



# ATLANTIS HEALTH PLAN, INC.

## Group Agreement Form

Group Administrator: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

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

Tax ID #: \_\_\_\_\_

In consideration of the payment of Premiums in accordance with the terms and provisions of this Group Agreement Form, Atlantis Health Plan, Inc. ("Atlantis") shall hereby arrange or pay for medical and hospital services in accordance with the terms and provisions of the Subscriber Contract for Subscribers and their Covered Dependents ("Members"). Terms not defined herein shall have the meaning set forth in the Subscriber Contract.

### I. Effective Date and Term of Agreement:

This Agreement shall be effective on the \_\_\_\_\_ day of \_\_\_\_\_ at 12:00 a.m. Eastern Time and will remain in effect for a period of \_\_\_\_\_ consecutive Months, ending on the \_\_\_\_\_ day of \_\_\_\_\_ at 11:59 p.m. Eastern Time at which time coverage provided pursuant to the Subscriber Contract will be renewed automatically for one (1) year periods thereafter unless written notice of cancellation has been given by either party as set forth in Section XIII of this Agreement.

### II. Coverage - Plan Design:

**Tier:**       2       3       4

**Plan:**       HMO     HMO-Low     POS     POS-Low

**Co-Pay:**    \$10     \$10E     \$15       \$15E  
               \$20     \$20E     \$25/\$40     \$25/\$40E

**Coinsurance:**     70%     80%

**Deductible:**       \$300/\$750       \$1000/\$2500  
                           \$500/\$1250       \$2000/\$4000

#### Riders:

- A \$10/20/30     I \$7/30/50/250     30+MH IP  
 B \$15/25/35     O \$0/20/30       30+MH/SA IP  
 C \$20/30/40     P \$0/30/50       MHPAEA - 09  
 D \$10/15/30     M-A 29           SA - MHPAEA - 09  
 E \$15/20/35     Vision-High       Timothy's Law  
 F \$20/25/40     Vision-Low       PPACA - 1  
 G \$7/30/50       60 SNF           SIGN \$0 - PPACA  
 H \$7/30/50/100  40+MH OP       Other: \_\_\_\_\_  
 M Mandatory Generic \$10 - PPACA

**Hospital Co-Pay:**     \$0     \$250     \$500

### III. Premium Rate Schedule

<u>Type of Coverage</u>	<u>Total Monthly Premium</u>
Single	\$ _____
Husband/Wife	\$ _____
Parent/Child(ren)	\$ _____
Family	\$ _____

### IV. Eligibility:

Eligible members must reside or live in the Service Area or work in the Area and receive all covered health care there. In addition, eligible subscribers and their eligible family members shall meet the eligibility criteria set forth in the Subscriber Contract. Coverage ends on the last day of the month premium covers.

\*Waiting Period \_\_\_\_\_ days/months from date of hire.  
(Eligible the first of the month following waiting period).

Subscriber (employee) coverage ends on the last day of the month that employment ends.

Those groups subject to Patient Protection and Affordable Care Act (PPACA), Family Members are spouse and dependent children until child reaches age 26. Coverage ends on the last day of the month in which the child's birthday occurs.

Eligibility will be restricted to an individual or small group where the individual or small group has had coverage terminated within the previous twelve (12) months for non-payment of premiums per Section 360.3(11) of Regulation 145.

### V. Notice:

Any notice hereunder to be given to Group Administrator shall be addressed to

Attn: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone# \_\_\_\_\_

Fax# \_\_\_\_\_

E-mail: \_\_\_\_\_

Any notice hereunder to be given to Atlantis shall be addressed to:

**Atlantis Health Plan, Inc.**  
45 Broadway, Suite 300  
New York, NY 10006



## **VI. Premium Due Date and Payments:**

The first day of a month of coverage hereunder is the "Premium Due Date". The Group Administrator agrees to remit to Atlantis on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Subscriber and Covered Dependent enrolled as of such date as determined by Atlantis by reference to Atlantis member records. If such Premium payment is not made in full by Group on or prior to the Premium Due Date, a thirty (30) day Grace Period shall be granted to Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then Atlantis pursuant to Section XIII may terminate this Agreement.

