[EXHIBIT N]

[Carrier]

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS [POLICY]

Please print or type [Policy] number ([Carrier] Use Only)

☐ New [Policy] ☐ Change in [Policy]
Requested Effective Date _______________
Note: The Effective Date will be on or after the date [Carrier] approves the application.

SECTION I: [POLICY]HOLDER INFORMATION

1. Policyholder (full legal name of company):___________________________
2. Tax Identification Number:____
3. Main Address:____
   Street City State Zip
   Mailing Address:____
   Street City State Zip
   Telephone: ( )_______________ Facsimile: ( )_______________
4. Name of Correspondent:____
5. Type of organization: ☐ Corporation ☐ Partnership
   ☐ Proprietorship ☐ Other (explain):_______________________________
6. Nature of business (specify):____
   SIC Code _________________________
7. Number of eligible employees in your company: ________________________

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 coverage 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 due to disability? ☐ Yes ☐ No
13. Waiting period before employees become insured: (may not exceed 6 months) ☐ Present employees:_________ ☐ New or Rehired Employees:________
14. What percentage of the premium will the employer pay?_______________
15. Deposit $______________

Premium Paid: ☐ Monthly [☐ Quarterly] [☐ Automatic checking withdrawal]
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 & Location	No. eligible employees in this company	No eligible employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

[**HEALTH BENEFITS**

Plan: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO-POS ☐ Dual Contract POS

Deductible -Carrier to identify available options

High Deductible Options: ☐ $ ☐ $

Co-Payment (Options for HMO Plans Only): ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $30 ☐ $40 ☐ $50

Managed Care Delivery System: ☐ PPO ☐ POS ☐ None

PRESCRIPTION DRUG BENEFITS
Program Type: [Carrier to identify available options]
NON-STANDARD OPTIONAL BENEFIT RIDERS
]

[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]

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) and name of insurance carrier(s)

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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.

Name of Employee/ Dependent	**Date of Birth**	**Type of Continuation State/Federal/ Extended Benefits**	**Reason for Termination Disability /Other**	**Continuation Dates**	
				Start	**End**

If additional space is needed, attach a separate sheet, signed and dated.

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.

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8. 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 a Professional Employer Organizations.)

SECTION IV: AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]

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 [Carrier] to make or modify any request or application for insurance or to bind [Carrier] 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 [Carrier]. [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.