2012 Sole Proprietor Agreement

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

ENROLLMENT PROCESSING CENTER
48 South Service Road - Suite 301
Melville, NY 11747 • 1-800-431-1290

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

☐ #1 HMO 20.....Rx $20/$30/$40

☐ #2 HMO 20.....Rx $0 Generic*

☐ #3 HMO 10.....Rx $20/$30/$40

☐ #4 POS 20/2000 .....Rx $20/$30/$40
(Available for Renewal Only)

*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.

☐ 2 Tier ☐ 4 Tier

HIP Benefit Plan Selections

☐ Plan A PPO 30/50 IN 2000... Rx Not Covered

☐ Plan B PPO 30/50 IN 2000... Rx Deductible $300, $20/30/50

☐ Plan C PPO 30/50 IN 2000… Rx Ded. $100, $10 Generic only

Please be aware that HIP's renewal is April 1st of each year.

Emblem Benefit Plan Selections

☐ EPO HSA - $5,800/100%

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 _____, 2012 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

1/2012