If this Agreement is terminated for any reason, Group Administrator shall continue to be held liable for all Premium payments due and unpaid before termination, including, but not limited to, Premium payments for any time this Agreement is in force during the Grace Period. Notwithstanding any language to the contrary in this Agreement or the Subscriber Contract, Atlantis shall have no obligation to provide benefits or pay claims for any Member during any period for which the required Premium payment has not been made (except during any Grace Period). If Atlantis does provide benefits or pay claims for any Member during any period for which the Premium payment has not been made, such provision of benefits or payment of claims shall not constitute a waiver of Atlantis' rights to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

## **VII. Premium Rate Changes:**

The Premium Rate Schedule set forth on page one of this Agreement shall be valid only for the Initial Contract Period. If Atlantis elects to offer coverage to the Group for any Subsequent Contract Period after the Initial Contract Period, Atlantis may change the Premium Rate Schedule for any Subsequent Contract Period. Atlantis will give Group at least forty-five (45) days advance notice of the Premium Rates for each Subsequent Contract Period. If Atlantis fails to give Group such forty-five (45) days advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period shall remain in effect for a period of forty-five (45) days after the Group was notified by Atlantis of the new Premium Rates for the Subsequent Contract Period, after which period the new Premium Rates will go in to effect. Under no circumstances shall Atlantis' failure to provide forty-five (45) days advance notice of new Premium Rates obligate Atlantis to continue coverage for the Group beyond the end of the Initial Contract Period or a Subsequent Contract Period as the case may be. At any time, with a forty-five (45) day notice, Atlantis may change the premium schedule for any subsequent contract period when a change required by statute or regulation increases Atlantis' risk under the agreement.

## **VIII. Member Effective Dates of Coverage:**

Coverage of prospective Subscribers and Covered Dependents shall be subject to receipt by Atlantis of Enrollment Form for each prospective Subscriber and Covered Dependent within thirty-one (31) days of each Subscriber or Covered Dependent becoming eligible for coverage under this Agreement, together with receipt of the monthly Premium for such Subscriber or Covered Dependent as applicable.

## **IX. Ineligible Members:**

If, upon a Member becoming ineligible, Group Administrator fails to immediately notify Atlantis of such Member's termination, and Group Administrator has made or continues to make the Premium payment specified herein for such Member, such Premium payment will only be credited by Atlantis to Group back to the last day of the month immediately prior to the month in which such termination notice is received by Atlantis, provided Atlantis has not authorized or incurred claims for health services for such Members after such Member became ineligible, but before Atlantis received a proper disenrollment notification from the Group with respect to such Member's termination.

## **X. Annual Renewal**

The Group Administrator shall hold an annual renewal meeting at least once each year at which time the group and eligible members, as determined by this Agreement and the Subscriber Contract, may elect changes under this Agreement.

## **XI. Responsibilities of Group:**

Group agrees to:

- A. Offer coverage to eligible members and their family members, as described in Section IV above. It is understood that eligible members of a Group shall be free to choose either Atlantis coverage or such other coverage as may be available through the Group during both the initial and subsequent Group Open Enrollment Periods. Every eligible member of the Group shall be given a fair opportunity to elect one of such options over the other and shall not be penalized by the Group because of such a choice, other than through differential payroll deductions as may be indicated by premium variations from insurer to insurer.
- B. Offer each new member the opportunity to elect Atlantis coverage as a procedure of employment when such person attains the status of an eligible member as provided in this Agreement.
- C. Provide notification to each Member, within fifteen (15) days after termination of the Member's coverage, of the Member's right to convert to an Atlantis individual direct payment contract, and the duration of such conversion coverage.
- D. Furnish to Atlantis, on a monthly basis on Atlantis approved forms, such information as may reasonably be required by Atlantis for the administration of Atlantis' prepaid program and coverage provided hereunder, including any change in a Member's eligibility status. In addition, Atlantis may, at reasonable times, examine the group's administrator's pertinent records with respect to eligibility and premium payments hereunder. Per the employee's signature on the Atlantis enrollment application, the member agrees to allow the group to remit membership information to Atlantis Health Plan.
- E. Comply with all policies and procedures established by Atlantis in administering and interpreting this Agreement and communicated to Group Administrator by Atlantis.
- F. Furnish all Member enrollment and termination/change notification to Atlantis solely on Atlantis enrollment and termination forms within the time periods required by this Agreement.

