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

TRANSACTION FORM FOR SMALL GROUPS

MEMBERSHIP / P.O. BOX 2820 • NEW YORK, NY 10116-2820

A. REASON(S) FOR SUBMISSION – Check one or more of the boxes below that apply.

☐ New Enrollment
☐ Reinstatement
☐ Termination
☐ Address Change
☐ Name Change
Former Name _____

☐ **Change Contract To:** ☐ Individual ☐ Husband/Wife ☐ Parent & Child(ren) ☐ Family ☐ Medicare Carve-Out

TRANSFER

☐ To Another Carrier
☐ From GHI Group No. _____
To GHI Group No. _____

CHANGE OF DEPENDENTS

☐ Add Spouse
☐ Delete Spouse
☐ Add Child(ren)
☐ Delete Child(ren)

B. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.	EMPLOYMENT DATE

HOME ADDRESS	APT#	DATE OF BIRTH	SEX
			☐ MALE ☐ FEMALE

CITY	STATE	ZIP CODE	MARITAL STATUS: ☐ SINGLE ☐ MARRIED
			EMPLOYMENT STATUS: ☐ EMPLOYED ☐ NOT EMPLOYED ☐ RETIRED ☐ COBRA

Telephone number where you can be reached between 9:00am and 5:00pm Monday through Friday ( ) _____

C. DO YOU HAVE PRIOR HEALTH COVERAGE Yes ☐ or No ☐ Please provide a 12-month history of all coverages below.

	Name and Address of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Current or Prior Policy	Termination Date of Current or Prior Policy
Hospital						
Medical						

D. DEPENDENT INFORMATION – List all dependent family members below (including spouse) to be covered or terminated.

(INDICATE DIFFERENT LAST NAME IF APPLICABLE)			DATE OF BIRTH	RELATIONSHIP	FULL TIME STUDENT YES OR NO	ADD ✓	DELETE ✓
LAST NAME	FIRST NAME	MI			If Yes, see #3 on reverse side		

E. OTHER CARRIER INFORMATION

Do you or any of your dependents have other health care coverage? ☐ Yes ☐ No If "Yes", please complete the following information:

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.

OTHER HEALTH INSURANCE CARRIER INFORMATION	POLICY NUMBER	EFFECTIVE DATE	NAME OF CARRIER

CARRIER'S ADDRESS	CITY	STATE	ZIP CODE

F. SUBSCRIBER AUTHORIZATION

Please read statement on the back of this form before signing this document

SUBSCRIBER'S SIGNATURE _____ DATE ___/___/___

GROUP AUTHORIZATION

AUTHORIZED SIGNATURE _____ DATE ___/___/___

G. GROUP'S NAME AND ADDRESS

EFFECTIVE DATE OF TRANSACTION	GHI GROUP NUMBER
MEDICAL	MEDICAL
HOSPITAL	HOSPITAL
DENTAL	DENTAL

LETTER OF CERTIFICATION

This form must be completed by a licensed attorney or a Certified Public Accountant (CPA) who is not related to either a) a principal or senior executive of the group or b) any employee of the group.

I am submitting this letter of certification to Group Health Incorporated (GHI) on behalf of the group shown below. I understand that GHI will use the information provided in this certification, as well as in any supporting documentation, as part of the group's application for insurance to determine eligibility and/or to make underwriting decisions.

I am a duly licensed (check one):

- ❑ Attorney
- ❑ Certified Public Account (CPA)

Section I. Please provide your name and your firm's name, address, telephone number, and state of licensure.

Name: _____
Firm Name: _____
Firm Address: _____
Telephone Number: _____
State of Licensure: _____

Section II. Please provide the following information on the group.

This letter of certification is provided on behalf of the following business entity:
Group's Name: _____
Group's Address: _____
Group's Telephone Number: _____Group's TIN: _____

This group's principal place of business is New York. This business is a (check one box only):

- ❑ Sole Proprietorship, and the proprietor works a minimum of 20 hours per week
- ❑ Partnership
- ❑ Corporation
- ❑ Limited Liability Company (LLC)
- ❑ Trust (attach supporting documentation)
- ❑ Other type of business entity (explain and attach copies of supporting documentation)
  _____

Section III. Check one or both boxes below:

- ❑ The following new employee _____ is a bona fide employee who began working for this company on _____ , works full-time (20 hours or more per week), and will be shown on payroll tax documents, which can be reviewed by GHI on or after _____.
- ❑ This group is a new business, which started on _____. The firm's tax year ends on _____. The group will be filing tax documents on or about _____ , which can be reviewed at a future date.

I hereby certify that the information stated above is true based upon my review of the books, records, or other written documentation provided to me by the group. I further certify that

the documentation I have attached to this letter in support of this certification are true and are accurate copies of the group's records. This certification forms part of the group's application for insurance. New York State insurance law provides that any person who knowingly and with the 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of person completing form: _____

Print Name and Title: _____

Date: _____