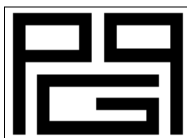

PROFESSIONAL GROUP PLANS, INC.
Specializing in Employee Benefits

Vytra
New Business Submission
Checklist

___ **Employer Group Health Benefits Application**

___ **Employee Enrollment Form(s)**

___ **Waiver Form On POS Plans Only**

___ **NYS-4 Signed (1-4 Lives)**

___ **First Month's Premium Check Payable to:** Vytra

___ **Forms Must Be Submitted to PGP**
*Prior to the effective date

If you have any questions please contact your PGP representative.

Updated 07/28/03

225 Wireless Blvd., 2nd Fl. • Hauppauge, New York 11788 • Tel: 631.951.9200 • Fax: 631.951.9623 • www.pgpbenefits.com

Premium Quote Sheet

Name of Company ____ Effective Date Requested __________________

Plan Selected:

❑ **HMO Option #______** **Rating Structure Quoted** ❑ Two Tier ❑ Three Tier ❑ Four Tier

❑ **POS Option #______** ❑ 80th UCR ❑ 90th UCR Four Tier Rating

❑ *MaxAccess* **Option ______** **Four Tier Rating** | ❑ **SmartStart** **Three Tier Rating**

Rx Plan ❑ None ❑ $5/$10/$30 ❑ $5/$12/$35 ❑ $7/$15/$50 ❑ $10/$20/$50 ❑ $15/$25/$50
❑ Other____________

Except as noted below:

HMO Options ❑ Option A $5/$10/$35 Rx incl. ❑ Option B $7/$15/$35 Rx incl. ❑ Option D $10/$20/$40 Rx incl.

POS Options ❑ Option B $5/$10/$35Rx incl. ❑ Option F $7/$15/$35 Rx incl. ❑ Option M $10/$20/$40 Rx incl.

Vision Buy-Up Option ❑ Yes ❑ No

Group Breakdown

Plan Type ______	**No. of Insured**	**x (Premium Quoted + Vision)**	**=**	**Total**
Single	____________	x(____________ + ____________)	=	_______________
Emp. + 1	____________	x(____________ + ____________)	=	_______________
Emp./Child(ren)	____________	x(____________ + ____________)	=	_______________
Family	____________	x(____________ + ____________)	=	_______________
			Total Due	_______________

Plan Type ______	**No. of Insured**	**x (Premium Quoted + Vision)**	**=**	**Total**
Single	____________	x(____________ + ____________)	=	_______________
Emp. + 1	____________	x(____________ + ____________)	=	_______________
Emp./Child(ren)	____________	x(____________ + ____________)	=	_______________
Family	____________	x(____________ + ____________)	=	_______________
			Total Due	_______________

____
Grand Monthly Total

____
Broker, Agent or Owner *(Please print name)*

____
Date

____
**Managing Agent/
Associate Managing Administrator**

QUOTE 1200

Small Business Employer Group Health Benefits Application

Company Name: ______________________________ Effective Date: ______________

Address: ______________________________ Billing Address: ______________________________
______________________________ (if different) ______________________________
______________________________ ______________________________

Type of Business: ____

Contact: ______________________________ Title: ______________________________

Phone: ______________________________ Fax: ______________________________

Email: ______________________________

Present Health Insurance Carrier: ____________________ Dates of Coverage: From __ / __ / __ To __ / __ / __

Has your group insurance ever been cancelled for non-payment of premium? ❑ Yes ❑ No
If your answer is yes, please explain on a separate page.

Total number of employees: ____________________ *(Include full and part-time)*

- Number of employees working 20 hours per week or more: ______________
- Please indicate the required time period of employment, if any, before an employee becomes eligible for health care coverage *(eligibility lag):* ______________________________

Indicate how much you contribute toward employee coverage:

Single _______ Employee/Spouse _______ Employee/Child(ren) _______ Family _______

Agent/Broker of Record: (if applicable)

____
Name of Agent/Broker

The agent/broker named above is hereby appointed as agent/broker in all dealings between Vytra Health Plans and ______________________________. This appointment will remain in effect until it is rescinded in writing by
Company Name
the undersigned.

Signature ______________________________
Signature of Owner, Partner or Officer

The information provided above is true and correct to the best of my knowledge. I understand that coverage and benefits may be affected by failure to provide complete and accurate information. **<u>I understand all current employees eligible for health coverage have the option of joining Vytra now, or on my group's next annual anniversary date.</u>**

______________________________ ______________________________
Signature of Owner, Partner or Officer *Print Name*

______________________________ ______________________________
Title *Date*

Please see reverse side for Premium Quote Sheet.

Small Group
Membership Application

Vytra Health Plans Long Island, Inc.
Vytra Health Services, Inc.

