LIA Health Alliance®
Consumer Driven Health Insurance™

ENROLLMENT / CHANGE FORM

Rate: $ *Broker Use Only*

LIA #:

A. EMPLOYEE INFORMATION

Employee Name (Last) (First) (Middle)

Home Phone ( )

Work Phone ( )

Date of Hire Month Day Year

Address (Street No.)

(City) (State) (Zip)

NEW EMPLOYEE / CHANGE INFORMATION **Check One:**

- ☐ Initial Enrollment
- ☐ Renewal
- ☐ Status Change
- ☐ Active Medicare Participation
- ☐ New Hire
- ☐ **COBRA:**
- ○ Direct Bill
- ○ Group Bill

Effective Date: _____

B. OTHER INSURANCE

Do you or any of your dependents have coverage under any other medical plan? ☐ YES ☐ NO

If yes, provide the information. — here

Were you covered by another medical/hospital plan within the last 12 months? ☐ YES ☐ NO If yes, provide the information in **Section E.**

Name of Insured | Employer Name: | Tel: | ☐ Individual Coverage ☐ Family Coverage

Health Insurer Name | Dental Insurer Name

Are you or any of your dependents eligible for Medicare or Medicaid? ☐ YES ☐ NO

C. TYPE OF COVERAGE (Please select one of the following)

Atlantis

- ☐ HMO Center 0/40
- ☐ HMO Center 0/40A
- ☐ HMO 20
- ☐ HMO 20A
- ☐ HMO 20 Plus
- ☐ HMO 25/40
- ☐ HMO 25/40A
- ☐ HMO 25/40 Plus
- ☐ POS 20/500
- ☐ POS 20/1000
- ☐ POS 20/2000
- ☐ POS 25/40-1000 Plus
- ☐ POS 25/40-2000
- ☐ POS 25/40-2000A

Consumer

- ☐ POS 20/2000 HRA-1
- ☐ POS 20/2000 HRA-2
- ☐ POS 20/2000 HRA-3
- ☐ POS 20/2000 HRA-4

GHI

Non Cost Sharing

- ☐ EPO 20
- ☐ EPO 20A
- ☐ EPO 30/500
- ☐ EPO 30/1000
- ☐ EPO 30/1000A
- ☐ EPO 40/1000
- ☐ PPO 20/500
- ☐ PPO 25/1000
- ☐ PPO 30/1000

Cost Sharing

- ☐ CS EPO 30/500
- ☐ CS EPO 30/1000
- ☐ CS EPO 40/1000
- ☐ CS EPO 40/1000A
- ☐ CS EPO 40/2000
- ☐ CS PPO 30/2000
- ☐ CS PPO 30/2000A

Consumer

EPO	PPO
☐ 1100 HSA-1	☐ 1100/80% HSA-1
☐ 2500 HSA-2	☐ 2500/100% HSA-2
☐ 2850 HSA-3	☐ 2500/80% HSA-3
☐ 5500 HSA-4	☐ 5000/100% HSA-4

HIP

- ☐ HMO 5
- ☐ HMO 10
- ☐ HMO 15
- ☐ HMO 20
- ☐ HMO Value
- ☐ HMO Super Value
- ☐ HMO 25/40A
- ☐ POS 20/1000
- ☐ EPO 15/1000
- ☐ EPO 25/1000
- ☐ EPO 25 SmartStart
- ☐ EPO 30/50/1000
- ☐ EPO 30/50/1000A
- ☐ PPO 15/1000
- ☐ PPO 25/1000
- ☐ PPO 30/50/1000

HIP/Vytra

- ☐ HMO 10 Open Access
- ☐ HMO 15 Open Access
- ☐ HMO 20 Open Access
- ☐ POS 10/250
- ☐ POS 15/500
- ☐ POS 20/1000

