LIA Health Alliance℠
New York's Health Insurance Exchange℠

Employer Agreement

Employer Name:	Type of Industry:
Address: City: State: **NY** Zip:	
Tel: Fax:	Employer Contact:
E-MAIL:	
New Employee Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ____ Date of Hire _____ (the First of the Month Following)	

The Employer acknowledges and represents that it understands that the LIA Health Alliance is not providing health, dental, vision, multi plan or supplemental insurance and that the insurers are providing the insurance products offered through the LIA Health Alliance.

There is a monthly billing fee of $10.00. Please include the $10 billing fee with your first payment.

PLEASE SELECT A TIER FOR EACH INSURER:
(EMBLEM AND HIP MUST MATCH)

	Two Tier	Four Tier
EASY CHOICE	☐	☐
EMBLEM & HIP	☐	☐
GUARDIAN	☐	☐
UNITED CONCORDIA	☐	☐

Supplemental Insurance
☐ Colonial Medical Bridge

COBRA ☐ Yes ☐ No

Age 29 ☐ Yes ☐ No

SECTION 125 ☐ $300 setup charge.
Make check payable to LIA Health Alliance.

This agreement shall take effect on _____ 01, 2012, upon receipt of the first month's insurance premium and the monthly billing fee. This agreement is delivered in and governed by the internal laws of the State of New York.
(month)

By signing this agreement, I hereby acknowledge that I understand the above; I also hereby acknowledge and agree that the enrollment information provided (including tax documentation) is complete and true. I also understand that the information provided forms the basis upon which insurance will be made available. I understand, further, that omissions, misrepresentations, and misstatements about the employer information, employment history and employee data could result in termination of insurance and denial of claims. I also agree to make additional documentation available (on request) to validate the enrollment and eligibility data.

Print Name/Title:	Date:
Employer Signature:	TAX ID #:

Broker Name: _____ Tel: _____

Broker License #: _____ BROKER E-MAIL:

GA: ☐ Yes ☐ No If Yes, name of GA: _____

Broker must complete this section. If this is a first submission, please complete the Broker Registration form.

ALLIANCE USE ONLY

L	I	A					

Total Employees:_____ Total Eligible Employees:_____

LIA Health Alliance℠
New York's Health Insurance Exchange℠

Employer Renewal Agreement

Employer Name:		Type of Industry:
Address:	City:	State: **NY** Zip:
Tel:	Fax:	Employer Contact:
E-MAIL:		
New Employee Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ____ Date of Hire _____ (the First of the Month Following)		

The Employer acknowledges and represents that it understands that the LIA Health Alliance is not providing health, dental or supplemental insurance and that the insurers are providing the insurance products offered through the LIA Health Alliance.

The Employer further acknowledges and represents that it understands that the LIA Health Alliance is not providing a vision discount program, and that Davis Vision is providing the vision discount program offered through the LIA Health Alliance. **There is a monthly billing fee of $10.00 which will be reflected on your monthly invoice.**

PLEASE SELECT A TIER FOR EACH INSURER:
(EMBLEM AND HIP MUST MATCH)

	Two Tier	Four Tier
EASY CHOICE	☐	☐
EMBLEM & HIP	☐	☐
GUARDIAN	☐	☐
UNITED CONCORDIA	☐	☐

Supplemental Insurance
☐ Colonial Medical Bridge

Dental Insurance ☐ Guardian ☐ United Concordia

COBRA ☐ Yes ☐ No

Age 29 ☐ Yes ☐ No

SECTION 125 ☐ $300 setup charge.
Make check payable to LIA Health Alliance.

This agreement shall take effect on _____ (month) 01, 2012, upon receipt of the renewal premium and the annual billing fee. This agreement is delivered in and governed by the internal laws of the State of New York.

By signing this agreement, I hereby acknowledge that I understand the above; I also hereby acknowledge and agree that the enrollment information provided (including tax documentation) is complete and true. I also understand that the information provided forms the basis upon which health insurance will be made available. I understand, further, that omissions, misrepresentations, and misstatements about the employer information, employment history and employee data could result in termination of group insurance and denial of claims. I also agree to make additional documentation available (on request) to validate the enrollment and eligibility data.

