

**Underwriting Requirements for Employer Groups enrolling in a Chamber of Commerce
Association Group with Independent Health**

- _____ 1. Completed applications

- _____ 2. Company Tax Documentation (NYS45-ATT or Partnership K-1's)

- _____ 3. Chamber of Commerce/Association Group Membership Information Form

- _____ 4. Check for the first month's premium, made payable to Bene-Care



511 Farber Leites Drive
Buffalo, NY 14221
1-800-453-1910
www.independenthealth.com

- Encompass D
- FlexFit Select
- Active
- Family
- Independent

Chamber of Commerce and Professional Association

1. Please check one: GROUP ENROLLMENT APPLICATION CHANGE FORM COBRA ELECTION
 2. EFFECTIVE DATE: ____ / ____ / ____ GROUP # ____ PLAN # ____
 (Add, Change or Cancellation) (Please Reference Benefit Summary)

Change Only / Please check all that apply:
 PLAN CHANGE PHYSICIAN CHANGE
 NAME CHANGE ADDRESS CHANGE
 ADD DEPENDENT / QUALIFYING EVENT (birth, marriage, etc.)

Reason codes on reverse side:
 CANCEL POLICY / Reason code
 REMOVE DEPENDENT / Reason code
 DEPENDENT ID #

Chamber/Association
Initials
REQUIRED FOR
PROCESSING

Initials
Today's Date

3. PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION.
 THANK YOU FOR CHOOSING INDEPENDENT HEALTH.

8. EMPLOYER ATTESTATION (employer must complete this section)
 CHAMBER OR ASSOCIATION

APPLICANT'S LAST NAME: _____ MI: _____
 EMPLOYER NAME: _____
 ADDRESS (NUMBER, STREET, APARTMENT): _____
 EMPLOYER ADDRESS: _____
 CITY: _____ STATE: _____ COUNTY: _____ STATE: _____ ZIP * 4: _____
 TELEPHONE: _____ EMPLOYER TELEPHONE: _____ EMPLOYER TAX ID: _____
 HOME: () WORK: () EMAIL: _____ DATE JOINED CHAMBER/ASSOCIATION: _____ DATE OF EMPLOYMENT: _____
 HAVE YOU EVER BEEN A MEMBER OF INDEPENDENT HEALTH? YES NO
 IF YES, list your identification number: _____
 WAS APPLICANT GIVEN A CHOICE OF HEALTH PLANS? YES NO
 WHAT IS YOUR PRIMARY LANGUAGE? _____ GENDER: MALE FEMALE
 FROM: _____ TO: _____
 EMPLOYER SIGNATURE: _____ DATE: _____
 EMPLOYER SIGNATURE: _____ DATE: _____

4. Member Information:

APPLICANT	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	IH PHYSICIAN NUMBER (for full name and address)	PHYSICIAN NUMBER	PHYSICIAN NUMBER
APPLICANT						SELF			
SPOUSE						Code - <input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE			
CHILD						Code - <input type="checkbox"/> Daughter <input type="checkbox"/> Son			
CHILD						Code - <input type="checkbox"/> Daughter <input type="checkbox"/> Son			
CHILD						Code - <input type="checkbox"/> Daughter <input type="checkbox"/> Son			

5. While enrolled in Independent Health, will you or your dependent(s) be covered by any of the following: if additional space is required, please attach a separate sheet.

CHECK YES OR NO:
 * MEDICARE Yes No (Please list all covered members)
 * OTHER HEALTH INSURANCE* Yes No (Please list all covered members)
 *including no fault and/or workers' compensation (in the event of an injury).

6. Is your child (or children) a full-time college student? Yes No
 If yes, please complete section on back of application.

7. AUTHORIZATION: I have read and agree to the authorization on the reverse side of this form.

ALL SECTIONS MUST BE COMPLETED BEFORE PROCESSING. SUBSCRIBER'S SIGNATURE: _____ DATE: _____

IH USE ONLY Effective Date: _____ Pre-Ex: _____ Account Number: _____ Group Number: _____ Account Number: _____ Title Code: _____ Benefit Package Code: _____

REASON CODES:

- B. Dependent Reached Age 23/24/25
- C. Group Cancel - Open Enrollment
- D. Deceased
- G. Group Cancel - Mid-contract
- I. Transferring to Another Group
- L. Layoff
- M. Moved out of Area
- N. Nonpayment
- O. Member Cancel - Open Enrollment
- P. Personal Reasons
- R. Retired
- T. Terminated Employment
- U. Dependent Age Cut-off (age 19)
- V. Medicare
- W. Now Under Spouse's Plan
- X. No Longer Eligible
- Y. Dissatisfaction with the Plan
- Z. Dependent Age Cut-off - Waiver Required

ELIGIBILITY FOR STUDENT COVERAGE

(applies only to those members whose contract includes an age extension rider)

Your contract may require that a dependent age 19 or above maintain full-time student status (a minimum of 12 credit hours) at an accredited college or university to remain eligible as a dependent on your contract.