## **XII. Termination:**

- A. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder may be terminated by Atlantis:

1. In the event that the policyholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the contract as set forth in Section VI of this Agreement, or Atlantis has not received timely premium payments.

2. In the event that the policyholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract, upon not less than one month's prior written notice.

3. Upon discontinuance of this class of HMO contract upon not less than five (5) months' prior written notice. In exercising the option to discontinue coverage, Atlantis shall act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and shall give the option to purchase all other individual health insurance coverage currently being offered by Atlantis to applicants in that market.

4. Upon discontinuance of all hospital, surgical or medical expense insurance contracts for which the premiums are paid by a remitting agent of a group, in the small group market, or the large group market, or both markets, in this state. Written notice shall be given to the Superintendent and to each subscriber not less than one hundred eighty days (180) prior to the date of the expiration of such coverage. In the event of such a withdrawal, the Corporation must also provide the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by such withdrawal. In addition, Atlantis may not provide for the issuance of any hospital, surgical or medical expense coverage in such market in this state during the five-year period beginning on the date of the discontinuance of the last health insurance coverage not so renewed.

5. The policyholder ceases to meet the requirements for a group under Section 4235 of the Insurance law, or a participating employer, labor union, association or other entity ceases membership or participation in the group to which this Agreement is issued. Termination shall be done uniformly without regard to any health status-related factor relating to any covered individual.

6. Pursuant to this network Plan, there is no longer any enrollee in connection with such Plan who lives, resides or works in the Atlantis Service Area for which the corporation is authorized to do business.

7. Upon written notice, if the Group ceases to operate or relocates outside the Service Area; or

8. Such other reasons as the Superintendent may approve and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act, upon not less than one month's prior written notice.

B. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder **may be terminated by the Group upon one month's prior written notice of termination.**

### **XIII. Amendments:**

Any amendments to this Agreement shall be in writing and must be approved and authorized by representatives of both the Group Administrator and Atlantis. No other individual has the authority to modify this Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind Atlantis by making any other commitment or representation.

Formal acceptance of an amendment to this agreement by the Group Administrator shall not be required: if the change has been negotiated by means of a request by the Group Administrator and agreed to by Atlantis; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered-or of the federal government; or if the Group Administrator makes payment of any applicable Premium on or after the effective date of such amendment.

### **XIV. Entire Agreement:**

This Agreement, the Member Enrollment Application of each member, and the Subscriber Contract constitute the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this Agreement shall be binding unless executed in writing by authorized representatives of the parties.

### **XV. Applicable Law:**

The laws of the State of New York shall govern this agreement.

### **XVI. Inconsistency:**

In the event of any inconsistency between this Group Agreement Form and the Subscriber Contract, the terms of this Group Agreement Form shall govern.

### **Community Rates:**

New York State requires HMOs to charge Groups premium rates that are consistent from one Group of the same type to another. This concept is called Community Rating. Atlantis does not base the premium your Group is charged on the actual cost of providing services to your Group alone, but an average of all Groups which fit into the same category as yours. Atlantis may, of course charge different premiums for different benefit packages. Atlantis may also, if we so choose, develop premiums that vary by certain factors such as group size.

Because all HMOs are required to get approval by the New York State Department of Insurance for each benefit package and rider for a specific time period, the HMO is also required to charge and collect premiums equivalent to that approved rate. There are a number of factors, which could impact whether or not your Group is being charged the approved premium rate:

- Timing of Premium Rate Quote;
- The Period which the Premium Rate Quote is different than the community rating period;
- Rate adjustments required due to an over- or undercharge for a prior period.

