2013 Sole Proprietor Agreement

NY HA
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

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.**

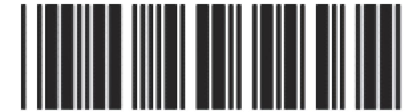
Please note that all sole proprietors must submit current and complete tax documentation.

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

EmblemHealth®

TRANSACTION FORM FOR GROUP ACCOUNTS



I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	ZIP Code

Were you ever a member of EmblemHealth? ☐ NO ☐ YES If YES, member ID

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner

Birth Date: Mo. Day Yr.

Telephone #: Home: Work:

E-Mail Address:

☐ **"GO PAPERLESS" and save trees (see back of application)***

Young Adult Coverage: ☐ 26 And Under — Family ☐ 26 - 29 — Single Parent ID:

Subscriber Employment Status: ☐ Applicant working at least 20 hours per week

Disabled? ☐ NO ☐ YES

Primary Care Physician Name: **(Not required for EPO/PPO members)** ID Number:

OB/GYN Selection Name: **(Optional)** ID Number:

Prior Health Insurance Information:
Carrier Name:
Coverage Begin Date:
Coverage End Date:

Are you covered by any other health insurance or Medicare?
☐ NO ☐ YES If YES, indicate:
Insurance Co. Name:
Insurance Co. Telephone #: Type of Coverage:
Policy #: Effective Date:

Check One:
☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Change to Ind.

Status:
☐ Add Dependent
☐ Remove Dep.
☐ Address Change
☐ Name Change

Transfer:
☐ To Another Carrier
☐ EmblemHealth Group Change:
From:
To:

II. ENROLLMENT INFORMATION — IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST EACH ONE BELOW — SEE ELECTION OF COVERAGE FOR ELIGIBILITY

Last Name (if different)	First Name	Social Security Number	Sex	Relationship	Birth Date			✓ if Disabled	Primary Care Physician Name/ID Number (Not required for EPO/PPO members)	OB/GYN Selection Name/ID Number (Optional)
					Mo.	Day	Yr.			
DEPENDENT				☐ Spouse ☐ DP ☐ Child						
Current/Prior Health Insurance Information:	Carrier Name:			Coverage Begin Date:				Coverage End Date:		
DEPENDENT				☐ Child						
Current/Prior Health Insurance Information:	Carrier Name:			Coverage Begin Date:				Coverage End Date:		
DEPENDENT				☐ Child						
Current/Prior Health Insurance Information:	Carrier Name:			Coverage Begin Date:				Coverage End Date:		

Note: A birth/marriage certificate or 1040 Form will be required for spouse/dependents with different last name.

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form.

Applicant must sign here: **Date:**

III. EMPLOYER INFORMATION — THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group:

Group Number:

☐ EmblemHealth ☐ GHI ☐ GHI HMO ☐ HIP
Plan Name:

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse/DP ☐ Employee & Child

Requested Effective Date:
Medical: Dental:

Hire Date:

Waiting Period:

Date Submitted:

Approved By: (Group Plan Administrator)

Instructions to Benefit Administrators or Group Representatives: For groups with 50 employees or fewer, you MUST complete Section A on the reverse side of this form. Required documentation MUST be attached to this Transaction Form to be processed.

ELECTION OF COVERAGE

Pre-existing conditions will not be covered during the first 12 months of enrollment in the EmblemHealth CompreHealth program or during the first 11 months of enrollment in the EmblemHealth EPO, EmblemHealth PPO, EmblemHealth ConsumerDirect PPO or EmblemHealth ConsumerDirect EPO plans. For policies issued or renewed after September 23, 2010, pre-existing condition limitations will be waived for enrollees under age 19. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice of treatment was recommended or received during the six-month period prior to your enrollment date. EmblemHealth will credit the time you were covered by prior creditable health insurance coverage toward the 12-month or 11-month period, as long as the break in coverage between the prior coverage and your EmblemHealth coverage does not exceed 63 days, exclusive of any waiting periods. If requested, you or your group must provide EmblemHealth with information about your pre-existing conditions and/or previous coverage. You have the right to request a Certificate of Creditable Coverage from your prior health plan. If needed, EmblemHealth will help you get such a certificate from your prior plan.

A large group (51 or more eligible employees) may elect to cover pre-existing conditions from the start of your EmblemHealth coverage. In such a case, your EmblemHealth policy will not contain a pre-existing condition limitation or it will state that the pre-existing condition limitation does not apply.