Print Name/Title:	Date:
Employer Signature:	TAX ID #:

Broker Name: _____ BROKER E-MAIL:

GROUP NUMBER

L	I	A					

GA: _____

Total Employees: _____ Total Eligible Employees: _____

LIA Health Alliance
New York's Health Insurance Exchange

2012 Required Documentation for Small Businesses (2-50 employees)

New Business & Renewals

Required Documentation:

____ Completed Employee Enrollment Form.
____ Employer Agreement / Broker Registration Form.
____ Copy of Prior Insurer Termination Letter.
(Necessary only if the Prior Insurer is in the Alliance).
____ All Groups must have a Federal Employer Identification Number (EIN) and New York State worksite address.
____ Must be actively in business with a street address in Nassau, Suffolk, New York City, Brooklyn, Queens, Bronx, Staten Island, Westchester or Rockland counties. Street addresses must be provided even for worksites with post office box listings.
____ Employees that enroll in Atlantis must live or work in Manhattan, Brooklyn, Queens, Bronx or Staten Island.
____ Emblem Health Benefit Waiver form(s) if selecting Emblem plans.
____ A copy of most recent carrier invoice if selecting Emblem plans.
____ HSA Set-up form for Consumer Driven Benefit Plans.

Required Tax Documentation Requirements for all Small Businesses:

Existing Business:	____	The most recently filed, signed NYS-45 or NYS-45 ATT Form
Partnership:	____	Two signed Schedule K-1's (Form 1065 or 1120S) Two pages for each partner; if both partners do not draw salary, a NYS-45 must also be submitted.
Proprietorship:	____	Schedule C & Schedule SE and a NYS-45.
Atlantis 1099's:	____	Atlantis accepts 1099's. Documentation must show a 6 month minimum employment with a $15,000 minimum salary. Groups must have a minimum of two eligible employees.
New Business:	____	Letter of Certification from group's attorney or CPA.
	____	Articles of Incorporation issued by NYS or Business Certificate issued by NYS.
	____	Acceptable payroll record for each employee (i.e. W4s).

Ancillary Requirements:

- **United Concordia (UCCI)**:
  - United Concordia Application for Group Dental Insurance.
  - LIAHA Enrollment Forms with the dental selection box checked.
  - UCCI Dental premium should be included with the health premium in one check payable to the LIA Health Alliance.
  - NYS-45.

- **EMBLEM Dental**:
  - LIAHA Employer Agreement.
  - LIAHA Enrollment Form with dental selection box checked.
  - NYS-45.
  - Check for one month's premium made out to LIA Health Alliance.
  - Signed copy of the quote.

Please note that all small businesses are required to submit current and complete tax documentation.
Please see carrier Small Group Underwriting Guidelines for more detailed information.
(Available on our website: liahealthallliance.com)

Submit to your General Agent or:
LIA Health Alliance
Enrollment Processing Center – Small Group
48 South Service Road - Suite 301
Melville, NY 11747
1-800-542-5513

REV 1/2012

LIA Health Alliance
New York's Health Insurance Exchange

NEW BUSINESS ENROLLMENT / CHANGE FORM

Rate: $ *Broker Use Only*

LIA #: ☐☐☐☐☐

A. EMPLOYEE INFORMATION

Employee Name (Last) (First) (Middle)

Home Phone ( ) Work Phone ( )

Date of Hire Month Day Year

Address (Street No.) (City) (State) (Zip)

NEW EMPLOYEE / CHANGE INFORMATION

☐ Initial Enrollment
☐ Renewal
☐ Status Change
☐ Active Medicare Participation

Check One:

☐ New Hire
☐ Age 29 Mandate
☐ **COBRA:**
○ Direct Bill
○ Group Bill

Effective Date: _____

B. OTHER INSURANCE

Do you or any of your dependents have coverage under any other medical plan? ☐ YES ☐ NO

If yes, provide the information. — here

Were you covered by another medical/hospital/dental plan within the last 12 months? ☐ YES ☐ NO If yes, provide the information in **Section E.**

Name of Insured | Employer Name: | Tel: | ☐ Individual Coverage ☐ Family Coverage

Health Insurer Name | Dental Insurer Name

Are you or any of your dependents eligible for Medicare or Medicaid? ☐ YES ☐ NO

C. TYPE OF COVERAGE (Please select one of the following)

EASY CHOICE

☐ HMO 20
☐ HMO 20A
☐ HMO 20 Plus
☐ HMO 25/40
☐ HMO 25/40A
☐ HMO 25/40 Plus

HIP

☐ EPO 30/50/1000A
☐ EPO 30/50/1000B
☐ EPO 30/50 2000/80%
☐ EPO 30/50 1500/90%
☐ PPO 30/50/1000D
☐ PPO 30/50/2000A
☐ PPO 30/50 1500/90%

GUARDIAN

DHMO
☐ MDG U20M10
☐ MDG U40M5

PPO
☐ ZZ
☐ VP

***Multi-Coverage**
☐ Option I
☐ Option II

*Beneficiary Designation/Change Form must be filled out.