**Group Information**

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_

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

Number of Full-Time Employees \_\_\_\_\_

Number of Part-Time Employees \_\_\_\_\_

Number of Employees Eligible for Health Insurance Benefits \_\_\_\_\_

**Broker/ Sales Agent Information**

1. Full legal name of firm/Agent: \_\_\_\_\_

2. Address of firm/Agent: \_\_\_\_\_

3. Contact: \_\_\_\_\_

4. Telephone No. \_\_\_\_\_

5. SS # or Fed. Tax ID# \_\_\_\_\_

6. Broker/Agent ID Codes: \_\_\_\_\_

**ATLANTIS HEALTH PLAN, INC.**

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_

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

**General Agent Information**

1. Full legal name of firm: \_\_\_\_\_

2. Address of firm: \_\_\_\_\_

3. Contact: \_\_\_\_\_

4. Telephone No. \_\_\_\_\_

5. SS # or Fed. Tax ID# \_\_\_\_\_

6. GA ID Codes: \_\_\_\_\_

I acknowledge that my Atlantis Health Plan identification cards may not be received by the 1<sup>st</sup> day of my effective month. However, I understand that my benefits will be covered the 1<sup>st</sup> day of my effective month.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

READ THE FOLLOWING STATEMENTS VERY CAREFULLY.

YOUR SIGNATURE(S) ON THIS PAGE INDICATE(S) THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE PROVISIONS SET FORTH ON THIS APPLICATION. PLEASE SIGN AND DATE.

- A. **Coverage Request:** I/We hereby request coverage of the type indicated in the attached application. If this request is for a family contract, the names of my spouse and eligible dependent children are listed. I make this application on their behalf as well as my own. If this request is accepted, coverage will be effective only if my payment of the subscription charge is paid in full to Atlantis Health Plan.
- B. **Statement of Fidelity:** I/We affirm that all attached documents, statements, and answers in this application are true and are representations made to induce the issuance of the contract applied for. If accepted, this application will be part of the contract. The contract will become effective on the date specified on the identification card or the identification stub. Any misrepresentation by me of facts which are material to this application may result in rescission of this contract.
- C. **Pre-Existing Conditions:** I/We understand that there will be an 11 month waiting period for benefits for any physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on my/our enrollment date for this coverage. Credit for prior creditable coverage will be applied to this waiting period if such coverage was continuous to a date not more than 63 days prior to my/our enrollment date for this coverage. In the case of previous health insurance coverage, any affiliation period prior to that previous coverage becoming effective will also be credited. Upon request, I/we must provide appropriate documentation of prior coverage to Atlantis Health Plan.
- D. **Privacy Statement:** I/We authorize any health care provider, payer of health and health related claims, or government agency to furnish to Atlantis Health Plan or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim, or services in conjunction with managed care. I/We authorize Atlantis Health Plan to disclose such information to my/our physician; another payer or self-insurer, and if my/our coverage is under a group contract held by an employer, association, trust fund, or similar entity, to the group contract holder, or to an Atlantis Health Plan designee for purposes of continuity of care and medical management, disease management, managed disability coordination or financial audits.
- E. **Effective Date:** I/We acknowledge that the effective date stated on the attached agreement is in effect upon approval of the underwriting department. Although membership identification cards may not be issued by the effective date of the policy, if they are received within 30 days of the said effective date then no change to the agreed upon effective date will occur.
- F. **Voluntary Termination:** If this coverage is issued, I/we may make a written request to cancel the contract within 10 days after receipt. I understand that any medical services rendered during this time will not be covered. Thereafter, I understand that 30 days advance written notification to Atlantis Health Plan is required to terminate coverage.

All statements and answers in this application are true, and are representations made to induce the insurance of coverage. Any misrepresentation of material fact may result in cancellation or rescission of coverage.

