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 2000/80%
- ☐ EPO 30/50 2000/80A
- ☐ EPO 30/50 2000/80B
- ☐ EPO 30/50 2000/80C
- ☐ 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

Health Essentials EPO
- ☐ EPO Hospital Only

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

NYCHA

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:

SECTIONA

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

SECTIONB

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.

SECTIOND

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.

SECTIONE

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.

The employer and employee must sign and date the form.

Return completed forms to:

LIA Health Alliance
300 Broadhollow Road
Suite 110W
Melville, NY 11747
1 631-493-3008