Vision
☐ Davis Vision Materials Only Plan 0
☐ Davis Vision Materials Only Plan 25
☐ Davis Vision Full Feature

EMBLEM

Non Cost Sharing
☐ EPO 30/1500/750
☐ EPO 30/1500/750A
☐ EPO 40/1000A
☐ EPO 40/1000/750
☐ PPO 40/500/5000
☐ PPO 40/500/5000B

Cost Sharing
☐ CS EPO 40/2500/80
☐ CS EPO 40/2500/80A
☐ CS EPO 40/2500/80C
☐ CS EPO 50/2500/70
☐ CS EPO 50/2500/70A

Consumer
☐ EPO 5800/100%

Comprehealth
☐ HMO 30/50 1000
☐ HMO 30/50 1000A

STATUS CHANGE

Date: _____

☐ Add Dependent
☐ Remove Dependent
☐ Name Change
☐ Address Change
☐ Employee Termination
☐ Loss of Coverage
☐ Age 29 Mandate
☐ COBRA Exp. Date: _____

Reason: _____

D. EMPLOYER INFORMATION

Employer Name:_____ Telephone #:_____ Is employee currently working at least 20 hours per week? ☐ Yes ☐ No

E. ENROLLMENT INFORMATION

Name (Indicate If Last Name Is Different) (Last Name) (First) (MI)	*Birth Date Mo / Day / Yr*	*Social Security No.*	*Sex*	*Relationship Code*	*Former Health Insurance Coverage (Previous 12 months)*	*Date of Former Coverage FROM - TO*	*Primary Care Physician ID # or Name (Choose for each family member)*	*✓ if current Patient*
Employee		- -				Mo. Yr. Mo. Yr.		
Spouse		- -						
Dependent		- -						
Dependent		- -						
Dependent		- -						
Dependent		- -						

Relationship Codes: **001** Spouse **002** Child **003** Student* **004** Disabled* **005** Stepchild* **006** Legal Guardianship* ***Documentation Required**

Please read the information in the following section carefully and then sign and date this form.

- I hereby apply for the health insurer and benefit plan selected. I acknowledge that I understand all the benefits and coverage as specified in the enrollment materials and agree to abide by all the rules and regulations therein specified. I certify that I work a minimum of 20 hours per week.
- I certify that I elect to enroll myself and the family members (dependents) indicated on this form with the health insurer that I selected. I certify that all dependents listed on this form are eligible for benefits and coverage under the terms of the selected health insurer's subscriber agreement. I acknowledge that I understand that my selected insurer has no liability to provide benefit and coverage for ineligible dependents.
- I acknowledge that I understand that if I have a new dependent as a result of a marriage, birth or adoption, that I must provide appropriate documentation to enroll that new dependent within 30 days after the qualifying event.
- I acknowledge that I understand that pre-existing conditions will not be covered during the first 12 months of the contractual coverage with my selected health insurer. I further understand, however, that my selected health insurer will reduce the pre-existing limitation if (1) I provide my selected health insurer with a certificate of coverage identifying substantially similar health insurance coverage that I/we had before my selected health insurer's coverage effective date and (2) such coverage did not have a gap of more than 63 days. The pre-existing condition limitation will be reduced by the amount of time covered by the previous policy. A pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received during 6 months preceding my selected health insurer's coverage effective date; excluding pregnancy.
- On behalf of myself and each eligible Family Member, I authorize all physicians, nurses, hospitals and other providers who or which have at any time, either before or after we became covered by my selected health insurer, provided any diagnosis, treatment or any other service to any of us, to furnish to my selected health insurer or its authorized representative all information and records relating thereto.
- If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and remit same to the LIA Health Alliance.
- 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 civil penalty not to exceed five thousand dollars, and the stated value of the claim for each violation.
- I have carefully read this section and certify that all information on this form is true and complete.

