2013 Sole Proprietor Agreement

NYSHA
LIA HEALTH ALLIANCE
NEW YORK'S HEALTH INSURANCE EXCHANGE

LIA Health Alliance
300 Broadhollow Road
Suite 110W
Melville, NY 11747

Company Name: _____ Industry: _____
Tax ID#: _____
Mailing Address: _____
City: _____ County: _____ State: _____ ZIP+4: _____
Telephone: _____ Ext.: _____ Fax: _____
E-MAIL: _____ Web site URL: _____

EASY CHOICE HEALTH Plan Selections

☐ #1 HMO 20.....Rx $20/$30/$40

☐ #2 HMO 20.....Rx $0 Generic*

☐ #3 HMO 10.....Rx $20/$30/$40

☐ #4 POS 20/2000 .....Rx $20/$30/$40
(Available for Renewal Only)

*Generic Drugs: $0 copay, $0 deductible – no maximum. Brand drugs: $25 copay, $250 annual deductible & an annual maximum of $2,000 for covered brand drugs only.

☐ 2 Tier ☐ 4 Tier

HIP Benefit Plan Selections

☐ Plan A PPO 30/50 IN 2000... Rx Not Covered

☐ Plan B PPO 30/50 IN 2000... Rx Deductible $300, $20/30/50

☐ Plan C PPO 30/50 IN 2000… Rx Ded. $100, $10 Generic only

Please be aware that HIP's renewal is April 1st of each year.

Emblem Benefit Plan Selections

☐ EPO HSA - $5,800/100%

GHI Benefit Plan Selections

☐ PPO 30/1000 ….. Rx $100 Deductible
$10/50%/50%

The LIAHA agrees to perform the following administrative services for sole proprietors: enrollment, billing, collection, delinquency management, premium disbursement, commission disbursement, reconciliation and records management. The LIAHA will perform those functions so that all enrollment information will remain privileged and confidential and that the confidential process will follow HIPAA protected health information guidelines. The LIAHA adds a $15 monthly administrative fee to the health insurance premium for the aforementioned services. The administrative fee will be detailed on each monthly premium bill. There is also a $60 Enterprise billing fee (due at renewal) which will be billed separately. Please prepare a separate check for the $60 annual billing fee at initial enrollment and renewal.

The Sole Proprietor acknowledges and represents that it understands that the LIAHA is not providing health or dental insurance and that the participating insurers are providing the insurance offered. The Sole Proprietor further acknowledges and represents that it understands that the LIAHA is not providing a vision discount program and that Davis Vision is providing the vision discount program offered through the LIAHA.

A $15 MONTHLY ADMINISTRATIVE FEE WILL BE ADDED TO YOUR PREMIUM AND IT WILL BE DETAILED ON EACH BILL.

Proprietor Name _____

Last Name _____ First Name _____ Middle Initial _____

Full-time sole proprietor working more than 20 hrs/wk
☐ Yes ☐ No

By signing this form I certify that the above company is a legal entity. I also certify that I am the salaried sole proprietor of that company. I agree to submit tax documentation and understand that the documentation and information provided is complete and true, and further, that it is the basis upon which health insurance is being made available. I also understand that omissions, misrepresentations and misstatements about company information or employment data could result in termination of my sole proprietor health insurance and denial of claims.

Signature / Sole Proprietor _____ Date _____

Print Name/Title _____

This agreement shall take EFFECT on the 1st of _____, 2013 upon receipt of the first month's premium and the annual $60 billing fee. This agreement is delivered in and governed by the laws of the State of New York.

LIE | | | | | |

Broker _____
Name License # Broker E-mail

GA _____
Name

02/2013

NYHA
LIA HEALTH ALLIANCE
NEW YORK'S HEALTH INSURANCE EXCHANGE

2013 Required Documentation for Sole Proprietors

New Business & Renewal

Enrollment must be received by the LIAHA Processing Center no later than the day before the effective date.

