NYHA
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	N/A	☐
GUARDIAN	☐	☐
UNITED CONCORDIA	☐	☐

Supplemental Insurance
☐ Colonial Medical Bridge

Dental Insurance ☐ Guardian ☐ United Concordia

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 _____ (month) 01, 2013, 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: _____