NEW YORK HEALTH ALLIANCE
NEW YORK'S HEALTH INSURANCE EXCHANGE

Off Exchange Employer Agreement

Employer Name:		Type of Industry:
Address:	City:	State: **N Y** Zip:
Tel:	Fax:	Employer Contact:
E-MAIL:		
New Employee Waiting Period: (the First of the Month Following)	☐ 30 days ☐ 60 days	☐ Date of Hire
Date Business was Established:		

The Employer acknowledges and represents that it understands that the NY 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 NY Health Alliance.

There is a monthly billing fee of $15.00, please include this fee with your first payment. (Fee does not apply to stand alone ancillary products).

SMALL GROUP 1-99 MEDICAL:

Carriers	Four Tier
CARECONNECT	☐
MVP	☐
	☐
	☐

ANCILLARY PRODUCTS:

☐ **Guardian**

☐ **Davis Vision**

☐ **GVS Vision & Hearing**

Shelter Point:
☐ Hospital Cash $200 Downstate

☐ Hospital Cash $165 Upstate

Supplemental Insurance:
☐ Colonial Medical Bridge $1000 Benefit

☐ Colonial Medical Bridge $2000 Benefit

Riders Available for Purchase:
☐ Age 29 Rider, If applicable

This agreement shall take effect on _____ 01, 2017, upon receipt of the first month's insurance premium and the monthly billing fee.
Month

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 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 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

N	Y							

Total Employees:_____ Total Eligible Employees:_____