

2012 OXFORD Sole Proprietor Enrollment Agreement



Enrollment Processing Center
 48 South Service Road – Suite 301
 Melville, NY 11747
 1-800-431-1290

Company Name: _____ Tax Documentation: _____
 Tax ID# _____
 Mailing Address: _____
 City: _____ County: _____ State: _____ ZIP+4 _____
 Telephone: _____ Fax: _____
 E-MAIL: _____ Web site URL: _____

The LIA Health Alliance agrees to perform the following administrative services for sole proprietors: enrollment, billing, collection, delinquency management, premium disbursement and records management. The LIA Health Alliance 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 LIA Health Alliance adds a \$15 monthly administrative fee to the health insurance premium charged by the health insurance carrier for the aforementioned administration services. The administrative fee will be detailed on each monthly premium bill. There is also an annual \$60 LIA Health Alliance membership fee that will be billed separately. Please prepare a separate check for the \$60 membership fee at initial enrollment and renewal.

The Sole Proprietor acknowledges and represents that it understands that the LIA Health Alliance is not providing health or dental insurance and that the participating insurers are providing the insurance offered. The Member 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. Finally, the Member acknowledges and understands that executing the LIAHA enrollment agreement is NOT a guarantee of insurance coverage and that coverage will not be initiated until approved by the issuing insurance carrier. Insurance carrier's offering coverage to you may require that you complete additional forms, provide certain attestation statements and provide certain tax documents before coverage is made available and offered through the LIAHA. A membership fee of \$60 must be included with the first month's premium.

Sole Proprietor Name			Full-time sole proprietor working more than 20 hrs/wk <input type="checkbox"/> Yes <input type="checkbox"/> No
Last Name	First Name	Middle Initial	

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 may be 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. I hereby authorize LIA Health Alliance and the participating carriers to share enrollment information and tax documentation for the purpose of obtaining health insurance coverage and performing the administrative functions described above.

Signature of Owner/Sole Proprietor _____ Print Name/Title _____ Date _____

The LIAHA enrollment agreement shall take EFFECT on the 1st of _____, 2012 upon receipt of the first month's premium, administrative fee and the annual \$60 membership fee. This agreement is delivered in and governed by the laws of the State of New York.

For NY Health Insurance Exchange Use Only:

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Broker _____
 Name License # Broker E-mail

GA _____
 Name