable consideration, or a combination of all three.

The per employee dollar amount(s) or percentage(s) of premium are in the table below. All amounts and/or percentages are additive. If something does not apply, it is marked "None" or "NA". If there is compensation, whether or not in addition to the compensation shown, whose amount cannot be determined, enter "CBD" (cannot be determined) on the appropriate line. Use the "Other" line for all other compensation, whether or not the amount is determinable.

| | Agent/Producer | |
|-----------------------------|----------------|---|
| | Percentage (%) | Amount in Dollars (\$) (per employee basis) |
| Commission of Issuing Agent | | |
| Commission of General Agent | | |
| Consultant Fee | | |
| Brokerage Fee | | |
| Other: | | |

PRODUCER INFORMATION

Agent Name: _____

General Agent Name: _____

CARRIER INFORMATION

Company Name: _____

Date

[_____
Agent/Producer Signature]¹

¹Carriers: omit this signature block if sending the disclosure form directly to the purchaser.