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.

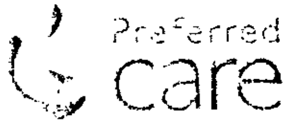
2.) If there are any persons who are proposed for health insurance WHO ARE NOT listed on the NYS-45-ATT-MN, the employer must provide one of the following as documentation and indicate they are eligible for coverage:

   - 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)

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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 heath 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)

Preferred Care
It's time to live well

259 Monroe Avenue, Rochester, NY 14607
www.preferredcare.org

CHAMBER OF COMMERCE AND PROFESSIONAL ASSOCIATION ENROLLMENT APPLICATION

Please make sure to complete all six sections

☐ APPLICATION FOR ENROLLMENT
- ☐ new hire
- ☐ open enrollment
- ☐ loss of coverage

☐ REQUEST FOR CHANGE
- ☐ change health plan
- ☐ add dependent
- ☐ remove dependent
- ☐ other ____________

☐ CANCEL COVERAGE
- ☐ open enrollment
- ☐ employment terminated
- ☐ moved out of area
- ☐ employee deceased
- ☐ other ____________

☐ COBRA/NYSC
- ☐ former employee
- ☐ former dependent

I. SUBSCRIBER INFORMATION

LAST NAME: FIRST NAME: M.I.:

ADDRESS:

CITY: STATE: ZIP: COUNTY:

TELEPHONE:
HOME: WORK:

SOCIAL SECURITY NUMBER: MARITAL STATUS: SEX:

CURRENT HEALTH INSURANCE:

HAVE YOU EVER BEEN A MEMBER OF PREFERRED CARE? ☐ YES ☐ NO

CONTRACT NUMBER:

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 on the back and attach all qualifying documentation.

- You must select a PCP in order for Preferred Care to properly administer coverage under your Preferred Care health plan unless you are a Preferred Care PPO member.

II. SUBSCRIBER and DEPENDENT INFORMATION

	SUBSCRIBER	DEPENDENT	DEPENDENT	DEPENDENT
NAME (last if different) FIRST, MI				
BIRTHDATE (MM/DD/YY)	/ /	/ /	/ /	/ /
RELATIONSHIP (SPOUSE, CHILD)	SUBSCRIBER			
SOCIAL SECURITY NO.				
SEX	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE
PRIMARY CARE PHYSICIAN NAME	(PCP)	(PCP)	(PCP)	(PCP)
(Females may also choose an OB/GYN)	(OB/GYN)	(OB/GYN)	(OB/GYN)	(OB/GYN)
PHYSICIAN SEQUENCE NUMBER (from Physician's listing)	(PCP) ________ (OB/GYN) ________	(PCP) ________ (OB/GYN) ________	(PCP) ________ (OB/GYN) ________	(PCP) ________ (OB/GYN) ________
PRIMARY CARE PHYSICIAN ADDRESS	(PCP)	(PCP)	(PCP)	(PCP)
	(OB/GYN)	(OB/GYN)	(OB/GYN)	(OB/GYN)
CURRENT PATIENT?	☐ YES ☐ NO ☐ Will Accept	☐ YES ☐ NO ☐ Will Accept	☐ YES ☐ NO ☐ Will Accept	☐ YES ☐ NO ☐ Will Accept
FULL TIME STUDENT?		☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A

III. PREVIOUS INSURANCE INFORMATION

	SUBSCRIBER	DEPENDENT	DEPENDENT	DEPENDENT
EFFECTIVE DATE OF PREVIOUS COVERAGE:				
TERMINATION DATE:				
CARRIER'S NAME:				
IS MEMBER ELIGIBLE FOR MEDICARE?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

IV. ASSOCIATION/CHAMBER INFORMATION

ASSOCIATION/CHAMBER NAME: ROCHESTER BUSINESS ALLIANCE

(PLEASE CIRCLE PLAN CHOICE):

Group HMO:		TriVantage:		PPO Plan:	
	Opportunity		Active Lifestyles		USdirect
	Basix		Family Focus		CareFund HSA
	Community		Healthy Alternatives		CareFund HRA
	Comprehensive			Other:	

EPO # ____

DIVISION # ____

V. MUST BE COMPLETED IN FULL BY EMPLOYER AND ASSOCIATION

EMPLOYER NAME:

EMPLOYER ADDRESS: EMPLOYER PHONE NUMBER:

TAX ID NUMBER:

DOES EMPLOYEE MEET WAITING PERIOD CRITERIA? ☐ YES ☐ NO

WHEN WAS EMPLOYEE HIRED? (N/A FOR RETIREE)

WHEN DID EMPLOYEE BECOME ELIGIBLE FOR COVERAGE? (N/A FOR RETIREE)

EFFECTIVE DATE OF COVERAGE/CHANGE: 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:

SIGNATURE: DATE:

PLEASE BE SURE YOUR APPROPRIATE DOCUMENTATION IS ATTACHED

VI. AUTHORIZATION AND AGREEMENT

I certify that the information given on this form is correct to the best of my knowledge and I have read and agree to the authorization. I understand that Preferred Care (PC) may require verification of my employment with a bonafide employer, or as sole proprietor. I understand that benefits are not payable for expenses resulting from pre-existing conditions during the first twelve (12) months of coverage received, unless all or part of the twelve (12) month waiting period has been satisfied by prior coverage. If I have applied for an HMO plan, I understand that beginning on my effective date, I must get all my health care from PC Participating Providers, except for Emergency and Urgent Care. I understand that I must select a Primary Care Physician (PCP) who must coordinate my care in order to properly administer my benefits under the PC HMO coverage. I also understand that if I am applying for TriVantage Healthy Alternatives I am purchasing a POS insurance plan, in addition to my PC HMO coverage , which will require me to work with my physician to obtain any necessary precertification, while I am out of the service area. I understand that if I have applied for a USdirect PPO plan it is my responsibility to work with my physician and PC to obtain any necessary precertification. I also understand that I am applying for a PC Health Plan as specified on my application that is subject to the rules and guidelines as specified in that certificate/contract. I understand that my signature on this application means that I have read and understand the contents of this application. I hereby authorize any physician hospital or other medical facility or provider to release to PC any and all records and information regarding services requested while any of the persons on this contract are members of PC, and I also authorize the release of records and information relating to prior treatment and/or services. I represent to you that all information furnished by me on this form is true and complete to the best of my knowledge.

SUBSCRIBER 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.