Please check the statement that best describes your child's student status:

- Yes, my child is a full-time college student as defined above. Following is information that may be verified:

Child _____ College or University _____ Student ID No. _____

Address _____ City, State, Zip Code _____ Expected Date of Graduation _____

Child _____ College or University _____ Student ID No. _____

Address _____ City, State, Zip Code _____ Expected Date of Graduation _____

(Please attach separate sheet if you have additional children who are eligible full-time students)

- Yes, my child is a full-time college student but is currently on medical leave. Please attach a note from your physician verifying your child's condition.
- No, my child is not a full-time college student. Please send me information on a direct pay policy.

PRIOR HEALTH INSURANCE (CONTINUED)

HEALTH INSURANCE COMPANY (include address and phone number of previous carrier)	ID #	COVERAGE FROM MONTH/YEAR	COVERAGE TO MONTH/YEAR

CERTIFICATION/ACKNOWLEDGEMENT

I certify that the information given on this form is current to the best of my knowledge and I have read and agree to this acknowledgement. This Application CANNOT be processed if Birth date(s) and Social Security Number(s) are not completed. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact materials thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

I understand that this application and subsequent acceptance of services on behalf of myself, spouse and eligible dependent(s) listed are subject to the terms of the applicable contracts and riders issued by Independent Health, its affiliates or subsidiaries ("Independent Health"). I authorize my employer to deduct the necessary Health Services Fees, if any, from my wages or salary, with the understanding that he/she acts as my agent in all dealings with Independent Health, and that all acts performed by him/her and all notices given to him/her in such dealings are binding upon me, as not prohibited by statute or regulation. I understand that any person or institution who shall have rendered services to me or to any of my dependents under an Independent Health contract shall make available to Independent Health to such an extent as may be reasonable, any photographs, records, or information regarding such services, required by Independent Health, which shall be kept confidential by Independent Health unless disclosure is permitted by applicable law, regulation and/or contract.

I acknowledge that if I am presently without coverage for longer than sixty-three (63) days, then a pre-existing condition waiting period may apply. Pre-existing condition waiting periods apply to individuals with conditions diagnosed or recommended for treatment within six (6) months prior to the enrollment date of new coverage and shall not exceed twelve (12) months following this date.

Independent Health's Encompass and Encompass Elect are issued through Independent Health Association, Inc. Independent Health's Encompass Plus, Encompass Elect Plus and Select Plus are issued by Independent Health Benefits Corporation, an affiliate of Independent Health Association, Inc. Independent Health's Custom Coverage is administered by Independent Health Corporation, an affiliate of Independent Health Association, Inc.



**CHAMBER OF COMMERCE / ASSOCIATION
GROUP MEMBERSHIP INFORMATION FORM**

Please check the appropriate box for the type of business entity represented:

- Sole proprietor (Group of One) Partnership/Corp. Small Business (2-50 employees)
- Large Business (51 or more employees) Other, please explain _____

Chamber / Association Name _____ Group# _____

Business Name _____

Contact Name _____ Telephone _____

Business Address _____

Tax ID # _____ Date Business joined chamber/Assoc. _____

Number of employees eligible for health coverage through this employer _____

Total # of employees working at least 17.5 hours per week (20 hours for Sole Proprietors) _____

In order to verify the eligibility of our Independent Health subscribers we require the following information to be included with each application:

- 1. Business validation information.
 - A.) Copy of Doing Business As (DBA) certificate **OR** copy of NYS Dept of Taxation & Finance Certificate of Authority.
 - B.) Copy of Schedule C for tax return **OR** Estimated Schedule C.

- Partnerships provide all of the following:
 - A.) Federal Tax ID number **OR** copy of current Partnership Agreement.
 - B.) Copy of Schedule 1065 K-1 **OR** Estimated Schedule 1065 K-1.

- Incorporated businesses provide all of the following:
 - A.) Federal Tax ID number **OR** Articles of Incorporation **OR** Federal 941 report **OR** initial for SS4.
 - B.) Copy of Corporate Tax Return (1120C, 1120S or Schedule E)-Income & Expense page(s) only **OR** Estimated Corporate Tax Return Income & Expense information only.

- 2. Employee information.
 - Groups of 2 or more eligible employees:
 - Provide a copy of the last NYS-45 or 45 ATT form filed for all employees.

Individual employees:
Provide Schedule C or Schedule E as required above or a copy of W-2 or Form 1099.

By signing below, the employer group or sole proprietor has read the following:
I certify that all information furnished hereon is true and complete to the best of my knowledge. I understand that the Association/Chamber, in conjunction with Independent Health, reserves the right to request additional information prior to approving my application for insurance. I understand that Independent Health will conduct annual audits to ensure compliance with enrollment guidelines, which may require us to provide verification of our being a bona fide employer or sole proprietor. I understand that all subscribers must be employed a minimum of 17.5 hours per week (20 hours for sole proprietors) in order to qualify for benefits under this contract. If self-employed, I certify that my main source of income is the result of my self-employed status.

Employer Signature _____ Date _____

Print Name _____ Title _____