



**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 _____

Applicant Name _____ ID# _____

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.

- Copy of Doing Business As (DBA) certificate or state license or Federal Tax ID number.
- Copy of Schedule C for 2005 tax return or 2006 Estimated Schedule C.

Partnerships provide all of the following:

- Federal Tax ID number or copy of current Partnership Agreement
- Copy of 2005 Schedule 1065 K-1 or 2006 Estimated Schedule 1065 K-1.

Incorporated businesses provide all of the following:

- Federal Tax ID number or Articles of Incorporation or Federal 941 report or initial for SS4.
- Copy of 2005 Corporate Tax Return (1120C, 1120E, 1120S or Schedule E)-Income & Expense page(s) only or 2006 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 2006 W-2 or 2006 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 _____