_____
Employee/Applicant Signature Date

EMPLOYER AUTHORIZATION

This form must be signed and dated by an authorized company employee.
By signing this form, I verify that to the best of my knowledge, the information contained, herein, is true and complete. I also certify that the person(s) are eligible employees (or dependents) and work for the employer identified on this form.

_____
Signature-Authorized Company Representative

_____
Print Name/Title Date

5/2012 A

LIA Health Alliance℠

New York's Health Insurance Exchange℠

The LIA Health Alliance is in the process of implementing HIPAA (Health Insurance Portability & Accountability Act) electronic interfaces with its participating insurers. These electronic interfaces are governed by Federal regulations that require complete and accurate enrollment information. Therefore, Enrollment Forms must be completed in full. Please review the following:

SECTION A

Please provide the employee information requested. The Date of Hire must be the actual Month/Day/Year.

SECTION B

Please provide the other insurance information as requested and answer questions. If the answer to dependents having other coverage is yes, then, the other coverage information must be provided.

If the answer to the question regarding previous coverage over the past 12 months is yes, then, please provide the former health insurance coverage information in Section E.

SECTION C

Within each insurer's column, please check the appropriate box for the benefit plan that you want.

Please also check the appropriate box for the specific type of life status change and give the reason for that change in the space provided. Proof of the Life Status Change (e.g. Marriage Certificates, Divorce papers, HIPAA Certificates) are required.

SECTION D

The employer must complete all the information in this section including: employer name and telephone number. Please also indicate whether employee is working more than 20 hours.

SECTION E

Please provide the following employee related information: name of spouse, dependents, birth dates and social security numbers. Please also include sex, relationship code, former health insurance coverage and check current patient box, if appropriate.

The Primary Care Physician ID must be detailed as the Insurer Provider #...or the physician name, if a provider number is not used by the insurer. Please utilize the Insurer Directories for provider ID information. (Available at: LIAHealthAlliance.com)

The employer and employee must sign and date the form.

Return completed forms to:
LIA Health Alliance
Enrollment Processing Center
48 South Service Road
Suite 301
Melville, NY 11747
1-800-542-5513

LIA Health Alliance
New York's Health Insurance Exchange

RENEWAL ENROLLMENT / CHANGE FORM

Rate: $ *Broker Use Only*

LIA #:

A. EMPLOYEE INFORMATION

Employee Name (Last) (First) (Middle)

Home Phone ( )

Work Phone ( )

Date of Hire Month Day Year

Address (Street No.)

(City) (State) (Zip)

NEW EMPLOYEE / CHANGE INFORMATION — **Check One:**

- ☐ Initial Enrollment — ☐ New Hire
- ☐ Renewal — ☐ Age 29 Mandate
- ☐ Status Change — ☐ **COBRA:** ○ Direct Bill ○ Group Bill
- ☐ Active Medicare Participation

Effective Date: _____

B. OTHER INSURANCE

Do you or any of your dependents have coverage under any other medical plan? ☐ YES ☐ NO

If yes, provide the information. — here

Were you covered by another medical/hospital/dental plan within the last 12 months? ☐ YES ☐ NO If yes, provide the information in **Section E.**

Name of Insured | Employer Name: | Tel: | ☐ Individual Coverage ☐ Family Coverage

Health Insurer Name | Dental Insurer Name

Are you or any of your dependents eligible for Medicare or Medicaid? ☐ YES ☐ NO

C. TYPE OF COVERAGE (Please select one of the following)

EASY CHOICE

- ☐ HMO 20
- ☐ HMO 20A
- ☐ HMO 20 Plus
- ☐ HMO 25/40
- ☐ HMO 25/40A
- ☐ HMO 25/40 Plus
- ☐ POS 20/500
- ☐ POS 20/1000
- ☐ POS 20/2000
- ☐ POS 25/40-1000 Plus
- ☐ POS 25/40-2000
- ☐ POS 25/40-2000A

Consumer

- ☐ POS 20/2000 HRA-1
- ☐ POS 20/2000 HRA-2
- ☐ POS 20/2000 HRA-3
- ☐ POS 20/2000 HRA-4

GUARDIAN

DHMO
- ☐ MDG U20M10
- ☐ MDG U40M5

PPO
- ☐ ZZ
- ☐ VP

***Multi-Coverage**
- ☐ Option I
- ☐ Option II

Vision
- ☐ Davis Vision Materials Only Plan 0
- ☐ Davis Vision Materials Only Plan 25
- ☐ Davis Vision Full Feature

*Beneficiary Designation/Change Form must be filled out.

