

**A. EMPLOYEE INFORMATION**

Employee Name (Last) (First) (Middle) Home Phone ( ) Work Phone ( ) Soc. Sec. #:

Date of Hire Month Day Year Address (Street No.) (City) (State) (Zip)

**B. OTHER INSURANCE**

Do you or any of your dependents have coverage under any other medical plan  YES  NO If yes, provide the information below:

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

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

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

Initial Enrollment  New Hire

Renewal  **COBRA:**

Status Change

Active Medicare Participation  Direct Bill  Group Bill

Effective Date: \_\_\_\_\_

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

<p><b>Atlantis</b></p> <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 20A <input type="checkbox"/> HMO 20 Plus <input type="checkbox"/> POS 20/500 <input type="checkbox"/> POS 20/1000 <input type="checkbox"/> POS 20/2000	<p><b>GHI</b></p> <input type="checkbox"/> EPO 15 <input type="checkbox"/> EPO 20 <input type="checkbox"/> EPO 30 <input type="checkbox"/> EPO 30A <input type="checkbox"/> EPO 30/750 <input type="checkbox"/> EPO 30/750 Plus <input type="checkbox"/> EPO 30/1000 <input type="checkbox"/> EPO 30/1000 A <input type="checkbox"/> EPO 30/2000 <input type="checkbox"/> PPO 25/1000	<p><b>HIP</b></p> <input type="checkbox"/> HMO 5 <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 15 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 25/40 <input type="checkbox"/> HMO 25/40A <input type="checkbox"/> HMO Value <input type="checkbox"/> HMO Super Value <input type="checkbox"/> EPO Super Value <input type="checkbox"/> EPO 20/1000 <input type="checkbox"/> POS 10/250 <input type="checkbox"/> POS 15/500 <input type="checkbox"/> POS 20/1000 <input type="checkbox"/> PPO 15/2000	<p><b>Vytra</b></p> <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 15 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO Super Value <input type="checkbox"/> POS 10/250 <input type="checkbox"/> POS 15/500 <input type="checkbox"/> POS 20/1000	<p><b>Horizon Healthcare Network</b></p> <input type="checkbox"/> EPO 20 <input type="checkbox"/> EPO 25/500 <input type="checkbox"/> EPO 25/40-1000 <input type="checkbox"/> EPO 30/45-3000 <input type="checkbox"/> PPO 10/250 <input type="checkbox"/> PPO 15/500 <input type="checkbox"/> PPO 20/1000 <input type="checkbox"/> PPO 30/1000	<p><b>MDNY Flex Network</b></p> <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 15 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO Value <input type="checkbox"/> HMO Super Value <input type="checkbox"/> HMO 25/40 <input type="checkbox"/> POS 10/250 <input type="checkbox"/> POS 15/500 <input type="checkbox"/> POS 20/1000	<p><b>MDNY Focus Network</b></p> <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO Value <input type="checkbox"/> HMO Super Value <input type="checkbox"/> HMO F 20	<p><b>United Concordia</b></p> <input type="checkbox"/> Dental	<p><b>Coverage</b></p> <p>Medical Coverage <input type="checkbox"/> Single <input type="checkbox"/> Dependent</p> <p>United Concordia <input type="checkbox"/> Single <input type="checkbox"/> Dependent</p>	<p><b>STATUS CHANGE</b></p> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Employee Termination Date: _____ <input type="checkbox"/> COBRA Exp.Date: _____ <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Reason: _____
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**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)	Birth Date Mo / Day / Yr	Social Security No.	Sex	Relation-ship Code	<input checked="" type="checkbox"/> if Full-time Student 19 to 25	Former Health Insurance Coverage (Previous 12 months)	Date of Former Coverage FROM - TO	Primary Care Physician ID # or Name (Choose for each family member) See Insurer Directory	<input checked="" type="checkbox"/> if current Patient
Employee (Last Name) (First) (MI)		- -		X	X		Mo. Yr. Mo. Yr.		
Spouse		- -							
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 \_\_\_\_\_

# LIA Health Alliance®

## Consumer Driven Health Insurance

The LIA Health Alliance is in the process of implementing HIPAA (Health Insurance Portability & Accountability Act) electronic interfaces with its participating insurers. These electronic interfaces are governed by Federal regulations that require complete and accurate enrollment information. Therefore, Enrollment Forms must be completed in full with the following guidelines:

### **SECTION A**

Please provide the employee information requested. The Date of Hire must be the actual Month/Day/Year.

### **SECTION B**

Please provide the other insurance information as requested and answer questions. If the answer to dependents having other coverage is yes, then, the other coverage information must be provided.

If the answer to the question regarding previous coverage over the past 12 months is yes, then, please provide the former health insurance coverage information in Section E.

### **SECTION C**

Within each insurer's box, please check the appropriate box for the benefit plan that you want.

Please also check the appropriate box for the specific type of life status change and give the reason for that change in the space provided. Proof of the Life Status Change (e.g. Marriage Certificates, Divorce papers, HIPAA Certificates) are required.

### **SECTION D**

The employer must complete all the information in this section including: employer name and telephone number. Please also indicate whether employee is working more than 20 hours.

### **SECTION E**

Please provide the following employee related information: name of spouse, dependents, birth dates and social security numbers. Please also include sex, relationship code, student information, former health insurance coverage and check current patient box, if appropriate.

**The Primary Care Physician ID must be detailed as the Insurer Provider #...or the physician name, if a provider number is not used by the insurer. Please utilize the Alliance Combined Insurer PCP Directory or the appropriate Insurer Directory for provider ID information.**

**The employer and employee must sign and date the form.**

**Return completed forms to:  
LIA Health Alliance  
Enrollment Processing Center  
1747 Veterans Memorial Highway  
Suite 22A • Islandia, NY 11749**