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 purposes 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 five thousand dollars and the stated value of the claim for each such violation. I have read, understand, and agree to all the provisions set forth.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_

Date \_\_\_\_\_

## UFSBS Insurance Disclaimer

**A. An individual cannot assume he/she has effective insurance coverage even if he/she has filled out and submitted an application, provided proof of business, made a payment, completed a census, received an acknowledgement letter from USFSB verifying that their application has been sent to the appropriate carrier and/or performed any other function on the website or otherwise. An individual can not assume that they have insurance coverage until the carrier has sent the individual a verification of coverage with the appropriate effective date.**

**B. The insurance carriers have the right to change the rules, regulations, terms of coverage, availability and guidelines that are placed on the application, policies and enrollment at any time. USFSB continues to make every effort to keep up to date with the rules, regulations, terms of coverage, availability and guidelines that the insurance carriers determine; however, USFSB cannot guarantee that the website has been updated to reflect the current rules, regulations, terms of coverage, availability and guidelines.**

**C. Rates change periodically depending on the carrier, open enrollment for the carrier and the type of available insurance products. USFSB continues to make every effort to verify these rates for our members; however, USFSB cannot guarantee that the website has been updated to reflect the current rates.**

**D. There will be situations where insurance products will have the same coverage or benefits but different rates solely due to multiple tier structures. In addition, not every product found in a statewide search will be available in every county**

**E. Whenever both a USFSB Summary of Benefits and the Carrier's Summary of Benefits are presented, the Carrier's Summary of Benefits should be considered more accurate. However, in either case, the Summary of Benefits is simply an overview of the coverage provided by the carrier and USFSB cannot guarantee that the information posted is current, complete, or accurate.**

**F. The monthly cost of insurance plans billed by USFSB includes an administrative/association participation fee.**

By submitting an application, you are indicating that you have read and understand these Notices and agree to be bound by all terms and conditions for using the United States Federation of Small Businesses website.

## USFSB Insurance Checklist

1. USFSB Membership Application with \$60 dues payable to USFSB.
2. Completed and signed Group Enrollment forms (original signature of owner/principal)
3. Completed and signed employee application form for each employee enrolling in the plan (Original signature of each employee)
4. Proof of business – listed on the USFSB Guidelines
5. 2 month's premium made payable to USFSB
6. BOR Letter – See sample below: *(not needed for 1 person businesses)*

Dear Insurance Company,

“Company Name” hereby designates the broker/consultant listed below at the commission percentage split indicated as the broker/consultant (BOR) of record for the group. Further, the group hereby authorizes “the Insurance Company” to send all quotes, policies and notices to the BOR and to the group. This BOR designation shall remain in effect until it is expressly terminate by the group in writing.

BOR Designation:

Joseph R. Cardamone  
249 Green Street  
Schenectady, NY 12305 - 100% commission split

Thank you,

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Printed Name

7. Letter on company letterhead : See below: *(not needed for 1 person businesses)*

Dear “Carrier Name”,

“Company Name” would like Darlina Barber listed as the Group Administrator and Kristie Senich listed as the billing agent for the group.

Signed/Title/Date

8. Applications need to be submitted by the date indicated on the bottom summary of benefit page.

All the above are to be sent to: USFSB  
249 Green Street  
Schenectady, NY 12305

\*The 1<sup>st</sup> month's premium and dues can be in one check.

\*Dues only may be paid by credit Card.

**++Not needed for one-person businesses**



**NATIONAL HEADQUARTERS**  
249 Green Street  
Schenectady, NY 12305  
**Phone: 800 637-3331**  
Fax: 518-370-4129  
Fax: 888-568-3823

**GOVERNMENT AFFAIRS**  
6916 Wolf Run Shoels Road  
Fairfax Station, VA 22039  
**Phone: 800-637-3708**  
Fax: 703-978-8039