Subscriber Information

Last Name	First Name	Middle Initial	Telephone No. (Home) (Work)	Fax No.
				E-mail
Address (Street No.)	City	State	Zip	❒ Male ❒ Female

While enrolled in Vytra, will you or any member of your family be covered by: Name of Contract Holder ______________________

❒ Other Health Insurance (Name of insurance)______________________ Ins. ID# ______________ ❒None End Stage Renal Disease ❒ Yes

Social Security Disability Medicare ❒ Part A. ID # ______________ ❒ Part B ID # ______________ ❒ Individual Coverage ❒ Family Coverage

Enrollment Information

Name *Indicate if Last Name is different*	Birth Date Mo/Day/Yr	Social Security No.	Sex	Relation-ship	Former Health Coverage *(Previous 12 months)*	Dates of Former Coverage *From*	*To*	Primary Care Physician *(Choose for each family member)* *(See Provider Directory)*	ID #	Check if current Patient
Your Last Name First M.I.						/ /	/ /			
Spouse						/ /	/ /			
Dependent						/ /	/ /			
Dependent						/ /	/ /			
Dependent						/ /	/ /			
Dependent						/ /	/ /			

Ob/Gyn Selection *(optional for female members)*

Name of Member	Ob/Gyn	ID No.

❒ I decline dependent coverage for my spouse. ❒ I decline dependent coverage for my other dependents.

Have you or any of your dependent(s) ever been a member of Vytra before? ❒ Yes ❒ No

If yes, Indicate the former employer and your name *(if different from shown)*

____

Employer Information *Please complete all shaded areas*

Employer Name	Employer Group No.	Date of Hire	Effective Date	Employer Waiting Period
Address	City	State	Zip	Telephone

Enrollment

❒ I hereby apply for enrollment in Vytra Health Plans Long Island, Inc., which provides health maintenance organization benefits (For HMO use only).

❒ I hereby apply for enrollment in Vytra Health Plans Long Island, Inc., which provides health maintenance organization benefits. I also apply for coverage under a separate contract from Vytra Health Services, Inc. which provides health insurance. (For POS and MaxAccess use only).

The information provided is true and correct to the best of my knowledge. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information.

In the event that a premium contribution is required of me, I agree to pay, in advance the premium amounts applicable for the contract under which I am covered. I authorize the employer identified above to deduct from payroll such applicable premium amounts and to remit them to Vytra.

I understand that coverage is not included for a pre-existing condition during a 12 month waiting period, or lesser period if eligible for credit for previous coverage. I understand and agree that my employer may discuss my health care coverage with Vytra and provide you with information regarding the coverage and benefits I had with them.

I authorize all medical information relative to my care or that of any member of my family to be released to Vytra for all purposes, including but not limited to, compliance with all applicable laws, rules and regulations, quality assurance purposes, HEDIS studies, and those required by HCFA, and for program management purposes.

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 is subject to a civil penalty not to exceed the limits defined in the Insurance Law and the stated value of the claim for each such violation.

Applicant Signature	Date

Check one: ❒ Open Enrollment ❒ New Hire ❒ Conversion *(Direct Pay)* ❒ Status Change *(see below)*

Status Change: ❒ Add dependent ❒ Remove dependent ❒ Address change ❒ Name change

Reason:____

Is applicant currently working at least 20 Hrs./Wk.? ❒ Yes ❒ No

Employer Signature (*Employer must cosign)*

For Vytra Use Only

Please verify employee selection

❒ HMO Option __________

❒ POS Option __________

❒ MaxAccess Option __________

The information provided in this application will be kept confidential.

How to Complete the Application

New Members:

- Please complete all applicable information (Enrollment, Subscriber and your signature).
- You **must** select a Primary Care Physician (PCP) for each person covered by the contract. (Please refer to the Provider Directory) Always indicate the Provider ID number.
- Primary Care Physicians include the following specialties: Family Practice, Internal Medicine, and Pediatrics. Female members have the additional option of selecting a participating Vytra Ob/Gyn Provider.
- You may change your PCP by calling Vytra's Customer Service Department. The change will be effective the following day. A new ID card will be sent to you within approximately 10 working days of the change.

Employers:

- Please complete the shaded area, Employer Information. All questions **must** be answered.

For use as a Status Change Form:

- For existing members of Vytra, the form may be used to initiate a change of contract status. For example, single to family coverage, (including name change if applicable) or adding a dependent.
- Check Status Change (the shaded area) and complete form as a new member, with exception of **Effective Date** (the shaded area), which should reflect the date on which the change in contract status takes place. **Note: Additions to the contract (other than newborns) will only be effective on a first of the month basis.** Vytra requires notification within 30 days of event for status changes and may require evidence. (For example: birth certificate, marriage license)

Corporate Center • 395 North Service Road • Melville, NY 11747
516-694-6565 • Fax 516-249-1280

APPLICATION

Small Group

Vytra
HEALTH PLANS

Medical Insurance Waiver

Name of Employer Association or Union

____

Employee's Name ______________________________________ **SS#** ___________________________

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed**

Number of eligible dependent children ____________

I was given the opportunity to enroll in this plan of group insurance offered by my employer and I am refusing contributory medical coverage due to:

❑ **Coverage by another employer sponsored health plan**

❑ **Spousal coverage**

Answer if you are refusing employee, spouse and/or child medical coverage:

Are your dependents now covered by any other group plan? ❑ **Yes** ❑ **No**

If yes, please indicate:
Policyholder's Name ________________________________ ***Carrier Name*** ___________________
(Your dependents may be insured by this plan although they are covered elsewhere.)

I understand that if I do not enroll at this time I must wait until the next open enrollment period.

____ _______________________________
Signature of Employee *Date*

____ _______________________________
Signature of Witness *Date*