LIA Health Alliance℠
New York's Health Insurance Exchange℠

Employer Agreement

Employer Name:		Type of Industry:
Address:	City:	State: **NY** Zip:
Tel: Fax:		Employer Contact:
E-MAIL:		

New Employee Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ____ Date of Hire ______
(the First of the Month Following)

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 monthly billing fee of $10.00. Please include the $10 billing fee with your first payment.**

PLEASE SELECT A TIER FOR EACH INSURER:
(EMBLEM AND HIP MUST MATCH)

	Two Tier	Four Tier
EASY CHOICE	☐	☐
EMBLEM & HIP	☐	☐

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 ________________ (month) 01, 2012, upon receipt of the first month's health insurance 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:______________________________ Tel:______________________________

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

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Total Employees:_____ Total Eligible Employees:_____

1/2012