## ASSOCIATION MEMBERSHIP AND INSURANCE PARTICIPATION GUIDELINES

1. The United States Federation of Small Businesses, Inc. is a national association of small businesses for small businesses.
2. Membership is applied for by the business owner and not the individual employee; however, once the business is an active member of USFSB the employees are also eligible for many membership benefits.
3. Member businesses are dues paying entities with a recognizable business structure (i.e. self-employed, partnership, corporation).
4. Member businesses must be legally recognized by their state and file taxes as a business.
5. A business check must accompany all applications.
6. One business check must be sent for all premium payments for all participating employees.
7. Documentation showing business legitimacy and verifying the number of employees must accompany the membership application. No insurance applications will be processed or sent to the insurance carrier without the required documentation.  
**Acceptable documentation is as follows:**

### ONE PERSON BUSINESS

A One Person Business is:

- A. Sole Proprietor** when the sole owner is the only employee of the business.  
**Documentation Required:**  
Most recent Schedule C, which the insurance carriers require you to sign, plus the 1040 portion of the federal tax return. A Schedule C is the profit and loss form that indicates the income and expenses for your business; or Most recent Schedule F, which the insurance carriers require you to sign, plus the 1040 portion of the federal tax return. A Schedule F shows farming income and expenses.  
**Alternate Proof for A New Business:**  
A letter from a CPA or Attorney, on their letterhead stating the business is new, the owner will work more than 20 hours per week, will earn at least \$xxxxxx per year and will send us the Schedule C or F once it is filed. Many carriers also require a copy of the filed DBA and a voided business check or letter from the bank stating that a business account has been set up and checks have been ordered.
- B. Corporation** when there is only one shareholder who is the only employee.  
**Documentation Required:**  
Most recent 1120 Corporate tax return, signed by you, showing the sole shareholder plus a copy of the Certificate of Incorporation.
- C. Limited Liability Company**
  - When the only member of the LLC is an individual and also the only employee.  
**Documentation Required:**  
Most recent Schedule C or Schedule F, which the insurance carriers require you to sign, plus the 1040 portion of the federal tax return.
  - When the only member of the LLC is a Corporation.  
**Documentation Required:**  
Most recent copy of the 1120 or 1120S Corporate tax return, signed by you.  
**Alternate Proof for A New LLC**  
Copy of the Articles of Organization showing the member involved.

### BUSINESS WITH 2 OR MORE EMPLOYEES

A 2+ Person Business is:

- A. Sole Proprietor** when, in addition to the owner, there is at least one other employee on payroll.  
**Documentation Required:**  
Most recent Schedule C, which the insurance carriers require you to sign, plus a signed copy of your Quarterly Wage and Tax Report listing the employee or employees. The Quarterly Wage and Tax Report, which is submitted to your state, lists the employees' name, social security number, wages, taxes and unemployment insurance information. Ex: In New York the Quarterly Wage and Tax Report is called the NYS45. Each state has its own version of this report.
- B. Corporation** that either has more than one shareholder and/or one employee or more.  
**Documentation Required:**  
Most recent 1120 Corporate tax return, signed by you, listing the shareholders, a copy of the Certificate of Incorporation plus the most recent signed Quarterly Wage and Tax Report listing the employee or employees.

