NYSHA
LIA HEALTH ALLIANCE
NEW YORK'S HEALTH INSURANCE EXCHANGE

Employer Agreement

Employer Name:		Type of Industry:
Address:	City:	State: **N Y** 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, Life, LTD, STD, AD&D 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	N/A	☐
GUARDIAN	☐	☐
UNITED CONCORDIA	☐	☐

Supplemental Insurance
☐Colonial Medical Bridge

COBRA Billing ☐Yes ☐No

Riders Available for Purchase
☐ Age 29 Rider ☐ MHP Rider

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

This agreement shall take effect on _____ 01, 2013, 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 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 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:_____