HIP

- ☐ HMO 25/40A
- ☐ EPO 25/1000
- ☐ EPO 30/50/1000
- ☐ EPO 30/50/1000A
- ☐ EPO 30/50/1000B
- ☐ EPO 30/50 1500/90%
- ☐ EPO 30/50 2000/80%
- ☐ PPO 15/1000
- ☐ PPO 30/50/1000D
- ☐ PPO 30/50 1500/90%
- ☐ PPO 30/50/2000
- ☐ PPO 30/50/2000A

EMBLEM

Non Cost Sharing
- ☐ EPO 30/1500/750
- ☐ EPO 30/1500/750A
- ☐ EPO 30/1500/750B
- ☐ EPO 40/1000A
- ☐ EPO 40/1000C
- ☐ EPO 40/1000/750
- ☐ PPO 40/500/5000
- ☐ PPO 40/500/5000B
- ☐ PPO 40/500/5000C

Cost Sharing
- ☐ CS EPO 40/2500/80
- ☐ CS EPO 40/2500/80A
- ☐ CS EPO 40/2500/80B
- ☐ CS EPO 40/2500/80C
- ☐ CS EPO 50/2500/70
- ☐ CS EPO 50/2500/70A

Consumer
- ☐ EPO 3000/80%
- ☐ EPO 5800/100%
- ☐ PPO 3000/6000 80/60A

Comprehealth HMO
- ☐ HMO 30/50 1000
- ☐ HMO 30/50 1000A
- ☐ HMO 30/50 500
- ☐ HMO 25/40 500A
- ☐ HMO 25/40 500

STATUS CHANGE

Date: _____

☐ Add Dependent ☐ Remove Dependent ☐ Name Change ☐ Address Change ☐ Employee Termination ☐ Loss of Coverage ☐ COBRA Exp. Date _____

Reason: _____

D. EMPLOYER INFORMATION

Employer Name:_____ Telephone #:_____ Is employee currently working at least 20 hours per week? ☐ Yes ☐ No

E. ENROLLMENT INFORMATION

Name (Indicate If Last Name Is Different) (Last Name) (First) (MI)	*Birth Date Mo / Day / Yr*	*Social Security No.*	*Sex*	*Relationship Code*	*Former Health Insurance Coverage (Previous 12 months)*	*Date of Former Coverage FROM - TO* Mo. Yr. Mo. Yr.	*Primary Care Physician ID # or Name (Choose for each family member)*	*✓ if current Patient*
Employee		- -						
Spouse		- -						
Dependent		- -						
Dependent		- -						
Dependent		- -						
Dependent		- -						

Relationship Codes: **001** Spouse **002** Child **003** Student* **004** Disabled* **005** Stepchild* **006** Legal Guardianship* ***Documentation Required**

EMPLOYEE SIGNATURE

Please read the information on the back of this form carefully and then sign and date this form.

Employee/Applicant Signature Date

EMPLOYER AUTHORIZATION

This form must be signed and dated by an authorized company employee. By signing this form, I verify that to the best of my knowledge, the information contained, herein, is true and complete. I also certify that the person(s) are eligible employees (or dependents) and work for the employer identified on this form.

Signature-Authorized Company Representative Print Name/Title Date

LIA Health Alliance℠

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The LIA Health Alliance is in the process of implementing HIPAA (Health Insurance Portability & Accountability Act) electronic interfaces with its participating insurers. These electronic interfaces are governed by Federal regulations that require complete and accurate enrollment information. Therefore, Enrollment Forms must be completed in full. Please review the following:

SECTION A

Please provide the employee information requested. The Date of Hire must be the actual Month/Day/Year.

SECTION B

Please provide the other insurance information as requested and answer questions. If the answer to dependents having other coverage is yes, then, the other coverage information must be provided.

If the answer to the question regarding previous coverage over the past 12 months is yes, then, please provide the former health insurance coverage information in Section E.

SECTION C

Within each insurer's column, please check the appropriate box for the benefit plan that you want.