- C. **Limited Liability Company** that either has more than one member and/or one employee or more.  
**Documentation Required:**  
Most recent 1120 or 1120S Corporate tax return, signed by you, plus the most recent signed Quarterly Wage and Tax Report listing the employee or employees; or Copy of the most recent 1120, 1120S or 1065, signed by you, plus the most recent signed K-1s for all partners and the most recent signed Quarterly Wage and Tax Report listing the employee or employees.
- D. **Partnership** that either has more than one partner and/or one employee or more.  
**Documentation Required:**  
Most recent 1065 Partnership tax return, signed by you, plus most recent signed K-1s for all partners. Plus the most recent signed Quarterly Wage and Tax Report listing the employee or employees.  
**Alternate Proof for A New Partnership**  
Certificate of Partnership listing all partners and the percentage of ownership with a letter stating the K-1s will be sent once they are filed.
- E. A W-4 must be provided for all new employees who are enrolling in health insurance plans. A signed copy of your Quarterly Wage and Tax Report must also be provided even though the new employee is not on it. A copy of the Quarterly Wage and Tax Report listing the new employee must be provided within 90 days of the new person's employment.
8. If you are unable to file your taxes by the required date, you can file for an extension by using Form 4868 for a Sole Proprietor, Form 7004 for a Corporation or Form 8736 for a Partnership. A signed copy of this form along with the prior years filed tax documents is acceptable proof of business for some insurance carriers.
9. Insurance carriers have different annual business income requirements. For example, Blue Shield of Northeastern New York requires \$15,000.
10. Many health insurance carriers have specific group enrollment forms to be filled out and submitted along with the insurance application, including a waiver form to be filled out by any employee electing not to enroll in the coverage.
11. In many cases, the number of employees, including the owner, in the business will determine the premium rate.
12. In some cases insurance products will have the same coverage or benefits but different rates solely due to multiple tier structures.
13. Some carriers have Participation Requirements which means they require a minimum number of employees or a specific percentage of the employees to enroll in their health plan.
14. Membership and health applications are reviewed upon receipt. USFSB may request additional information at any time to verify the business status. This is done on a case-by-case basis.
15. Health insurance carriers have the legal right to ask for reverification of business status and/or updated information at any time. In most cases, this information will be requested once a year. If the requested information is not provided, the health insurance coverage will be cancelled by the carrier.
16. Member businesses applying for health insurance must be located in the requested insurance company's service area.
17. Health insurance participants must be actively working owners or employees of the member business and must be on the company payroll. Each insurance carrier determines the number of working hours in a week necessary to be eligible for their insurance plan. The week runs from Sunday to Saturday.
18. Eligible employees must enroll in the health insurance plan at the time the business chooses to participate, or they must wait for open enrollment or enroll within 30 days of a qualifying event.
19. A new employee must apply for insurance coverage within 45 days of employment to guarantee coverage takes effect within the required 90 days of employment. If they do not do so, they must wait until the insurance plan's open enrollment or within 30 days of a qualifying event unless otherwise indicated by the insurance carrier and employer upon enrolling the business in a group plan.
20. A married employee enrolling as an individual subscriber in the health plan cannot add the spouse or existing dependents until open enrollment or within 30 days of a qualifying event. If a qualifying event occurs such as a spouse loses their job or their health insurance, we can request a review of this policy and in some cases an exception to the enrollment procedures can be made.
21. A newborn must be added within 30 days of birth or must wait until open enrollment or within 30 days of a qualifying event.
22. A business owner has the option to change their health plan benefits, with their existing insurance carrier, each year on the open enrollment date for that particular plan.
23. Completing and submitting an insurance application is not a guarantee of coverage. The acceptance of the application is subject to carrier approval. Please do not cancel your current insurance until you receive verification from the new insurance carrier of your policy effective date. Please review your current carrier's insurance contract and termination policy. In some cases you are required to provide the health carrier with a 30 day written notice prior to a cancellation.
24. These guidelines are subject to change based on the specific underwriting requirements of each insurance carrier and state regulations.
25. Insurance carrier guidelines are regulated by the state's insurance department in which the company does business.

**NATIONAL HEADQUARTERS**

249 Green Street

Schenectady, NY 12305

**Phone: 800 637-3331**

Fax: 518-370-4129

Fax: 888-568-3823

**GOVERNMENT AFFAIRS**

6916 Wolf Run Shoels Road

Fairfax Station, VA 22039

**Phone: 800-637-3708**

Fax: 703-978-8039

**CANCELLATION & REINSTATEMENT PROCESS**

1. All payments must be received by the specified due date. If they are not received by that date, your insurance will be cancelled on the first of the coverage month that has not been paid for. A person who is cancelled for nonpayment of premium may not be able to enroll with the same health insurance carrier for one year.
2. If you choose to cancel your policy, we must receive your written cancellation request prior to the actual cancellation date.
3. All reinstatements are subject to the carrier's approval. Reinstatement payments may be required to be in the form of "guaranteed funds" i.e.: money order, bank check, cashier's check, etc. If a reinstatement is approved a reinstatement fee may apply.
4. Some insurance carriers do not allow reinstatements at any time.