MDNY

- ☐ HMO 10
- ☐ HMO 15
- ☐ HMO 20
- ☐ HMO 20A
- ☐ HMO 20B
- ☐ HMO 25
- ☐ HMO 25A
- ☐ POS 10/500
- ☐ POS 20/1000

PerfectHealth

Consumer

HIP Prime

- ☐ PPO 2500 HSA-22G
- ☐ PPO 5000 HSA-29G

Multiplan

- ☐ PPO 2500 HSA-22P
- ☐ PPO 5000 HSA-30P

Dental Insurance

- ☐ GHI
- ☐ United Concordia

Coverage

Medical Coverage
- ☐ Single
- ☐ Dependent

United Concordia
- ☐ Single
- ☐ Dependent

GHI
- ☐ Single
- ☐ Dependent

STATUS CHANGE

- ☐ Add Dependent — Date: _____
- ☐ Remove Dependent
- ☐ Name Change
- ☐ Address Change
- ☐ Employee Termination
- ☐ Loss of Coverage
- ☐ COBRA Exp.Date: _____

Reason: _____

D. EMPLOYER INFORMATION

Employer Name:_____ Telephone #:_____ Is employee currently working at least 20 hours per week? ☐ Yes ☐ No

E. ENROLLMENT INFORMATION

Name (Indicate If Last Name Is Different) (Last Name) (First) (MI)	*Birth Date Mo / Day / Yr*	*Social Security No.*	*Sex*	*Relationship Code*	*✓ if Full-time Student 19 to 25*	*Former Health Insurance Coverage (Previous 12 months)*	*Date of Former Coverage FROM - TO* (Mo. Yr. Mo. Yr.)	*Primary Care Physician ID # or Name/ SmartStart Primary Hospital (Choose for each family member)*	*✓ if current Patient*
Employee		- -							
Spouse		- -							
Dependent		- -							
Dependent		- -							
Dependent		- -							
Dependent		- -							

Relationship Codes: **001** Spouse **002** Child **003** Student* **004** Disabled* **005** Stepchild* **006** Legal Guardianship* ***Documentation Required**

EMPLOYEE SIGNATURE

Please read the information in the following section carefully and then sign and date this form.

- I hereby apply for the health insurer and benefit plan selected. I acknowledge that I understand all the benefits and coverage as specified in the enrollment materials and agree to abide by all the rules and regulations therein specified. I certify that I work a minimum of 20 hours per week.
- I certify that I elect to enroll myself and the family members (dependents) indicated on this form with the health insurer that I selected. I certify that all dependents listed on this form are eligible for benefits and coverage under the terms of the selected health insurer's subscriber agreement. I acknowledge that I understand that my selected insurer has no liability to provide benefit and coverage for ineligible dependents.
- I acknowledge that I understand that if I have a new dependent as a result of a marriage, birth or adoption, that I must provide appropriate documentation to enroll that new dependent within 30 days after the qualifying event.
- I acknowledge that I understand that pre-existing conditions will not be covered during the first 12 months of the contractual coverage with my selected health insurer. I further understand, however, that my selected health insurer will reduce the pre-existing limitation if (1) I provide my selected health insurer with a certificate of coverage identifying substantially similar health insurance coverage that I/we had before my selected health insurer's coverage effective date and (2) such coverage did not have a gap of more than 63 days. The pre-existing condition limitation will be reduced by the amount of time covered by the previous policy. A pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received during 6 months preceding my selected health insurer's coverage effective date; excluding pregnancy.
- On behalf of myself and each eligible Family Member, I authorize all physicians, nurses, hospitals and other providers who or which have at any time, either before or after we became covered by my selected health insurer, provided any diagnosis, treatment or any other service to any of us, to furnish to my selected health insurer or its authorized representative all information and records relating thereto.
- If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and remit same to the LIA Health Alliance.
- 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 civil penalty not to exceed five thousand dollars, and the stated value of the claim for each violation.
- I have carefully read this section and certify that all information on this form is true and complete.

Employee/Applicant Signature Date

EMPLOYER AUTHORIZATION

This form must be signed and dated by an authorized company employee.
By signing this form, I verify that to the best of my knowledge, the information contained, herein, is true and complete. I also certify that the person(s) are eligible employees (or dependents) and work for the employer identified on this form.

Signature-Authorized Company Representative

Print Name/Title Date