EMBLEM / GHI / HIP Required Documentation:

- □ LIAHA Sole Proprietor Agreement.
- □ EMBLEM, GHI or HIP Enrollment Form.
- □ Tax Documentation, must provide **TWO** of the following: A Schedule C, form 1120-S, or form 1065 with a Schedule K1, CT-4-S NYS Corp. Franchise Tax Return- short form for small business, Schedule F-Profit and Loss from Farming, current signed NYS-45 or NYS-45-ATT form, Articles of Incorporation or Certificate to Do Business, Signed copy of the most recent Schedule SE- Self employment Tax Form.
- □ Letter of Certification is recommended. (Required if only one of the above-listed tax documents is not available.
- □ A signed copy of the full tax return for the most recent tax year with appropriate W2's.
- □ A Business Check.
- □ **The check should include one month's premium, which includes a $15 monthly administration fee, plus the LIAHA Sole Proprietor Annual Billing Fee of $60.**

EASY CHOICE Required Documentation:

- □ LIAHA Sole Proprietor Agreement
- □ Easy Choice Enrollment Form
- □ Tax Documentation, must provide a Schedule C tax form, or another NY State tax document (NYS-45) showing a full-time annual minimum income of $15,000.
- □ Must be actively in business with a street address in Manhattan, Brooklyn, Queens, Bronx or Staten Island.
- □ A CPA letter for a new business.
- □ Business Check, (if not available, a check in the name of the insured).
- □ **The check should include one month's premium, which includes a $15 monthly administration fee, plus the LIAHA Sole Proprietor Annual Billing Fee of $60.**

Please note that all sole proprietors must submit current and complete tax documentation.

Please see carrier Small Group Underwriting Guidelines for more detailed information.
(Available on our website: liahealthalliance.com)

Submit to your General Agent or:
LIA Health Alliance
300 Broadhollow Road
Suite 110W
Melville NY 11747
1-800-431-1290

EMPLOYEE ENROLLMENT FORM

(Please print & complete in full to avoid any delays)

Easy Choice HEALTH PLAN OF NEW YORK

45 Broadway, Suite 300
New York, NY 10006
Tel: (212) 747-0877
www.easychoiceny.com

PLAN OPTION:	☐ HMO ☐ POS ☐ HNY	TYPE OF COVERAGE:	☐ SINGLE ☐ COUPLE ☐ PARENT/CHILD ☐ FAMILY

EMPLOYEE INFORMATION

Last Name	First Name	MI	Date Of Birth	Sex ☐ M ☐ F

Social Security Number	Email Address

Home Address	Apt. No.	City	State	Zip Code

Primary Phone Number	Alternate Phone	Primary Care Physician Name & ID	If married, date of marriage:

Name of Employer	Business Phone

TYPE OF ACTIVITY

☐ New Subscriber ☐ Change of Plan or Primary Care Physician ☐ Termination

☐ Add / Remove Spouse, Dependent Child Reason: _____ Date: _____

DEPENDENT INFORMATION (Please use another enrollment form if you have more dependents)

	Add / Remove	Last Name, First Name, MI	Sex	Date of Birth	Social Security	Primary Care Physician Name & ID
SUBSCRIBER	☐ / ☐					
SPOUSE	☐ / ☐					
CHILD 1.	☐ / ☐					
CHILD 2.	☐ / ☐					
CHILD 3.	☐ / ☐					
CHILD 4.	☐ / ☐					

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	Is any dependent disabled? ☐ Yes ☐ No	If yes, list first name of child

OTHER INSURANCE INFORMATION

Do you, your spouse or dependent children have other Health Insurance? ☐ Yes ☐ No	Name of Insured	Name of Insurance carrier & Policy No.

Give Name of Prior Insurer and Date of Termination	Proof of Prior Coverage

EMPLOYER INFORMATION

Name of Group	Group Number	Contract Plan

Employment Hire Date	Enrollment Effective Date	Date Submitted to Easy Choice	Approved by (employer representative signature):

Is employee active at work? ☐ Yes ☐ No Hours worked per week _____	Move coverage to COBRA: ☐ Yes ☐ No	Qualifying event: _____ Qualifying date: _____

I authorize deductions from my earnings for any required contributions. I authorize all health professionals to provide Easy Choice Health Plan of New York and its contracted professionals, information about health (including mental illness) care advice, treatment or supplies provided to me or my dependents relating to coverage for the purpose of coordinating patient care, evaluating and administering claims for benefits, and for fulfilling Easy Choice Health Plan of New York's obligations under state and federal law. I will discuss any questions concerning the plan with Easy Choice Health Plan of New York 's member services. My signature below affirms eligibility for coverage, and all that information provided is full, complete and true to the best of my knowledge.

I understand that any person who knowingly with intent to defraud any insurance 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 material fact thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation.

In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 11 months from the initial enrollment date.

EMPLOYEE/APPLICANT SIGNATURE: X _____ DATE: _____

"Easy Choice Health Plan of New York" is a marketing name for Atlantis Health Plan, Inc.

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

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