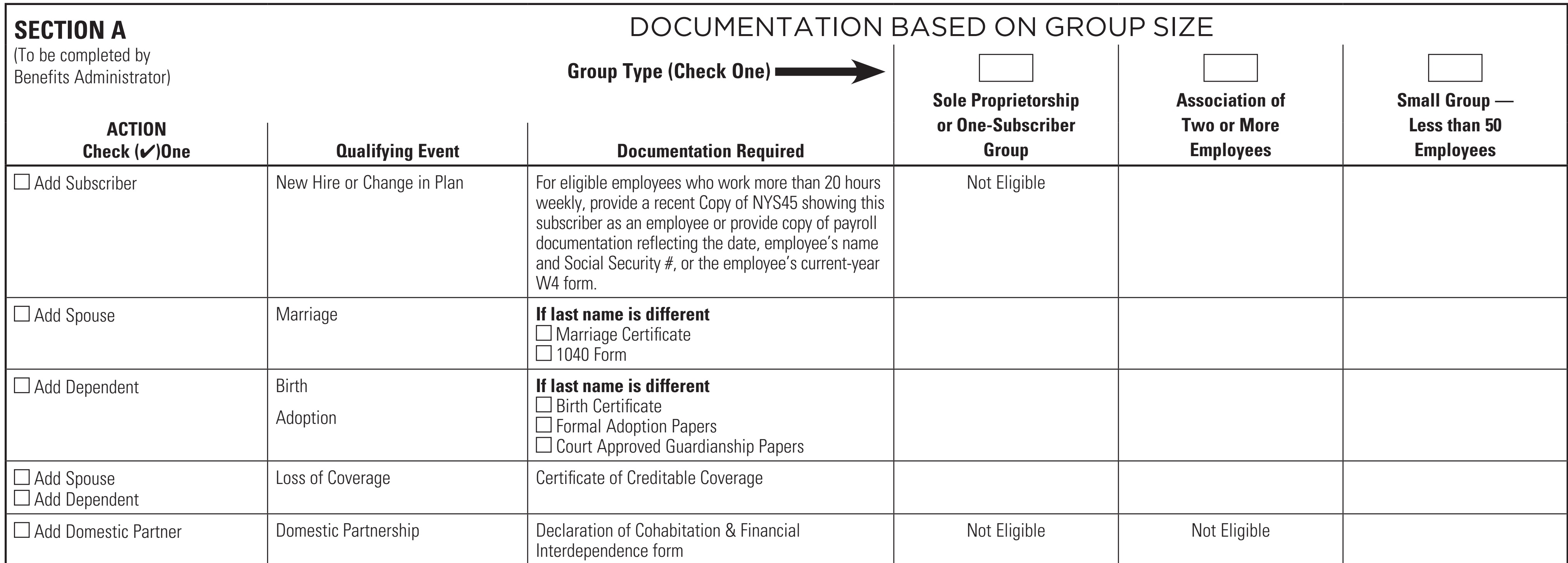
Please call EmblemHealth at 1-877-842-3625 for more information about a pre-existing condition limitation.

IMPORTANT INFORMATION

1. The subscriber must complete sections I and II. The group plan administrator must complete section III and if for a small group (50 employees or fewer), provide all necessary documentation.
2. All transactions are subject to EmblemHealth's retroactive policy (30 days for small groups, 90 days for large groups).
3. For policies issued or renewed after September 23, 2010, dependent children may stay on or be added to a parent's policy until age 26 (end of birthday month), regardless of student status, as part of federal health reform. The premium will be billed at the applicable coverage tier and, other than the basic enrollment form, nothing else is required. Most employer groups cannot limit dependent coverage eligibility even if the qualified dependent has access to his or her own employer-based coverage. Only standard GHI and HIP HMO Direct Pay, Healthy New York and GHI large groups have the possibility of restrictions for adding dependents up to age 26. As part of New York State's "age 29" law, eligible young adults through age 29 (up to 30th birthday) may continue or obtain coverage through a parent's group policy.
4. Failure to complete any part of this form (e.g., group number, reason for submission, certificate number, signature, etc.) will require EmblemHealth to return this transaction form to the employer group plan administrator and may delay the requested effective date of coverage.

Effective September 23, 2010, federal health reform may require changes to your coverage, depending on your plan. Get more information at **www.emblemhealthreform.com**.

