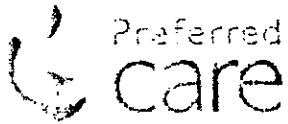


Below is a list of required documents from all groups and must accompany the New Group Setup Sheet when submitted.

- 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
B00161

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)



CHAMBER OF COMMERCE/PROFESSIONAL ASSOCIATION/MULTI-EMPLOYER GROUPS
Enrollment Application/Change Form

MVP Health Plan, Inc.
 MVP Health Insurance Company
 MVP Health Services Corp.
 Preferred Assurance Company, Inc.

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 **ROCHESTER BUSINESS ALLIANCE** 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 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.

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* PPO EPO HDHP/HSA HDHP Dental

Product ID # _____

*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 _____ Sole Proprietor OR 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) Yes No

Employer Signature _____ Date of Signature _____

Is applicant currently working at least 20 hrs/week? Yes No N/A for retiree *Subscriber, including sole proprietor, must be employed a minimum of 20 hours per week in order to qualify for benefits under this contract.*

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.