

Employer Renewal Agreement

Employer Name:		Type of Industry:	
Address:		City:	State: NY Zip:
Tel:	Fax:	Employer Contact:	
E-MAIL:			
New Employee Waiting Period: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other _____ Date of Hire _____ <small>(the First of the Month Following)</small>			

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 annual billing fee of \$120.00. Please prepare a separate check for the billing fee with your renewal.**

PLEASE SELECT A TIER FOR EACH INSURER:

	Two Tier	Four Tier
Atlantis	<input type="checkbox"/>	<input type="checkbox"/>
EMBLEM	<input type="checkbox"/>	<input type="checkbox"/>
EMBLEM <small>Formerly GHI</small>	<input type="checkbox"/>	<input type="checkbox"/>
HIP	<input type="checkbox"/>	<input type="checkbox"/>

Supplemental Insurance
 Colonial Medical Bridge

Dental Insurance Emblem United Concordia

COBRA Yes No

Age 29 Yes No

SECTION 125 \$300 setup charge.
Make check payable to LIA Health Alliance.

This agreement shall take effect on _____ 01, 2011, 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 Eligible Employees: _____	