Please also check the appropriate box for the specific type of life status change and give the reason for that change in the space provided. Proof of the Life Status Change (e.g. Marriage Certificates, Divorce papers, HIPAA Certificates) are required.

SECTION D

The employer must complete all the information in this section including: employer name and telephone number. Please also indicate whether employee is working more than 20 hours.

SECTION E

Please provide the following employee related information: name of spouse, dependents, birth dates and social security numbers. Please also include sex, relationship code, former health insurance coverage and check current patient box, if appropriate.

The Primary Care Physician ID must be detailed as the Insurer Provider #...or the physician name, if a provider number is not used by the insurer. Please utilize the Insurer Directories for provider ID information. (Available at: LIAHealthAlliance.com)

The employer and employee must sign and date the form.

Return completed forms to:
LIA Health Alliance
Enrollment Processing Center
48 South Service Road
Suite 301
Melville, NY 11747
1-800-542-5513

Please read the information in the following section carefully and then sign and date this form on the reverse side.

• I hereby apply for the health insurer and benefit plan selected. I acknowledge that I understand all the benefits and coverage as specified in the enrollment materials and agree to abide by all the rules and regulations therein specified. I certify that I work a minimum of 20 hours per week.

• I certify that I elect to enroll myself and the family members (dependents) indicated on this form with the health insurer that I selected. I certify that all dependents listed on this form are eligible for benefits and coverage under the terms of the selected health insurer's subscriber agreement. I acknowledge that I understand that my selected insurer has no liability to provide benefit and coverage for ineligible dependents.

• I acknowledge that I understand that if I have a new dependent as a result of a marriage, birth or adoption, that I must provide appropriate documentation to enroll that new dependent within 30 days after the qualifying event.

• I acknowledge that I understand that pre-existing conditions will not be covered during the first 12 months of the contractual coverage with my selected health insurer. I further understand, however, that my selected health insurer will reduce the pre-existing limitation if (1) I provide my selected health insurer with a certificate of coverage identifying substantially similar health insurance coverage that I/we had before my selected health insurer's coverage effective date and (2) such coverage did not have a gap of more than 63 days. The pre-existing condition limitation will be reduced by the amount of time covered by the previous policy. A pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received during 6 months preceding my selected health insurer's coverage effective date; excluding pregnancy.

• On behalf of myself and each eligible Family Member, I authorize all physicians, nurses, hospitals and other providers who or which have at any time, either before or after we became covered by my selected health insurer, provided any diagnosis, treatment or any other service to any of us, to furnish to my selected health insurer or its authorized representative all information and records relating thereto.

• If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and remit same to the LIA Health Alliance.

• 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 civil penalty not to exceed five thousand dollars, and the stated value of the claim for each violation.

• I have carefully read this section and certify that all information on this form is true and complete.

LIA Health Alliance℠
New York's Health Insurance Exchange℠

Electronic Debiting Form

The Alliance utilizes electronic funds transfer to simplify health insurance administration and reduce costs for small businesses. Electronic Debiting is the simplest and most worry-free way to pay your monthly health insurance bills. Some of the advantages of Electronic Debiting include:

✓ Worry-free payment. ✓ No check writing. ✓ Automated record keeping.

Worry-free payment: You never have to worry if a bill has been lost or misplaced. As long as sufficient funds are in your bank account, you will always pay on a timely basis.

No check writing: Electronic Debiting authorizes payment to be transferred electronically from your bank account with little or no administrative effort.

Automated record keeping: When funds are debited from your bank account, you will receive a detailed description of all transactions on your bank statement. It will detail the amount and date of the electronic payment transfer and the authorized party who initiated the transaction.

How It Works

The LIA Health Alliance will process payment transactions electronically with the Bank that you designate. With electronic debiting, monthly billed amounts are transferred electronically and your bill is "paid" timely and accurately.

Please take a moment to complete the information requested on the reverse side and return this form with your enrollment materials.

If you have any questions, please call the LIAHA Enrollment Processing Center at

1-800-542-5513

Please provide the Alliance with the following bank account information. Monthly billed amounts will be electronically transferred from the Bank that you designate below. Please attach a voided check to identify the designated Bank and the account you want debited.

