2013 Sole Proprietor Agreement

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	HIP Benefit Plan Selections
☐ #1 HMO 20...................................Rx $20/$30/$40	☐ Plan A PPO 30/50 IN 2000... Rx Not Covered
☐ #2 HMO 20...................................Rx $0 Generic*	☐ Plan B PPO 30/50 IN 2000... Rx Deductible $300, $20/30/50
☐ #3 HMO 10...................................Rx $20/$30/$40	☐ Plan C PPO 30/50 IN 2000… Rx Ded. $100, $10 Generic only
☐ #4 POS 20/2000 ....Rx $20/$30/$40 (Available for Renewal Only)	Please be aware that HIP's renewal is April 1st of each year.
*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.	**Emblem Benefit Plan Selections** ☐ EPO HSA - $5,800/100%
☐ 2 Tier ☐ 4 Tier	**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**

02/2013

HIP Subscriber/Member Enrollment Form

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

Street Address	Apt.	City	State	Zip Code

Were you ever a member of HIP? ☐ NO ☐ YES
If yes, indicate policy number(s): ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced

Birth Date: Mo. Day Yr.

Telephone #: Home: (____) ______________ Work: (____) ______________
E-Mail Address: ________________________________

Primary Care Physician: (not required for EPO/PPO members)
Physician Name ______________
Physician ID Number ______________

OB/GYN Selection: (Optional)
Physician Name ______________
Physician ID Number ______________

Prior Health Insurance Information
Carrier Name ______________
Coverage Begin Date __/__/__ Coverage End Date __/__/__

Qualifying Event: ☐ Birth/Adoption ☐ Marriage ☐ Loss of Coverage ☐ **Qualifying Event Date:** Mo.____ Day_____ Yr.

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: ___ / ___ / ___

Is your spouse 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: ___ / ___ / ___

**** If you are enrolling for your spouse and/or children, please list each one below – see Election of Coverage for eligibility***

Last Name (if different)	First Name	Soc. Sec. No.	Sex	Relationship	Birth Date Mo. Day Yr.	Check if disabled	Primary Care Physician Name/Number (not required for EPO/PPO members)	OB/GYN Selection Name/Number (Optional)
SPOUSE		___-__-____		☐ Wife ☐ Husband ☐ Other				
Prior Health Insurance Information		Carrier Name ______			Coverage Begin Date__/__/__	Coverage End Date __/__/__		
ADDITIONAL DEPENDENTS (List oldest first)		___-__-____		☐ Son ☐ Daughter				
Prior Health Insurance Information		Carrier Name ______			Coverage Begin Date__/__/__	Coverage End Date __/__/__		
		___-__-____		☐ Son ☐ Daughter				
Prior Health Insurance Information		Carrier Name ______			Coverage Begin Date__/__/__	Coverage End Date __/__/__		
		___-__-____		☐ Son ☐ Daughter				
Prior Health Insurance Information		Carrier Name ______			Coverage Begin Date__/__/__	Coverage End Date __/__/__		
		___-__-____		☐ Son ☐ Daughter				
Prior Health Insurance Information		Carrier Name ______			Coverage Begin Date__/__/__	Coverage End Date __/__/__		

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** ____________

This Section to be Completed by Employer/Contractor Group

Name of Group	Group Number

Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by *(Representative of Benefits Administrator)*

Select One: ☐ HIP PRIME HMO ☐ HIP PRIME POS ☐ HIP*access* I ☐ HIP*access* II ☐ HIP PRIME EPO ☐ HIP PRIME PPO

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

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

FOR HIP USE ONLY

PROCESSED BY	RECEIVED DATE	PROCESSED DATE

ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under 19 years of age and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

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 to remit same to HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

HIP PRIME POS and HIP*access* II applicants please note that your benefits are provided under two separate contracts: a HIP, HMO contract issued by the Health Insurance Plan of Greater New York and HIP PRIME POS and HIP*access* II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP*access* II coverage ends.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A

(To be completed by Benefits Administrator)

DOCUMENTATION BASED ON GROUP SIZE

Group Type (Check One) →

ACTION Check (✔)One	Qualifying Event	Documentation Required	☐ Sole Proprietorship or One Subscriber Group	☐ Association or Two or More Employees	☐ Small Group - Less Than 50 Employees
☐ Add Subscriber	New Hire **or** Change in Plan	Recent Copy of NYS45 showing this subscriber as an employee **or** copy of Payroll Check reflecting the date, employee's name & Social Security # **and** the employee's previous year W4 form.	Not Eligible		
☐ Add Spouse	Marriage	Marriage Certificate			
☐ Add Dependent	Birth	☐ Birth Certificate or			
	Adoption	☐ Formal Adoption Papers			
☐ Add Spouse		☐ Court Approved Papers			
☐ Add Dependent		☐ Guardianship Papers			
	Loss of Coverage	Certificate of Creditable Coverage			

Note: *No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.*

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: ____