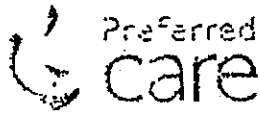




Below is a list of required documents from all groups and must accompany the New Group Setup Sheet when submitted.

- 1.) Copy of the company's most recent NYS-45-ATT-MN, with notations indicating eligible employees.
- 2.) If there are any persons who are proposed for health insurance WHO ARE NOT listed on the NYS-45-ATT-MN, the employer must provide one of the following as documentation and indicate they are eligible for coverage:
  - for partnerships, a copy of the most recent 1065K-1 with income amount stricken
  - for business owners, a copy of the most recent Schedule E# to Form 1120 or Schedule K-1 to Form 1120S, or Schedule E to Form 1120F
- 3.) The attached attestation is to be used for individuals that are not listed on the NYS-45-ATT-MN, or to list the individuals being proposed for coverage when the business is new and has not yet filed a NYS-45-ATT-MN.
  - If the employer has been in business for such a short time and has not yet received/ filed a NYS-45-AT-MN, a copy of its SS 4 from the employer ***is required***. They must also complete Preferred Care's Attestation Form and provide a copy of their most recent payroll register.



**ATTESTATION**

I, \_\_\_\_\_, the \_\_\_\_\_  
(Name) (Title)

At \_\_\_\_\_  
(Name of Employer Group)

Do hereby attest that:

The following individual(s) work at the above-named Employer. The eligible employees listed for coverage under a group health insurance plan to be issued by Preferred Care are designated by an "X".

*Please attach an employee census (list of active employees) with an X next to the names to indicate those active employees who are eligible for health insurance coverage or list the names of all employees below and indicate those who are eligible for health care coverage by placing an X in the appropriate column.*

Names of Employed Individuals

Eligible for Health Insurance  
(Place an X next to those individuals eligible)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**The undersigned certifies that, to the best of his/her knowledge and belief and under penalty of perjury, the information listed above is true and complete.**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



## Waiver of Coverage

Company Name \_\_\_\_\_

Employee Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Please check one:**

\_\_\_\_\_ I waive my employer's group health insurance coverage for myself and my dependents (if any).

\_\_\_\_\_ I am enrolling in my employer's group health coverage but I am waiving coverage for my dependents.

**Reason for waiving coverage – please check one:**

\_\_\_\_\_ Coverage through spouse's employer

\_\_\_\_\_ Coverage through parent's employer

Employer Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

\_\_\_\_\_ Other reason (explain)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Important note** – If you checked that you are declining coverage due to other coverage, you will be eligible to enroll in this plan within 30 days of the date that you are no longer eligible for the other coverage. If you did not state that the reason for waiving coverage is due to other coverage, then you cannot enroll in this plan until your employer's open enrollment period (except through birth, adoption or marriage).

The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Date:

Deb Link  
MVP Health Care  
220 Alexander Street  
Rochester, NY 14607

**RE: BROKER'S LETTER OF RECORD**

Dear Deb:

This confirms that as of \_\_\_\_\_, we have appointed Rochester Business Alliance Inc. as our exclusive Insurance Broker with respect to our Health Insurance Plan as follows:

MVP Health Care  
700161

The appointment of Rochester Business Alliance Inc. rescinds all previous appointments and the authority contained herein shall remain in full force until canceled in writing.

Rochester Business Alliance, Inc. is hereby authorized to negotiate directly with any interested company as respect to changes in existing insurance policies and in closing, changing, increasing or canceling insurance carried under temporary binders or cover notes. We understand, however, that they will not share responsibility for any deficiencies in the insurance program to which this letter applies until they have had reasonable opportunity to make a review and to provide us with their recommendations.

This letter also constitutes your authority to furnish Rochester Business Alliance's representatives with all information they may request as it pertains to our insurance contracts, rates, rating schedules, surveys, reserves, retentions and all other financial data they may wish to obtain for their study of our present and future requirements in connection with the insurance program to which this letter applies, except as may be restricted or prohibited by law and by MVP Health Care policy. We request that you do not communicate such information to anyone else.

Sincerely,

\_\_\_\_\_  
(Name of Company)

\_\_\_\_\_  
(Authorized Signature & Title of Officer)



# Enrollment Application/Change Form

**ACTION REQUESTED:**  Enroll  
 Change  
 Cancel

## 1 INFORMATION ABOUT YOURSELF

 INSTRUCTIONS TO EMPLOYEE: Please print or type and complete Sections 1 through 5.