**USFSB DUES POLICY**

1. Initial Membership Dues are refundable within 90 days of the effective date of the Membership, if you are not satisfied with your Membership, unless you wish to maintain any USFSB sponsored insurance coverage.
2. All payments of renewal Membership Dues are non-refundable.
3. You must be a dues paying member or a member of a dues paying organization to obtain and maintain any USFSB sponsored insurance coverage and/or maintain the privileges of Premium Membership.

**USFSB REFUND POLICY**

*If you are sent a refund check, the following rules apply:*

1. One time only, at your request and for good cause, we will send a reissued check upon receipt of the original check and if, for any reason, you cannot return the original check, a stop payment fee will be deducted from the amount of the reissued check.
2. If any refund check is not cashed or negotiated within six months of the date it was mailed to you, payment will be stopped, the refund will be deemed abandoned by you and no further checks will be issued.

Date \_\_\_\_\_

Company Name \_\_\_\_\_

Company Street Address \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City, ST \_\_\_\_\_ Zip \_\_\_\_\_

Telephone(\_\_\_\_\_) \_\_\_\_\_ Fax(\_\_\_\_\_) \_\_\_\_\_ Your Web Site \_\_\_\_\_

Owner/Principal  Ms.  Mr.  Mrs. \_\_\_\_\_

Title of Owner/Principal \_\_\_\_\_ E-mail \_\_\_\_\_

Type of Business/Trade \_\_\_\_\_ No. of Employees \_\_\_\_\_  
(including yourself)

**Annual Membership Fee..... \$ 100.00**

The annual membership fee will be reduced to \$60.00 if you enroll in any of USFSB's sponsored health or dental insurance, with an effective date within two months of your initial membership. Thereafter, on your membership renewal date, if you are enrolled in any of USFSB's sponsored health or dental insurance your annual membership fee will be \$60.00. If not, it will be \$100.00.

**Your Premium Membership gives you the opportunity to save money!**  
**Please visit our website, [www.usfsb.com](http://www.usfsb.com) and view the many products and services available to**

**Premium Members including:**

- Heartland Payment Systems (payroll services)
- Heartland Payment Systems (credit card services)
- LOW COST Health Insurance
- Office Products & Supplies Discounts
- International Health Insurance
- Movie Tickets & Resort Discounts
- Discount Prescription Card
- Member-To-Member Discount Program
- Free Web Pages (up to five pages)
- FedEx Shipping Discounts
- Sprint/Nextel Wireless Discounts
- McAfee Security (anti-virus software)
- LOW COST Dental Insurance
- Freightquote.com (discount freight shipping)
- Travel & Car Rental Program
- Collection Services Discounts
- LOW COST Vision Insurance
- USFSB Direct Marketing
- HighBeam Research
- FedEx Kinkos (printing service)

**We are confident that you will find your Premium Membership in USFSB to be a valuable asset**

**JOIN TODAY on our web site: [www.usfsb.com](http://www.usfsb.com)**

**Payment Information**       MasterCard       VISA

Account# \_\_\_\_\_

Expiration Date (Mo/Yr) \_\_\_\_\_ / \_\_\_\_\_

Signature \_\_\_\_\_

USFSB BROKER NUMBER (IF ANY): \_\_\_\_\_

**Enrollment Information**

**By Phone: Call 1-800-637-3331** MasterCard and VISA accepted.

**By Fax: Fax 1-518-370-4129 or 1-888-568-3823** Complete the Membership Application above, including the credit card information.

**By Mail:** Complete the Membership Application above and mail your personal or company check to:

**USFSB Inc., Attn: Membership Department, 249 Green Street, Schenectady, NY 12305**

**Office Hours: 9a.m.-5p.m. EST**

• **USFSB Use - Received:** \_\_\_\_\_

• **USFSB Use - Company No.:** \_\_\_\_\_

Payment must accompany application. Membership dues are deductible as an ordinary business expense. If within 90 days of your initial application you are not completely satisfied with your membership, USFSB will refund the membership dues in full. You must be a dues paying member to obtain and maintain any of USFSB's sponsored insurance.