PLEASE PRINT CLEARLY

Designated Bank Name:_____

Address: _____
Street Suite #

_____
City State ZIP

Designated Bank Tel. #: (____) _____

Account Number: _____

Name(s) on the Account: _____

Company Name:_____

Company Address: _____
Street Suite #

_____
City State ZIP

Company Telephone Number: (____) _____

Company Fax Number: (____) _____

COMPANY E-MAIL:

I authorize the Alliance, or its administrative agent, to transfer funds from the account identified above. The purpose of the transfer is to pay monthly health insurance bills for the above listed company. I understand that the funds will be requested from the Bank that I designate on or about the last business day of every month. I authorize monthly billed amounts for health insurance to be debited from the account listed above and transferred into the LIA Health Alliance Enrollment Processing bank account within twenty-four hours of the request.

Name/Title: _____Date: _____

Signature: _____
Authorized Company Representative

LIA Health Alliance℠
New York's Health Insurance Exchange℠

Broker Registration Form

Thank you for your effort in enrolling this Group in the Alliance. Completion of this form establishes a business relationship with the Alliance and provides the necessary information to process your commissions quickly. **Please follow HIPAA guidelines with respect to the protected health information that is provided on the enrollment forms. Please include a copy of your Broker License, if you are not affiliated with an Alliance General Agent. If you are affiliated with an Alliance General Agent, please submit a copy of your license to that General Agent.**

If you choose to receive your commissions by electronic fund transfer, please check yes ___ or no ___.
If yes, please complete Section B and submit a voided check to validate the bank and account number that is to receive the transfer (payment). This technology expedites the payment process, reduces your administrative efforts and allows you to use bank statements to simplify your record keeping.

Section A

BROKER NAME:

Address:	BROKER E-MAIL:
City, State, Zip:	
Telephone:	Fax:
Broker License Number:	Tax ID Number:
General Agent Affiliation:	

Section B

Bank Name:

Bank Account Number:

Please notify the Alliance of any changes to the required information in Sections A & B.
Call 1-800-542-5513 with that new information.

This Form must be completed only for your first submitted group with the Alliance or if you are changing your GA affiliation.
If you have any questions, please call the LIAHA Enrollment Processing Center at **1-800-542-5513.**

Selling Broker Signature: _____ **Date:** _____

General Agent Signature: _____ **Date:** _____

PREVIOUS INSURANCE COVERAGE FORM

Subscriber: To complete the enrollment process, information on any prior health insurance coverage you and/or your dependents have had in the last 12 months is required. Please attach the "Certificate of Coverage" from your prior health plan(s) or complete the following.

Within the last 12 months I have had: *(check one)*

☐ No Prior Coverage ☐ One Insurance Carrier ☐ Multiple Insurance Carriers

Subscriber Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐Group	☐Direct Payment
Coverage Type:	☐Family	☐Individual
Spouse Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐Group	☐Direct Payment
Coverage Type:	☐Family	☐Individual
Dependent Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐Group	☐Direct Payment
Coverage Type:	☐Family	☐Individual
Dependent Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐Group	☐Direct Payment
Coverage Type:	☐Family	☐Individual

If additional space is needed for dependents, please complete a separate sheet of paper.

To the best of my knowledge, the information provided above is true and complete. I understand that failure to complete this form may result in denied claim payment for services.

Print Name of Subscriber Signature of Subscriber Date

SMALL GROUP HEALTH BENEFITS WAIVER FORM

EmblemHealth®
GHI and HIP are EmblemHealth companies

Group name:			
Group number:			
Employee name:	*Last*	*First*	*Middle Initial*
Date of employment:			
Date of birth:			

I was given the opportunity to enroll in a group insurance health plan offered by my employer and insured by an EmblemHealth affiliated company.

(Note: Benefits provided on a noncontributory basis cannot be refused.)

I am declining to enroll for the reason shown below:

- ☐ Covered by spouse's/domestic partner's group coverage

  Carrier Name and Member ID _____

- ☐ Enrolled in another Insurance Carrier Plan

  Carrier Name and Member ID _____

- ☐ Covered by Medicare
- ☐ Covered by TRICARE or CHAMPVA
- ☐ Other *(Please explain)* _____

I acknowledge I have been given the opportunity to apply for this medical coverage. However, I am electing not to enroll. By declining this group health coverage I acknowledge that I and my dependents (if any) may have to wait until the plan's next anniversary date to enroll for group health coverage.

_____

Employee Signature Date