*** By electing "Go Paperless," you will receive claim statements and some other EmblemHealth letters by e-mail instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims section of the EmblemHealth Web site. Your enrollment in the "Go Paperless" option will continue as long as your account remains active, or until you choose to discontinue this option.**



SECTION A (To be completed by Benefits Administrator)

DOCUMENTATION BASED ON GROUP SIZE

ACTION Check (✔)One	Qualifying Event	Documentation Required	☐ Sole Proprietorship or One-Subscriber Group	☐ Association of Two or More Employees	☐ Small Group — Less than 50 Employees
		Group Type (Check One) →			
☐ Add Subscriber	New Hire or Change in Plan	For eligible employees who work more than 20 hours weekly, provide a recent Copy of NYS45 showing this subscriber as an employee or provide copy of payroll documentation reflecting the date, employee's name and Social Security #, or the employee's current-year W4 form.	Not Eligible		
☐ Add Spouse	Marriage	**If last name is different** ☐ Marriage Certificate ☐ 1040 Form			
☐ Add Dependent	Birth Adoption	**If last name is different** ☐ Birth Certificate ☐ Formal Adoption Papers ☐ Court Approved Guardianship Papers			
☐ Add Spouse ☐ Add Dependent	Loss of Coverage	Certificate of Creditable Coverage			
☐ Add Domestic Partner	Domestic Partnership	Declaration of Cohabitation & Financial Interdependence form	Not Eligible	Not Eligible	

Note: No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event/next billing date.

Effective September 23, 2010, federal health reform may require changes to your coverage, depending on your plan. Get more information at www.emblemhealthreform.com.

Group Health Incorporated (GHI), GHI HMO Select, Inc. (GHI HMO), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

Health Savings Account
Individual Enrollment Form

Qualified for a Health Savings Account

This enrollment form is to open a Health Savings Account that is used to accumulate assets for the payment of qualified healthcare expenses. Your Health Savings Account is your financial asset even if you change employers or health plans. To open a Health Savings Account you must meet three criteria: 1) You must be covered by a qualified high deductible health plan, 2) You cannot be covered by another health plan, including Medicare and 3) You cannot be claimed as a dependent on another individual's tax return.

Personal Information

Name: First: ____________ Last: ____________ Middle Initial: ____

Street Address: Street: ____________

if P.O. Box – also provide street City: ____________ State: ________ Zip: ________

Mailing Address: Street: ____________

(if different) City: ____________ State: ________ Zip: ________

Date of Birth: ________ Email: ____________ *(for statements and notices)*

Contact Phone: (____) ____________ Social Security Number: ____________ Gender: ☐ M ☐ F

Insurance Coverage: Company ____________ Annual Deductible: $________

Coverage Effective Date ____________ Coverage Type: Single Family

Broker Name (optional):____________

HSA Contributions

Option 1 ☐ Check – include initial contribution with your enrollment form (minimum of $50). Make check payable to First HSA.

Option 2 ☐ Electronic Funds Transfer (EFT): Amount of initial contribution (minimum of $50): $________
Amount of future monthly contributions: $________

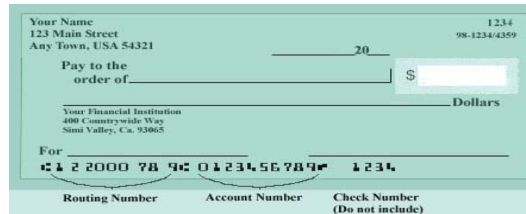
Your initial EFT contribution will be transferred from your checking account to your HSA within two weeks of the opening of your HSA. Please provide the information below for your checking account. Reimbursements that you request from your HSA will be deposited directly into your checking account unless you notify us otherwise.

Financial Institution ____________

City, State ____________

Routing Number ____________

Account Number ____________



Administrative Fees

☐ E-Statement – receive statements via email
☐ Paper Statement – receive statements via US Postal Service

Authorization and Certification

- I understand that I will be charged a $15.00 enrollment processing fee for submitting a paper enrollment application. There is no enrollment processing fee if you enroll online by going to www.1hsa.com .
- I accept the terms of the First HSA Health Savings Account enrollment form and the First HSA Health Savings Account Custodial Agreement. The HSA Custodial Agreement is available by clicking on "Forms and Documents" in the Resource Center on www.1hsa.com.
- In compliance with the USA PATRIOT Act, First HSA must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established.

____________ ____________ ________
Print Name Signature Date

The balance in your HSA is insured by the Federal Deposit Insurance Corporation (FDIC), subject to applicable deposit limits.

Please Mail or Fax Completed Forms to:
First HSA – New Accounts
2561 Bernville Rd.
Reading, PA 19605
Fax: 610-678-6818