

Employer Name:		Type of Industry:
Address:	City:	State: NY Zip:
Tel: E-mail:	Fax:	Employer Contact:
New Employee Waiting Period: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other _____		Date of Hire _____
Type of Business: (Must check if enrolling in Section 125) Corp <input type="checkbox"/> LLC <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Not-for-Profit <input type="checkbox"/> Partnership <input type="checkbox"/>		

The LIA Health Alliance agrees to provide the administrative services to the Employer as described in the Administration Guide. The Employer agrees to follow the policies and procedures outlined in the Administration Guide. The Employer acknowledges and represents that it understands that the LIA Health Alliance is not providing health insurance or dental insurance and that the insurers selected by the employer's employees are providing the insurance offered through the LIA Health Alliance.

The Employer further acknowledges and represents that it understands that the LIA Health Alliance is not providing a vision discount program, and that Davis Vision is providing the vision discount program offered through the LIA Health Alliance. **There is a annual billing fee of \$95.00 which must be included with the renewal premium.**

**PLEASE SELECT A TIER FOR EACH INSURER:**

	Two Tier	Three Tier	Four Tier
<b>Atlantis</b>	<input type="checkbox"/>		<input type="checkbox"/>
<b>GHI</b>	<input type="checkbox"/>		<input type="checkbox"/>
<b>HIP</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Horizon</b>	<input type="checkbox"/>		<input type="checkbox"/>
<b>MDNY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PerfectHealth</b>			<input type="checkbox"/>
<b>Vytra</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Suffolk Nassau Chamber of Commerce at Huntington

**Dental Insurance**  
If dental is selected, please complete the enclosed enrollment forms with your broker.  
Healthplex  United Concordia

**COBRA Administration**  Yes  No

**SECTION 125**  \$300 setup charge.  
Make check payable to CBCA.

This agreement shall take effect on \_\_\_\_\_ 01, 2006, upon receipt of the renewal premium and the annual billing fee. Health insurance effective dates are based on \_\_\_\_\_<sup>month</sup> guidelines described in the Administration Guide. This agreement is delivered in and governed by the internal laws of the State of New York.

By signing this agreement, I hereby acknowledge that I understand the above; I also hereby acknowledge and agree that the enrollment information provided (including tax documentation) is complete and true. I also understand that the information provided forms the basis upon which health insurance will be made available. I understand, further, that omissions, misrepresentations, and misstatements about the employer information, employment history and employee data could result in termination of group insurance and denial of claims. I also agree to make additional documentation available (on request) to validate the enrollment and eligibility data.

Print Name/Title:	Date:
Employer Signature:	TAX ID #:

<b>GROUP NUMBER</b>	Broker Name: _____	E-Mail: _____
<b>L I A</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	GA: _____	
Total Eligible Employees: _____		