Employee Name (Last, First, Initial, Suffix) \_\_\_\_\_ Marital Status  Single  Married

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone \_\_\_\_\_ Chamber/Association Name \_\_\_\_\_ Date Employed \_\_\_\_\_  Active  Retiree

Do you or any other family members have health insurance?  Yes  No If yes, by whom? \_\_\_\_\_ Spouse's health insurance carrier (if other than yours) \_\_\_\_\_ Coverage level  Individual  Family Spouse's health insurance ID# \_\_\_\_\_

Eligible for Medicare?  Yes  No Employee ID# \_\_\_\_\_ Spouse ID# \_\_\_\_\_

Employee  A Effective Date \_\_\_\_\_  B Effective Date \_\_\_\_\_ Spouse  A Effective Date \_\_\_\_\_  B Effective Date \_\_\_\_\_

## 2 ENROLLMENT/CHANGE

 For address or Primary Care Physician changes, call 1-800-318-8575 or visit [www.mvphealthcare.com](http://www.mvphealthcare.com).

**A** Effective Date \_\_\_\_\_

New Applicant **Reason:**

Name Change  New Hire

COBRA  Open Enrollment

Add Dependent  COBRA/State Continuation

Plan Change to \_\_\_\_\_  Qualifying Event (describe) \_\_\_\_\_

Address Change  Dependent to 30 \_\_\_\_\_

**B** Effective Date \_\_\_\_\_

Termination

Remove Dependent(s) only (please specify) \_\_\_\_\_

**Reason:**

Termination of Employment  Opting for Other Coverage

Moved From Area  Other \_\_\_\_\_

## 3 CHOOSE COVERAGE

HMO\* Product ID # \_\_\_\_\_

PPO

EPO

HDHP/HSA

HDHP

Dental

\*Please choose a Primary Care Physician—  
for each family member—in Section 4.

## 4 INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

1. Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee self

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_

2. Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee  spouse/civil union partner  Domestic Partner

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_

3. Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee \_\_\_\_\_ Check all that apply:  Disabled  Current Patient  Full-time Student over 18

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_\_ If applicable: College Name \_\_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_ Expected Graduation Date \_\_\_\_\_

4. Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee \_\_\_\_\_ Check all that apply:  Disabled  Current Patient  Full-time Student over 18

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_\_ If applicable: College Name \_\_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_ Expected Graduation Date \_\_\_\_\_

For additional dependents, please list on a separate form. ▶

## 5 PREVIOUS INSURANCE INFORMATION

	SUBSCRIBER	DEPENDENT	DEPENDENT	DEPENDENT
Effective Date of Previous Coverage				
Termination Date				
Carrier's Name				
Is Member Eligible for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you or any of your dependents been covered by another health plan during the last 63 days (excluding any waiting periods)?  Yes  No

Please note, that a "No" answer means that expenses resulting from any conditions for which care was received or recommended during the last six months (excluding employer waiting period) will not be covered until you have completed a twelve (12) month waiting period. If you had prior coverage which terminated within 63 days of your effective date (excluding employer waiting period), your prior coverage may be eligible to satisfy all or part of your twelve (12) month waiting period. **Please complete the Previous Insurance Information section above and attach certificate of creditable coverage issued by your former insurer.**

## 6 MUST BE COMPLETED IN FULL BY EMPLOYER AND ASSOCIATION

Employer Name	Group # 700161	Effective Date	<input type="checkbox"/> Sole Proprietor OR <input type="checkbox"/> Employer Group (Groups of 2 or more)
# of Employees (required)	Tax ID Number (required)		
When did employee become eligible for coverage (N/A for retiree)?	New Employer? (required) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer Signature	Date of Signature		
Is applicant currently working at least 20 hrs/week? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A for retiree <i>Subscriber, including sole proprietor, must be employed a minimum of 20 hours per week in order to qualify for benefits under this contract.</i>			
Association/Chamber Verification	ROCHESTER BUSINESS ALLIANCE		
Signature	Date		

## 7 AUTHORIZATION AND AGREEMENT

I have read and agree to the authorization below.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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 material thereto, commits a fraudulent insurance act, which is a crime and, in New York, shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under my plan may be subject to preexisting condition limitations. If applicable, a medical questionnaire will be forwarded to you for your completion. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month (6) period ending on the enrollment date. We will exclude coverage for health care services during the first twelve (12) months of this Contract that relate to pre-existing conditions.

We will credit to the Covered Person the time he was covered under previous health insurance plans, if the previous coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date of this Contract.

Additionally, no pre-existing condition exclusion will be imposed on an "eligible individual" as defined in section 2741(b) of the federal Public Health Service Act, 42 USC §300gg-41(b).

I authorize my employer to deduct from my earnings the necessary contribution, if any, required of me.

I hereby authorize any licensed physician, hospital or other health care provider to furnish MVP with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow MVP to administer my benefits. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.