Group Information Form

Please complete this form in its entirety. This form is required by New York State and failure to complete could result in your policy being cancelled.

Note: Underwriting may require additional documentation during review of the form, such as the most recently filed NYS-45 (or state equivalent).

Section 1: General Group Information

1. Group Number: ____________________ 2. Legal Entity Name: ____

3. Tax Identification Number (EIN/TIN): ______________________________ 4. ZIP Code for Business Physical Address: ___________

5. Does your business have any employees that are currently employed by a Professional Employer Organization (PEO) or leasing company and are covered as subscribers under this policy? ☐ Yes ☐ No

6. List Owners/Partners/Shareholders and Percentage of Ownership:
(Note: If there are more than four, please attach a separate listing.)

Name: ____ _______% of Ownership
Name: ____ _______% of Ownership
Name: ____ _______% of Ownership
Name: ____ _______% of Ownership

7. Commonly Owned or Related Businesses (if applicable): ____

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Section 2: Group Size Regulatory Information

1. Total number of full-time employees and full-time equivalents at all locations, including subsidiaries and businesses under common control within the United States, in the prior calendar year: _______________

2. Average number of owners and employees (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: _______________

Section 3: Medicare Coordination of Benefits

1. Did your business employ 20 or more employees who worked at least 20 weeks in the current year? ☐ Yes ☐ No
2. Did your business employ 20 or more employees who worked at least 20 weeks in the prior calendar year? ☐ Yes ☐ No
3. Did your business employ 100 or more employees on 50% or more of your business days in the current year? ☐ Yes ☐ No
4. Did your business employ 100 or more employees on 50% or more of your business days in the prior calendar year? ☐ Yes ☐ No

Section 4: Contribution

1. Annual Employer Contribution to a single-tier: Health Savings Account $__________ Health Reimbursement Account: $__________

2. If your organization offers Excellus dental what is the monthly Employer Contribution to single tier dental? __________%

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.

Employer Authorized Representative Signature: ____ Date: _________________

Print Name: ____ Email Address:______________________________________

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